STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395398	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Somerset Healthcare & Rehabilitation Center	228 Siemon Drive Somerset, PA 15501

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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 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. Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to store and prepare food in accordance with professional standards for food service safety.Findings include: The facility's policy for storage of refrigerated foods, dated February 4, 2026, revealed that refrigerated foods would be stored wrapped or in covered containers, labeled and dated and arranged in a manner to prevent cross contamination.Observations in the main kitchen on April 13, 2026, at 9:05 a.m. revealed a bowl of pasta salad that was opened and undated, a package of American cheese slices that was opened, wrapped in cellophane and undated in the walk in refrigerator; approximately one half of a jar of applesauce that was opened and undated, and one container of Lactaid milk that was opened and undated in the pantry refrigerator; a box of biscuits in the breakfast freezer that was open to the air; and a box of thickener in dry storage that was open to the air.Interview with the Dietary Director on April 13, 2026, at 9:05 a.m. confirmed that the food mentioned above should have been dated and not left open to air. 28 Pa. Code 211.6(f) Dietary 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

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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 a review of clinical records, observations, and resident and staff interviews, it was determined the facility failed to provide care in a manner that promotes and enhances each resident's dignity and quality of life by failing to respond in a timely manner to residents' requests for assistance for 1 resident out of 33 residents reviewed. (Resident 28). Findings include:A Comprehensive Minimum Data Set (MDS) assessment (a federally mandated assessment of a resident's abilities and care needs) for Resident 28 dated April 8, 2026, revealed that the resident was cognitively intact, was dependent on staff for toileting needs, and was always incontinent of bowel and urine.A review of Resident 28's comprehensive care plan, last revised on February 6, 2026, revealed a focus on bowel and bladder incontinence (inability to control urine or stool) with a history of chronic urinary tract infections and IBS, with interventions to include staff checking the resident for incontinence and changing the resident every two hours and as needed. Further review of the care plan revealed the resident required extensive assistance from two staff members for bed mobility.Observations of Resident 28 on April 17, 2026, at 12:15 p.m. revealed that the resident was waiting in the small dining area in the 200 hall and made a request to Nurse Aide 1 to go back to her room and Nurse Aide 1 replied that she would need to wait a minute. Observations of Nurse Aide 1 on April 17, 2026, at 12:26 p.m. walking into the dining area removing a tray from another resident and telling the resident she would be right back to take her to her room while ignoring and not acknowledging Resident 28. Observations of Nurse Aide 2 at 12:39 p.m. walking past the dining area and Resident 28 calling her over and requesting to go back to her room. Nurse Aide 2 went and got Nurse Aide 1 to assist resident to her bed. Observations of Resident 28 at 12:44 p.m. upon returning to her room revealed that she had been incontinent.Interview with Nurse Aide 1 on April 17, 2026, at 12:44 p.m. revealed that Resident 28 stated it was ok for her to wait until she was done removing lunch trays before taking her back to her room and Resident 28 spoke up and said, the hell I did, I told her it was ok to pass out trays first then take me to my room when she was done with that, not this long. Interview with Nurse Aide 1 also revealed that she had told Nurse Aide 3 to go to lunch prior to returning Resident 28 to her room and that she did not have the assistance she needed because Nurse Aide 3 went to lunch.Interview with Resident 28 on April 17, 2026, at 12:57 p.m. revealed that she requested to go back to her room due to being incontinent. Resident 28 did not want to state that in the dining area with other residents around. She simply requested to return to her room and once she was in the privacy of her room stated that she had been incontinent.Interview with the Assistant Director of Nursing on April 17, 2026, at 2:15 p.m. confirmed that the resident should have been returned to her room when requested. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.

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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 review of policies, as well as observations and staff interviews, it was determined that the facility failed to maintain a clean and homelike environment for one of 33 residents reviewed (Resident 49).Findings include: The facility's policy regarding a homelike environment, dated February 4, 2026, indicated that the facility was to provide a clean comfortable and homelike environment. A quarterly Minimum data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 49, dated February 18, 2026, revealed that the resident was cognitively intact and had diagnoses that included multiple sclerosis (a chronic medical condition where the immune system attacks the protective covering of the nerves in the brain and the spinal cord).Observations of Resident 49 on April 13, 2026, at 11:02 a.m., and April 14, 2026, at 10:50 a.m. respectively, revealed that she was lying in bed with a hole in the footboard of her bed measuring approximately six inches in diameter.Interview with the Director of Maintenance on April 14, 2026, at 11:34 a.m. revealed that he was unaware that Resident 49's bed had a hole in the footboard, and confirmed that it should have been replaced.28 Pa. Code 201.29(j) Resident Rights. 28 Pa. Code 207.2(a) Administrator's Responsibility.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on a review of facility policies and clinical records as well as staff interviews, it was determined that the facility failed to ensure that residents medication regime was free from unnecessary psychotropic medication (drugs that affect a person's mental state, emotions, and behavior) for one of 33 residents reviewed (Resident 37). Findings Include: A facility policy for psychotropic medication management dated February 4, 2026, indicated that as needed psychotropic medications shall be limited to no more than14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond the 14 days. The medical record should include documentation from the physician or prescriber for the rationale for the extended time period and indicate a specific duration. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 37, dated March 16, 2026, indicated that the resident was cognitively intact, required assistance with daily care needs, received antianxiety medications (psychotropic medications) and had a diagnosis of anxiety. Physician's orders for Resident 37, dated March 25, 2026, revealed that the resident was to receive 0.5 milligram (mg) of Lorazepam (psychotropic antianxiety medication) every 12 hours as needed for anxiety. Review of Resident 37's Medication Administration Record (MAR) for March and April 2026, revealed that the resident received 0.5 mg of Lorazepam on March 25 at 9:02 p.m.; March 27 at 7:51 p.m.; March 28 at 9:01 p.m.; March 29 at 8:35 p.m.; March 30 at 7:55 p.m.; March 31 at 7:15 p.m.; April 1 at 8:58 p.m.; April 2 at 7:26 p.m.; April 3 at 7:16 p.m.; April 4 at 9:07 p.m.; April 5 at 8:10 p.m.; April 6 at 9:41 p.m.; April 7 at 8:45 p.m.; April 8 at 8:52 p.m.; April 9 at 7:27 p.m.; April 10 at 9:14 p.m.; April 11 at 9:08 p.m.; April 13 at 8:59 p.m.; and April 14 at 8:59 p.m. There was no documented evidence that a physician provided the rationale as required to extend the as needed psychotropic medication past 14 days. Interview with the Director of Nursing on April 16, 2026, at 2:36 p.m. confirmed that the facility failed to ensure that Resident 37's as needed Lorazepam was limited to 14 days or had a clinical rationale for continuing beyond 14 days. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on review of policies, clinical records, and facility reports, as well as staff interviews, it was determined that the facility failed to conduct a thorough investigation to rule out abuse or neglect for two of 33 residents reviewed (Resident 28, 47). Findings include: The facility's policy regarding resident abuse/neglect, dated February 4, 2026, revealed that the facility would conduct a thorough investigation to determine facts specific to the case for any and all types of alleged violations.An Annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 28, dated April 8, 2026, revealed that the resident was cognitively intact, and was dependent on staff for daily care needs. A nursing note for Resident 28, dated April 8, 2026, at 5:08 p.m. revealed that the Nurse Aide notified the Registered Nurse that the resident had complaints of pain in her shoulder, and that during care she had assisted turning the resident and her bed moved. The resident's arm was jammed into the nightstand causing her shoulder pain. However there was no documented evidence that the facility investigated the above mentioned incident to rule out abuse or neglect as the cause.Interview with the Assistant Director of Nursing and Nursing Home Administrator on April 16, 2026, at 2:03 p.m. confirmed that the facility should have conducted an investigation into the cause of shoulder pain for Resident 28.A Quarterly MDS assessment for Resident 47, dated March 24, 2026, revealed that the resident was cognitively intact, was dependent on staff for daily care needs and had a diagnosis of Diabetic Neuropathy (a type of nerve damage caused by chronic high blood sugar).Investigation documents for Resident 47 dated April 3, 2026, at 1:45 p.m. revealed the writer was called to the residents room. Resident 47 was being transferred from bed to wheelchair utilizing mechanical lift and two staff members. Resident 47 was fidgeting in the sling and then reached out to grab his wheelchair. He then slid out of the sling onto the floor head first. Resident 47 was assessed and sustained a 3 cm laceration to the back of his head. No other injuries noted at time of assessment. The writer indicated the proper and correct size of sling was being used at the time of the transfer.A witness statement completed by Nurse Aide 4, dated April 3, 2026, revealed that she was transferring Resident 47 from his bed via a hoyer lift, and the resident slid from the sling and made contact with the floor. A witness statement completed by Nurse Aide 5, dated April 3, 2026, revealed that he was working with Nurse Aide 4 and when Resident 47 was being lifted he was reaching for his wheelchair and he slipped out of the sling and hit his head.There was no documented evidence that the facility's investigation indicated what type of lift was being used for the transfer and what type and size of sling was being used at the time of the transfer.Interview with the Director of Nursing on April 15, 2026, at 11:35 a.m. confirmed that she had no documented evidence that the investigation determined if the correct lift and sling was used at the time of the transfer when the resident slid out of the sling and onto the floor causing injuries and she should have.28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 201.18(e)(1) Management.28 Pa. Code 211.12(d)(1)(5) Nursing Services

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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 clinical record review, as well as staff interviews, it was determined that the facility failed to notify the resident's representative in writing regarding the reason for transfer to the hospital and to ensure that a bed-hold notice was provided to the resident's responsible party for four of 33 residents reviewed (Residents 1,10, 47, 82). Findings Include: A nursing note for Resident 1 dated February 14, 2025, at 7:51 p.m. revealed that the resident had been coughing all afternoon after eating a cookie and a large number of fluids. The physician was notified and advised to send the resident to the emergency room for evaluation. Review of Resident 1's clinical record revealed no documented evidence that that resident representative or the ombudsman was notified in writing of the transfer to the hospital on the above dates and times. A nursing note for Resident 10 dated September 8, 2025, at 2:40 a.m. revealed that during a dressing change the resident began spraying a steady stream of blood from his wound and was sent to the Emergency Room. A nursing note dated November 26, 2026, at 10:37 a.m. revealed that the resident was sent to UPMC Somerset Emergency Room. Review of Resident 10's clinical record revealed no documented evidence that that resident representative or the ombudsman was notified in writing of the transfer to the hospital on the above dates and times. A nursing note for Resident 47 dated April 3, 2026, at 1:45 p.m. revealed that the resident had a fall from a mechanical lift during a transfer, sustained injuries and was transferred to the hospital. Review of Resident 47's clinical record revealed no documented evidence that that resident representative or the ombudsman was notified in writing of the transfer to the hospital on the above dates and times. A nursing note for Resident 82 dated January 25, 2026, at 10:37 revealed that the resident was unresponsive and was being sent to the emergency room. Review of Resident 82's clinical record revealed that there was no documented evidence that the resident representative or the ombudsman was notified in writing of the transfer to the hospital. Interview with the Social Worker on April 16, 2026 at 9:26 a.m. revealed that she did not notify the resident's representative or the ombudsman of the hospital transfer for the resident's above, and was not aware that she was supposed to. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(2) Management .

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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 review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to develop and or implement a comprehensive care plan that included specific and individualized interventions to address the care needs of residents for two of 33 residents reviewed (Residents 5 and 12).Findings include: A facility policy for Care Plans, dated February 4, 2026, indicated that nursing staff and/or the interdisciplinary team were to develop and implement resident specific person-centered care plans. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated March 1, 2026, revealed that the resident was cognitively intact, required assistance with care needs and had a diagnosis of cancer. A care plan for the resident, dated February 12, 2026, indicated that the resident was receiving chemotherapy. Interview with Resident 5 on April 16, 2026, at 9:50 a.m. revealed that he was going for a PET (Positron Emission Tomography) scan (test used to detect cancer) today. He stated that he receives chemotherapy every three weeks and has had about four rounds so far. He indicated that he had a mediport (a surgically implanted device placed under the skin, usually in the upper chest, to provide easy, long-term access to a vein for chemotherapy, blood draws, and medications) and they use it for chemotherapy. He stated that they flush the port when he gets chemotherapy. A mediport was observed to his right chest. There was no documented evidence in the resident's clinical record that a care plan was developed for the mediport. Interview with the Director of Nursing on April 16, 2026, at 2:31 p.m. confirmed that there was no documented evidence in Resident 5's clinical record that a care plan was developed to reflect that the resident had a mediport. A quarterly MDS assessment for Resident 12, dated January 27, 2026, revealed that the resident was severely cognitively impaired, required extensive assistance from staff for her care, and had diagnoses that included vascular dementia and anxiety. Resident 12's current care plan, revised May 20, 2025, indicated that the resident was to have a Velcro STOP sign (a nylon banner that visually deters residents from entering) across her doorway. Observations of Resident 12's room/doorway on April 13, 14 and 15, 2026 respectively, revealed that she had no Velcro STOP safety banner in place across her doorway as care planned. Interview with the Social Service Director and Licensed Practical Nurse 6 on April 15, 2026, at 2:06 p.m. and 3:00 p.m. respectively, confirmed that the resident did not have a Velcro STOP safety banner across her doorway as care planned. They also revealed that Resident 65 roams throughout the facility and four other residents have STOP banners across their doorways to discourage her from entering those rooms. Interview with the Assistant Director of Nursing on April 15, 2026, at 3:25 p.m. confirmed that the resident did not have a Velcro STOP safety banner across her doorway as care planned, and she should have. 28 Pa. Code 211.11(d) Resident care plans.28 Pa. Code 211.12(d)(1)(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. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders were followed for one of 33 residents reviewed (Resident 49), and failed to obtain urine culture results for effective antibiotic treatment of a urinary tract infection for one of 33 residents reviewed (Resident 85).Findings include: Physician's orders for Resident 49, dated September 20, 2024, included an order for the resident to receive Refresh Relieva Opthalmic Solution 0.5-0.9% *Carboxymethylcellulose-Glycerin (eye drops used to rehydrate and protect hydration for eyes), instill 1 drop in both eyes three times a day for dry eyes unsupervised self-administration and may keep at bedside. Observations of Resident 49's room on April 16, 2026, at 10:10 a.m. revealed no evidence of Refresh Relieva Opthalmic Solution in her room. Interview with Licensed Practical Nurse 7 on April 16, 2026, at 10:10 a.m. revealed that she was not aware that Resident 49 did not have the physician ordered eye drops, and that the resident will inform staff when she needs more. Interview with Resident 49 on April 16, 2026, at 11:37 a.m. revealed that she has not had that eye drop for over a year. Interview with the Director of Nursing on April 16, 2026, at 1:51 p.m. confirmed that Resident 49 should have had her eye drops per physician's order. An admission note for Resident 85, dated April 7, 2026, at 5:24 p.m. indicated that the resident had a chronic indwelling catheter (a thin, flexible tube inserted into the bladder to drain urine from the bladder) related to cancer. An admission note for the resident, dated April 7, 2026, at 11:10 p.m. indicated the resident was admitted related to a fall and a urinary tract infection and that his indwelling catheter was draining dark, amber colored urine. A care plan for the resident, dated April 8, 2026, indicated that the resident had a urinary tract infection and he was receiving an antibiotic. Hospital discharge instructions for Resident 85, dated April 7, 2026, indicated that the resident had a pending urine culture (detects the specific bacteria in the urine to determine the best antibiotic for treatment) in process. Physician's orders for Resident 85, dated April 7, 2026, indicated that the resident was to receive 800-160 milligrams (mg) of Sulfamethoxazole-Trimethoprim (an antibiotic) every morning and at bedtime for a urinary tract infection for 20 administrations. Physician's notes for Resident 85, dated April 9, 2026, April 10, 2026, and April 13, 2026, respectively, revealed that the resident had a urinalysis showing many bacteria and were waiting on culture results. As of April 14, 2026, at 12:57 p.m. there was no documented evidence that the facility had obtained Resident 85's urine culture results from the hospital. Results of Resident 85's urine culture were obtained on April 14, 2026, at 2:24 p.m. The final results, dated April 9, 2026, showed that the resident had a positive urinalysis showing greater than 100, 000 colonies of Enterococcus faecalis (bacteria) with sensitivities (determines the best antibiotic for treatment) to Ampicillin, Daptomycin, Linezolid and Vancomycin (antibiotics). However, the resident had been receiving Sulfamethoxazole-Trimethoprim (an antibiotic without sensitivities to the bacteria) since admission to the facility on April 7, 2026. Interview with the Assistant Director of Nursing on April 15, 2026, at 12:19 p.m. indicated that the hospital would not give the results of Resident 85's urine culture to the facility because they were not the ordering physician; however, they were able to receive the results on April 14, 2026, when requested. 28 Pa. Code 211.12 (d) (1)(5) Nursing Services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on review of facility policies, as well observations and staff interviews , it was determined that the facility failed to maintain an environment free from potential safety hazards related to resident beds for three of 33 residents reviewed (Residents 10, 28, and 56) and by not having a formal system for choosing the correct mechanical lift sling for one of 33 residents reviewed (Resident 47).Findings include: A facility policy for safe and homelike environment dated, February 4, 2026, revealed the facility will provide a safe, clean, comfortable and homelike environment, and includes ensuring that the resident can receive care and services safely and that the physical layout of the facility both inside and outside, maximizes resident independence and does not pose a safety risk. Observations during care to Resident 28 on April 13, 2026, at 10:53 a.m. revealed that when the resident was being rolled in bed, the bed moved several feet the opposite direction from the resident and the resident was close to rolling out of bed. The wheels of Resident 28's bed could not be safely secured and locked so that the bed did not move during care, repositioning, or transfer of the resident. Observations of Resident 10's bed on April 13, 2026, at 11:13 a.m. revealed that the wheels did not safely lock and secure with the resident in the bed. Observations of Resident 58's bed on April 13, 2026, at 11:26 a.m. revealed that the wheels did not safely lock and secure with the resident in the bed. Interview with the Maintenance Director on April 13, 2026, at 11:30 a.m. revealed that he was not notified of any concerns by residents, staff, or visitors that the beds were not able to be locked and secured. He confirmed that he should have been notified and the beds should have been able to be locked and secured so that they did not move during care, repositioning, or transfers of the residents. A facility policy for using a mechanical lift (a battery-powered or hydraulic patient transfer device designed to safely move non-ambulatory, bedridden, or bariatric individuals) dated February 4, 2026, revealed that the facility will establish the general principles of safe lifting using a mechanical lift device and that it is not a substitute for the manufacturer's training or instructions. Steps in the facility's procedure included measuring the resident for proper sling size and purpose according to the manufacturer's instructions. Manufacturer's instructions for the Invacare Reliant Mechanical Lift dated 2022, recommend the use of an Invacare approved sling recommended by the individual's doctor, nurse or medical assistant for the comfort and safety of the individual being lifted. Invacare slings are made specifically for the use with Invacare patient lifts for the safety of the patient. Do not use slings and patient lifts from different manufacturers. A Quarterly MDS assessment for Resident 47, dated March 24, 2026, revealed that the resident was cognitively intact, was dependent on staff for daily care needs, required transfer with a mechanical lift and staff assistance of two, and had diagnoses that included diabetic neuropathy (a type of nerve damage caused by chronic high blood sugar). Facility investigation documents for Resident 47 dated April 3, 2026, at 1:45 p.m. revealed the writer was called to the resident's room. Resident 47 was being transferred from bed to wheelchair utilizing a mechanical lift and two staff members. Resident 47 was fidgeting in the sling and then reached out to grab his wheelchair. He slid out of the sling onto the floor headfirst. Resident 47 was assessed and had sustained a 3-centimeter (cm) laceration to the back of his head. He complained of arm pain, back pain and hip pain and was able to move all extremities. Resident 47 was sent to the emergency room for evaluation. The writer indicated that the proper and correct size of sling was being used at the time of the transfer. Observations in the shower room on April 14, 2026, at 11:15 a.m. revealed an Invacare reliant mechanical lift, several slings of different colors with faded labels, with no indication of weight limits or size information. Interview with Nurse Aide 3 on April 14, 2026, at 10:51 a.m. revealed that if she needs a sling, she just looks at the sling to see if it would fit the resident by holding it up to see if it is big enough. She also stated that she asks the resident which sling is usually used or checks with the Licensed Practical Nurse. Observations in the shower room with the Assistant Director of Nursing on April 16, 2026, at 2:38 p.m. revealed several slings of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	different colors and fabrics with faded labels with no indication of weight limits or size information or that they were compatible with the facility's lift equipment. Interview with Assistant Director of Nursing on April 16, 2026, at 2:45 p.m. confirmed that the facility does not have a formal system for choosing the correct patient lift sling to ensure safety and compatibility with lifting equipment. Interview with the Nursing Home Administrator on April 16, 2026, at 3:17 p.m. confirmed that the facility does not have a formal system for choosing the correct patient lift sling to ensure safety and compatibility with lifting equipment. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395398	A. Building B. Wing	04/16/2026

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on review of policies and clinical records, as well as resident and staff interviews, it was determined that the facility failed to provide appropriate care for one of 33 residents reviewed (Resident 85) who had an indwelling urinary catheter. Findings include: The facility's policy regarding catheter use, dated February 4, 2026, indicated that residents with indwelling catheters should receive appropriate care for the catheter in accordance with current professional standards of practice. An admission note for Resident 85, dated April 7, 2026, at 5:24 p.m. indicated that the resident had a chronic indwelling catheter (a thin, flexible tube inserted into the bladder to drain urine from the bladder) related to cancer. An admission note for the resident, dated April 7, 2026, at 11:10 p.m. indicated that the resident was admitted related to a fall and urinary tract infection and his indwelling catheter was draining dark, amber colored urine. Observations of Resident 85 on April 13, 2026, at 11:37 a.m. revealed that the resident was sitting in wheelchair in his room with his urinary catheter bag hanging under his wheelchair with the bag and tubing in direct contact with the floor with no dignity/privacy cover on the urinary bag. Interview with Registered Nurse 8 on April 13, 2026, at 11:42 a.m. confirmed that Resident 85's urinary catheter bag and tubing were lying in direct contact with the floor and should not have been, and he confirmed that there was no dignity/privacy cover on the catheter bag. Interview with the Nursing Home Administrator on April 13, 2026, at 3:30 p.m. confirmed that Resident 85's urinary catheter bag and tubing should not have been on the floor and there should have been a dignity/privacy cover on the urinary bag. A care plan for Resident 85, dated April 7, 2026, indicated that the resident had a urinary catheter and indicated that staff were to monitor and document urinary output per facility policy. A facility task for the resident indicated that urinary catheter output was to be documented every shift. Review of Resident 85's clinical record revealed that there was no documented evidence that his urinary catheter output was documented on April 10, 2026, on the day shift; April 12, 2026, on the evening shift; and April 9 through April 13, 2026, on the night shift. Interview with the Director of Nursing on April 14, 2026, at 3:05 p.m. confirmed that Resident 85's urinary catheter output was not documented on the above-mentioned dates/shifts and they should have been. 28 Pa. Code 211.12(d)(1)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents who were receiving enteral feedings received appropriate treatment and services to prevent complications for one of 33 residents reviewed (Resident 5). Findings include: A facility policy regarding care and treatment of feeding tubes, dated February 4, 2026, indicated that in accordance to facility protocol, licensed nurses will monitor and check that the feeding tube is in the right location. Tube placement will be verified before beginning a feeding and before administering medications. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated March 1, 2026, revealed that the resident was cognitively intact, required assistance with care needs, had a feeding tube and had a diagnosis of cancer. A care plan for the resident, dated February 24, 2026, indicated that the resident had a feeding tube and staff were to check for tube placement and gastric contents/residual per facility protocol. Physician's orders for Resident 5, dated February 26, 2026, included orders for the resident to receive Glucerna 1.2 Cal enteral feedings three times a day at 8:00 a.m., 12:00 p.m. and 7:00 p.m. continuous at a rate of 120 milliliters (ml) per hour via his peg tube and to take down approximately three hours or when total volume of 360 cubic centimeters (cc) have been infused. Physician's orders for Resident 5, dated March 4, 2026 and March 16, 2026, included orders for the resident to receive bolus Glucerna 1.2 Cal enteral feedings four times a day at 6:00 a.m., 10:00 a.m., 4:00 p.m. and 8:00 p.m. in the amount of 237 mL via his peg tube. Physician's orders for Resident 5, dated April 13, 2026, included orders for the resident to receive bolus Glucerna 1.2 Cal enteral feedings four times a day at 6:00 a.m., 10:00 a.m., 4:00 p.m. and 8:00 p.m. in the amount of 237 mL via his [NAME]. Review of Resident 5's clinical record revealed that there was no documented evidence that feeding tube placement was verified prior to beginning feedings as per the facility policy. A facility policy related to medication administration via enteral tube, dated February 4, 2026, indicated that enteral tube placement must be verified prior to administering any fluids or medications. Physician's orders for Resident 5, dated February 24, 2026, included orders for staff to flush his peg tube with 30 cc of water before and after medications and feedings. Review of Resident 5's clinical record revealed that there was no documented evidence that feeding tube placement was verified prior to administering any fluids or medications as per the facility policy. Interview with the Director of Nursing on April 16, 2026, at 12:44 p.m. confirmed there was no documented evidence in Resident 5's clinical record that feeding tube placement was verified prior to administering feedings and before and prior to administering any fluids or medications as per the facility policy. 28 Pa. Code 211.12(d)(3)(5) Nursing services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to maintain accountability for controlled medications (drugs with the potential to be abused) for two of 33 residents reviewed (Residents 37 and 49). Findings include: The facility's policy for medication administration, dated February 4, 2026, indicated that staff are to sign the Medication Administration Record (MAR) after a medication is administered; and if the medication is a controlled substance, staff are to sign the narcotic book. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 37, dated March 16, 2026, indicated that the resident was cognitively intact, required assistance with daily care needs, and was receiving routinely scheduled and as needed pain medication. Physician's orders for Resident 37, dated January 21, 2026, included orders for the resident to receive 5 milligrams (mg) of oxycodone (a narcotic pain medication) every six hours as needed for pain. Physician's orders for Resident 37, dated March 18, 2026, included orders for the resident to receive 5 mg of oxycodone every six hours as needed for pain. Review of the controlled drug records (a form that accounts for each tablet/pill/dose of a controlled drug) for Resident 37 for February 2026, March 2026 and April 2026, revealed that a 5 mg tablet of oxycodone was signed out on February 22, 2026, at 7:00 a.m.; February 26, 2026, at 7:00 a.m.; February 28, 2026, at 8:41 p.m.; March 22, 2026, at 8:30 p.m.; April 3, 2026, at 8:46 a.m.; and April 12, 2026, at 7:57 p.m. However, there was no documented evidence in Resident 37's clinical record that the signed-out doses of oxycodone were administered to the resident on the above-mentioned dates and times. Interview with the Director of Nursing on April 16, 2026, at 3:40 p.m. confirmed that there was no documented evidence in Resident 37's clinical record to indicate that the signed-out doses of oxycodone were administered to the resident on the above-mentioned dates and times. A Quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 49, dated February 18, 2026, indicated that the resident was cognitively intact, required assistance with daily care needs, and was receiving as needed pain medication. Physician's orders for Resident 49, dated June 25, 2025, included orders for the resident to receive 5 milligrams (mg) of oxycodone (a narcotic pain medication) every six hours as needed for pain. Review of the controlled drug records (a form that accounts for each tablet/pill/dose of a controlled drug) for Resident 49 for February 2026, revealed that a 5 mg tablet of oxycodone was signed out on February 6, 2026 at 6:00 a.m. However, there was no documented evidence in Resident 49's clinical record that the signed-out doses of oxycodone were administered to the resident on the above-mentioned dates and times. Interview with the Director of Nursing on April 16, 2026, at 3:38 p.m. confirmed that there was no documented evidence in Resident 49's clinical record to indicate that the signed-out doses of oxycodone were administered to the resident on the above-mentioned date and time. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations, and staff interviews, it was determined that the facility failed to provide a separately-locked, permanently-affixed compartment in the refrigerator for the storage of controlled drugs in one of one medication rooms reviewed. Findings include: Observations in the facility's medication room on A-Wing on April 15, 2026, at 10:55 a.m. revealed two locked compartments in the medication refrigerator that were secured to a shelf, and the shelf was not secured to the refrigerator and was able to be removed. This unsecured shelf with two locked compartments contained two opened bottles of liquid lorazepam (a controlled medication used to treat anxiety) and one unopened bottle of liquid lorazepam. Interview with Registered Nurse 9 at the time of the observation confirmed that the shelf with the fixed locked narcotic box was not secured to the refrigerator and was able to be removed from the refrigerator. Interview with the Nursing Home Administrator on April 15, 2026, at 10:57 a.m. confirmed that the shelf with the fixed locked narcotic box in the refrigerator in the A-wing medication room should be permanently affixed to the refrigerator and not able to be removed. 28 Pa. Code 211.9(a)(1) Pharmacy Services.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on a review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain clinical records that were complete and accurately documented for two of 33 residents reviewed (Residents 37 and 49).Findings include:The facility's policy for medication administration, dated February 4, 2026, indicated that staff are to sign the Medication Administration Record (MAR) after a medication is administered, and if the medication is a controlled substance, staff are to sign the narcotic book.A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 37, dated March 16, 2026, indicated that the resident was cognitively intact, required assistance with daily care needs, and was receiving routinely scheduled and as needed pain medication.Physician's orders for Resident 37, dated January 21, 2026, included orders for the resident to receive 5 milligrams (mg) of oxycodone (a narcotic pain medication) every six hours as needed for pain.Physician's orders for Resident 37, dated March 18, 2026, included orders for the resident to receive 5 mg of oxycodone every six hours as needed for pain.A review of Resident 37's MAR, dated January and April 2026, revealed that 5 mg of oxycodone was administered to the resident on January 29 at 8:35 a.m.; April 4 at 7:16 a.m.; and April 5 at 7:16 a.m. However, a review of the resident's controlled medication record (a form that accounts for each tablet/pill/dose of a controlled drug) for January and April 2026, revealed no documented evidence that 5 mg of oxycodone was signed out for administration on the above-mentioned dates and times. Interview with the Director of Nursing on April 16, 2026, at 3:40 p.m. confirmed that there was no documented evidence on Resident 37's controlled medication record to indicate that 5 mg of oxycodone was signed out for administration on the above-mentioned dates and times. A Quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 49, dated February 18, 2026, indicated that the resident was cognitively intact, required assistance with daily care needs, and was receiving as needed pain medication.Physician's orders for Resident 49, dated January 21, 2026, included orders for the resident to receive 5 milligrams (mg) of oxycodone (a narcotic pain medication) every six hours as needed for pain.Physician's orders for Resident 49, dated October 10, 2024, included orders for the resident to receive 0.5mg clonazepam (a medication used to treat anxiety) every 12 hours.A review of Resident 49's MAR, dated 2026, revealed that 5 mg of oxycodone was administered to the resident on March 10, 2026 at 8:17 p.m., and 0.5mg clonazepam was administered on April 1, 2026, at 9:00 a.m. However, a review of the resident's controlled medication record (a form that accounts for each tablet/pill/dose of a controlled drug) for March and April 2026, revealed no documented evidence that 5 mg of oxycodone was signed out for administration on the above-mentioned date and time, and that 0.5mg clonazepam was signed out in error on the above date and time.Interview with the Director of Nursing on April 16, 2026, at 3:40 p.m. confirmed that there was no documented evidence on Resident 49's controlled medication record to confirm that 5mg of oxycodone and 0.5mg of clonazepam were administered on the above dates and times.28 Pa Code 211.5(f) Clinical Records.28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include:.The facility's deficiencies and plans of corrections for a State Survey and Certification (Department of Health) survey ending March 13, 2025, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility-maintained compliance with cited nursing home regulations. The results of the current survey, ending April 16, 2026, identified repeated deficiencies related to care plan revision/implementation, quality of care, labeling/storage/disposal of medications, and proper infection control practices. The facility's plan of corrections for deficiencies regarding developing/implementing comprehensive care plans, cited during the survey ending March 13, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F656, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding developing/implementing comprehensive care plans.The facility's plan of correction for a deficiency regarding quality of care cited during the survey ending March 13, 2025, revealed that quality of care would be monitored by QAPI. The results of the current survey, cited under F684, revealed that the QAPI committee was ineffective in maintaining compliance with regulations regarding quality of care. The facility's plan of correction for a deficiency infection cited during the survey ending March 13, 2025, revealed that infection control would be monitored by QAPI. The results of the current survey, cited under F880, revealed that the QAPI committee was ineffective in maintaining compliance with regulations regarding infection control. The facility's plan of corrections for deficiencies regarding the storage/labeling/disposal of medications, cited during the survey ending March 13, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F761, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with the regulations regarding labeling/storage/disposal of medications.Refer to F656, F684, F761, F880. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(e)(1) Management.

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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. Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that appropriate signage was posted for a resident with special infection control isolation needs for two of 33 residents reviewed (Residents 5 and 79). Findings include: The facility's policy regarding Enhanced Barrier Precautions (EBP-infection control intervention designed to reduce transmission of multi-drug resistant organisms (a germ that is resistant to many antibiotic making treatment difficult) that employs targeted gown and glove use during high contact resident care activities), dated February 4, 2026, indicated that an order for enhanced barrier precautions will be obtained for residents with indwelling medical devices, such as urinary catheters (a thin, flexible tube inserted into the bladder to drain urine from the bladder),and feeding tubes (a mechanical device surgically implanted into the stomach to provide nutrition, fluids and medications to a person who is unable to eat or drink by mouth). A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated March 1, 2026, revealed that the resident was cognitively intact, required assistance with care needs, had a feeding tube and had a diagnosis of cancer. A care plan for the resident, dated February 23, 2026, indicated that the resident had a feeding tube and was on EBP. Physician's orders for Resident 5, dated February 24, 2026, included orders for Enhanced Barrier Precautions related to having a feeding tube. Observations of Resident 5's room on April 13, 2026, at 11:33 a.m. and again on April 15, 2026, at 9:38 a.m. revealed that there were no EBP signs posted at the entrance to the resident's room or inside the resident's room. An admission note for Resident 79, dated April 2, 2026, at 11:53 p.m. indicated that the resident was admitted with a urinary tract infection and had an indwelling catheter in place. A care plan for the resident, dated April 3, 2026, indicated that the resident had an indwelling catheter and was on EBP. Physician's orders for Resident 79, dated April 2, 2026, included orders for Enhanced Barrier Precautions related to having an indwelling catheter. Observations of Resident 79's room on April 13, 2026, at 11:50 a.m. and again at 2:44 p.m. revealed that there were no EBP signs posted at the entrance to the resident's room or inside the resident's room. Interview with the Assistant Diirector of Nursing/Infection Preventionist on April 15, 2026, at 12:27 p.m. confirmed that there was no signage posted at the entrance to Resident 5's and Resident 79's rooms or inside the resident's rooms to indicated they were on EBP. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observations and staff interviews, it was determined that the facility failed to ensure resident beds were in safe operating condition for 3 of 33 residents reviewed (Residents 28, 37 and 53).Findings include: An Annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 28, dated April 8, 2026, revealed that the resident was cognitively intact, and was dependent on staff for daily care needs.Observations in Resident 28's room on April 13, 2026, at 9:29 a.m. revealed that her bed was locked, however, it moved freely while locked. Interview with Resident 28 at the time of the observation revealed that the bed not locking had been an issue.Interview with Nurse Aide 2 on April 13, 2026, at 9:29 a.m. revealed that she was aware that the bed has not been locking and that she informed the Licensed Practical Nurse when she first noticed it.Interview with Licensed Practical Nurse 10 on April 13, 2026, at 11:37 a.m. confirmed that she was told that Resident 28's bed moved, and she told the Nurse Aides to lock the bed but did not check the bed to see if there was an issue with the bed wheels not locking and securing.A significant change MDS assessment for Resident 37, dated March 16, 2026, indicated that the resident was cognitively intact, required moderate assistance with bed mobility and was dependent on staff for transfers from bed to chair and chair to bed. Observations in Resident 37's room on April 13, 2026, at 12:03 p.m. revealed that her bed was locked, however, it moved freely while locked. Interview with Resident 37 at the time of the observation revealed that the bed not locking had been an issue. Interview with Nurse Aide 11 on April 13, 2026, at 2:26 p.m. revealed that she was aware that the bed did not lock fully and moved, but did not make anyone aware. She indicated that she never had an issue with it when doing care on the resident and stated if you know what you are doing, it's not an issue. Observations in Resident 63's room on April 13, 2026, at 12:45 p.m. revealed that her bed was locked, however, it moved freely while locked. Interview with the director of maintenance on April 13, 2026, at 12:45 p.m. confirmed that he was not made aware verbally or in writing through a work order that the wheels on the beds mentioned above did not lock securely. 28 Pa. Code 201.18(b)(3) Administrator's Responsibility.