STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395401	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ball Pavilion, The	5416 East Lake Road Erie, PA 16511

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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 - 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 policies, observations, and staff interviews, it was determined that the facility failed to ensure that food was stored in accordance with standards for food safety for one of six kitchen refrigerators, and three of three pantry refrigerator/freezers; and failed to monitor resident's personal refrigerators for temperatures for one of one residents reviewed with personal refrigerators (Resident R55).Findings include: Review of a facility policy entitled Cooler and Freezer Storage dated 2/19/26, revealed Leftover prepared foods will be discarded if not used within three days of preparation. Review of a facility policy entitled Pantry Stock of Nursing Units and Dining Rooms dated 2/19/26, revealed A server will stock the pantries on A, B, and C and dining rooms with food supplies each morning and evening; All outdated food items will be discarded; Leftover food items will be discarded if not used within three days; At your service items will be discarded if not used within 30 days. No policy was provided regarding Personal Refrigerators. Observations during a kitchen tour on 3/24/26, at 12:15 p.m. of cooler six revealed two pitchers of iced tea dated 3/17/26. During an interview with the Dietary Manager on 3/24/26, during the time of observation, he/she confirmed that the two pitchers of iced tea were past the use by date and should be discarded. Observation on 3/24/26, at 12:35 p.m. of resident refrigerator/freezer in A Hall pantry revealed three frozen prepared individually wrapped chicken breasts dated 10/22/25. During an interview with the Dietary Manager on 3/24/26, during the time of observation, he/she confirmed the three frozen prepared chicken breasts were expired and should be discarded. He/she further confirmed that the frozen chicken breasts were an at your service item and should be discarded if not used within 30 days. Observation on 3/24/26, at 12:40 p.m. of resident refrigerator/freezer in C Hall pantry revealed the following: one single serve yogurt cup with an expiration date of 2/5/26, one single serve yogurt cup with an expiration date of 2/17/26, two single serve yogurt cups with an expiration date of 3/9/26, one single serve yogurt cup with an expiration date of 3/17/26, five single serve yogurt cups with an expiration date of 3/19/26, two frozen prepared hamburger patties dated 2/10/26, one frozen prepared hamburger patty dated 10/23/25, and three frozen prepared hamburger patties dated 2/20/26. During an interview with the Dietary Manager on 3/24/26, during the time of observation, he/she confirmed the ten single serve yogurt cups were expired and should be discarded, and six frozen hamburger patties were expired and should be discarded. He/she further confirmed that the frozen hamburger patties were an at your service item and should be discarded if not used within 30 days. Observation on 3/24/26, at 12:50 p.m. of resident refrigerator/freezer in B Hall pantry revealed three frozen prepared hamburger patties dated 2/20/26, and seven frozen prepared hamburger patties dated 2/10/26. During an interview with the Dietary Manager on 3/24/26, during the time of observation, he/she confirmed the ten frozen hamburger patties were expired and should be discarded. He/she further confirmed that the frozen hamburger patties were an at your service item and should be discarded if not used within 30 days. Observation on 3/25/26, at 10:00 a.m. revealed Resident R55 had a personal refrigerator in his/her room. There was no evidence in the room of a temperature log sheet being present. During an interview on 3/25/26, at 10:45 a.m. the Nursing Home Administrator confirmed the facility lacked evidence of monitoring the refrigerator temperatures for (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident R55's personal refrigerator. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(e)(2.1) Management

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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 review of facility policy, observations, and staff interviews, it was determined that the facility failed to prevent the potential for cross contamination (the spreading of germs/microorganisms from one surface to another) during the administration of intravenous (IV) medications for one resident (Resident R49); the administration of feeding tube medications for one resident (Resident R52); and the administration of oral medications for two residents (Residents R15 and R63) observed during medication administration.Findings include:A facility policy entitled, Enhanced Barrier Precautions dated 2/19/26, indicated that enhanced barrier precautions will be implemented for all staff who care for residents during high-contact care activities and included device care and/or use of central lines and feeding tubes. A facility policy entitled, StatSafe (on-site medication dispensing system) - Assigning and Removing Access dated 2/19/26, indicated that licensed nurses will re-dispense doses when medications are dropped. A facility policy entitled, Hand Hygiene Monitoring dated 2/19/26, included the Hand Hygiene Monitoring Procedure which indicated that staff are expected to use a towel to turn off the water faucet and discard the towel. Resident R52's clinical record revealed an initial admission date of 7/17/25, with diagnoses that included pleural effusion (excess fluid build-up around the lungs), pneumonia (infection in your lungs that can cause difficulty breathing, fever and cough), kidney disease, irregular heartbeat. Resident R52's clinical record revealed a physician's order dated 3/03/26, for infection control enhanced barrier precautions [EBP] d/t PICC line (long, flexible tube (catheter) that is inserted into a vein in your upper arm to administer medications), and an order to administer cefazolin sodium {Rocephin (antibiotic)] intravenously three times a day into a venous catheter. Observation on 3/24/26, at 1:49 p.m. revealed EBP signage posted outside of Resident R52's door that indicated all staff are to wear gloves and gowns to perform high-contact care, and a supply of personal protective equipment [PPE (gowns, gloves, etc.)] was present. Registered Nurse Employee E5 donned gloves, flushed the PICC line with 10 cc of normal saline, and administered IV Rocephin through the PICC line and failed to don a gown prior to the administration. Observation on 3/25/26, at 8:35 a.m. revealed that Licensed Practical Nurse (LPN) Employee E4 opened the medication cart drawer, and removed an opened clear plastic pharmacy pill pack, reached inside the drawer with a bare hand and retrieved three pills that were lying loose in the drawer, and placed them inside a medication cup. LPN Employee E4 continued to prepare and administer the medications to Resident R49. Resident R49's clinical record revealed an initial admission date of 1/09/24, with diagnoses that included dementia, pneumonitis (lungs are irritated or inflamed by various factors, such as medications, molds, chemicals, or infections), and gastrostomy status [g-tube (feeding tube inserted through the abdomen directly into the stomach to provide nutrition, fluids, and medications when oral intake is insufficient)]. Resident R49's clinical record revealed a physician's order dated 10/28/25, for infection control EBP d/t g-tube. Observation on 3/25/26, at 8:42 a.m. revealed EBP signage posted outside of Resident R49's door that indicated all staff are to wear gloves and gowns to perform high-contact care, and a supply of personal protective equipment [PPE (gowns, gloves, etc.)] was present. LPN Employee E4 washed his/her hands and then turned off the spigot using a bare hand. LPN Employee E4 then donned gloves and proceeded to administer medications through a g-tube and failed to don a gown. During an interview at that time, LPN Employee E4 confirmed that he/she should have used a towel to turn off the spigot and stated that gowns are worn when the resident has an infectious disease. Observation on 3/25/26, at 9:00 a.m. revealed that LPN Employee E4 poured five medications from the clear plastic pharmacy pill pack into a medication cup, then tipped the medication cup to drop the tablets into the clear plastic pill crushing sheath while holding the capsule inside the medication cup with his/her bare finger. He/she proceeded to prepare the medications and administer them to Resident R15. During an interview at that time LPN Employee E4 confirmed that he/she picked up the medications with his/her hands and then administered them to residents. Observation on 3/25/26, at 9:10 a.m. revealed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that LPN Employee E3 removed a soft gel cap medication from the pharmacy bottle with his/her bare hand and placed it in the medication cup. He/she proceeded to prepare medications and administer them to Resident R63. During an interview at that time LPN Employee E3 confirmed that he/she should not have used their bare hand to touch the medication. During an interview on 3/25/26, at 10:05 a.m. the Director of Nursing confirmed that protective gowns should be worn while administering medications through an IV and g-tube, and medications should not be handled with bare hands, and loose medications should be discarded. During an interview on 3/25/26, at 11:20 a.m. the Infection Preventionist confirmed that staff should use a towel to turn off the spigot, and wear gowns during medication administration through an IV or g-tube. 28 Pa. Code 211.10(c)(d) Resident care policies28 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 review of facility policy, clinical records, and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider upon transfer to the hospital for three of 15 residents reviewed (Residents R4, R5, and R62).Findings include:Review of facility policy entitled Transfer to Hospital/Emergency dated 2/19/26, indicated Transfer of resident with the necessary paperwork and notifications once decision is made to transport; Nurse is to inform Emergency Department of transfer and will make copies of Face Sheet, Living Will (if resident has one), out of facility DNR, print out resident transfer sheet, vaccine records, and any other resident clinical records deemed necessary to be sent.Resident R4's clinical record revealed an admission date of 12/9/18, with diagnos2s that included Cerebral Infarction (a condition where a part of the brain is damaged or dies due to a lack of blood supply), Anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and High Blood Pressure.Resident R4's progress notes revealed notes dated 12/6/25, indicating a transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider.Resident R5's clinical record revealed an admission date of 7/8/24, with diagnoses that included gastro-esophageal reflux disease (GERD-a condition where stomach acid flows back into the esophagus [tube that passes food from the mouth into the stomach]), Depression (characterized by persistent feeling of sadness loss of interest in activities once enjoyed), and muscle weakness.Resident R5's progress notes revealed notes dated 1/29/26, indicating a transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. Resident R62's clinical record revealed an admission date of 2/18/26, with diagnoses that included Acute Respiratory Failure, Heart failure, and Dementia.Resident R4's progress notes revealed notes dated 3/6/26, indicating a transfer to assisted living. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider.During an interview on 3/27/26, at 10:00 a.m. the Director of Nursing confirmed that Residents R4, R5, and R62's clinical records lacked evidence that the necessary clinical information was provided to the receiving healthcare provider upon transfer and when the transfers occurred clinical information should have been provided to the receiving healthcare provider.28 Pa. Code 201.18(e)(1) Management28 Pa. Code 201.29(c.3) (2) Resident rights

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of facility policy and clinical records and staff interview, it was determined that the facility failed to review and/or revise resident care plans for two of 15 residents reviewed (Residents R5, and R55).Findings include: Review of facility policy entitled Care Plans dated 2/19/26, revealed that the Interdisciplinary Team will formulate goals and approaches after identifying resident problems/conditions; goals should be measurable and have a time frame for completion or evaluation; periodic reviews and revisions of each resident will be done. Resident R5's clinical record revealed an admission date of 7/8/24, with diagnoses that included gastro-esophageal reflux disease (GERD-a condition where stomach acid flows back into the esophagus [tube that passes food from the mouth into the stomach]), Depression (characterized by persistent feeling of sadness loss of interest in activities once enjoyed), and muscle weakness. Review of Resident R5's comprehensive care plan on 3/25/26, revealed that of the 31 care plans present, 28 had an outstanding target date (an identified date a care plan should be reviewed/revised) of 12/31/25, and two had an outstanding target date of 3/4/26. The care plans included the problem categories of: anticoagulant therapy, diuretic therapy, congestive heart failure, risk for dehydration, risk for infection, risk for malnutrition, pressure ulcer, range of motion, antidepressant medication, enhanced barrier precautions (EBP), risk for urinary tract infection, cognition, urinary tract infection, pain, treatment, decreased cardiac output, personalized care, wound management, depression, pain control, EBP related to ESBL (type of bacteria infection), impaired physical mobility, coping, sensory perception, self-care, risk for bleeding, altered fluid balance, skin integrity, cardiac function, and fluid restriction. Resident R55's clinical record revealed an admission date of 10/30/25, with diagnoses that included Diabetes (a health condition caused by the body's inability to produce enough insulin), kidney disease (the gradual loss of kidney function), and high blood pressure. Review of Resident R55's comprehensive care plan on 3/25/26, revealed that of the nine care plans present, six had an outstanding target date of 11/19/25. The care plans included the problem categories of: personalized care, risk for urinary tract infection, psychosocial wellbeing, skin tear, discharge planning, and pain. During an interview on 3/25/26, at 2:15 p.m. the Registered Nurse Assessment Coordinator confirmed that Resident R5 and Resident R55's care plans were not reviewed and/or revised as required. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of Title 49, Chapter 21 of the Pennsylvania Code and clinical records, observations, and staff interview, it was determined that the facility failed to provide services that adhered to accepted standards of practice for one resident's admission assessment (Resident R1) and one of seven residents observed during medication administration (Resident R63).Findings include: Review of Title 49 Pa. Code S 21.145. Functions of the Licensed Practical Nurse (LPN) stated (a) the LPN participates in the planning, implementation and evaluation of nursing care . (1) an LPN shall communicate with a licensed professional nurse and the patient's health care team members to seek guidance when: (i) the patient's care needs exceed the licensed practical nursing scope of practice. Resident R63's clinical record revealed an admission date of 3/24/26, with diagnoses that included spinal stenosis (narrowing of spaces within the spine, which can compress the spinal cord and nerves, leading to pain, numbness, or weakness), spondylolisthesis (degenerative condition that affects the spine and causes arthritis in the joints and disks), and radiculopathy of the middle back (pinching of a nerve root in the spine that can cause pain, weakness, numbness and tingling). Resident R63's clinical record lacked evidence that a self-medication assessment was completed and/or evidence of a care plan and/or physician's order to permit Resident R63 to administer his/her own medications. Observation on 3/25/26, at 9:10 a.m. revealed that Licensed Practical Nurse (LPN) E3 prepared and delivered medications to Resident R63, observed the resident self-administer his/her nasal spray and proceeded to exit the room and leave the resident's oral medications sitting on the tray table. During an interview at that time, LPN Employee E3 stated that Resident R63 was alert and oriented times four and so it is okay to leave his/her medications for them to take. During an interview on 3/25/26, at 10:05 a.m. the Director of Nursing confirmed that medications should not be left in resident rooms and that staff should observe residents take their medications. Resident R1's clinical record revealed an admission date of 2/27/26, with diagnoses that included bacterial pneumonia (infection of your lungs caused by certain bacteria), spinal stenosis, high blood pressure, and vertigo (sensation of spinning and feeling off balance). Resident R1's admission assessment revealed that his/her admission assessment dated [DATE], was completed by an LPN. Resident R1's departmental admission progress note dated 2/27/26, indicated that the admission assessment was completed by an LPN. During an interview on 3/26/26, at 11:15 a.m. Registered Nurse Employee E5 and the Infection Preventionist confirmed that Resident R1's admission assessment and following baseline care plan was completed by an LPN. During an interview on 3/26/26, at 11:38 a.m. the Registered Nurse Assessment Coordinator confirmed that Resident R1's admission assessment and baseline care plan was completed by an LPN. 28 Pa. Code 211.10(d) Resident care policies28 Pa. Code 211.12(d)(1)(2)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on review of facility policy and clinical records, observation, and staff interview it was determined that the facility failed to appropriately maintain respiratory care equipment to prevent the spread of infection regarding respiratory care equipment for one of 15 residents (Resident R1).Findings include: A facility policy entitled, Oxygen Concentrator (medical device that extracts oxygen from ambient air and delivers a concentrated oxygen supply to patients who need supplemental oxygen) Operation dated 2/19/26, indicated that oxygen tubing is be hung on the wall with specific label when not in use and/or change in deliver to portable oxygen. Resident R1's clinical record revealed an admission date of 2/27/26, with diagnoses that included congestive heart failure (chronic condition where the heart is unable to pump blood effectively, leading to fluid buildup in the lungs and other body parts), spinal stenosis (narrowing of the spine, which puts pressure on the spinal cord & nerves & can cause pain) of the neck and mid-back, and high blood pressure. A physician's order dated 2/27/26, revealed to administer oxygen via oxygen concentrator/portable at two liters per minute every shift. Observation on 3/24/26, at 1:00 p.m. revealed Resident R1 sitting in his/her room with the supplemental oxygen tubing from the concentrator in his/her nose and the oxygen tubing cannula for his/her portable oxygen canister was hanging over the top of the canister that was attached to the back of the wheelchair. Interview with LPN Employee E2 at that time, confirmed that the tubing for the portable canister should not be hanging over the top of the canister on the back of the wheelchair. Observation on 3/25/26, at 11:10 a.m. revealed Resident R1 sitting in his/her wheelchair with his/her feet on top of the bed. The concentrator tubing was in his/her nose and the tubing from the portable oxygen canister was hanging over the top of the canister that was attached to the back of the wheelchair. Observation on 3/25/26, at 11:20 a.m. revealed Resident R1's tubing from concentrator was lying on the top of his/her bed and Resident R1 was no longer in the room. During an interview at that time, the Infection Control nurse confirmed that the tubing should be hanging on the hook on the wall when not in use. 28 Pa. Code 211.12(d)(1)(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, review of facility policies, and staff interviews, it was determined that the facility failed to discard an outdated multi-dose vial of Tuberculin (solution used to test for Tuberculosis) in one of three medication room refrigerators (Unit B), and a multi-dose vial of insulin in one of four medication carts (Unit A-1).Findings include: Review of a facility policy entitled, Medication Storage dated 2/19/26, indicated that outdated medications are immediately removed from stock, disposed of according to procedures for medication destruction and reordered from the pharmacy. Nighttime nurse will complete medication cart check sheet daily after checking med cart and remove all expired medications. Observation on 3/24/26, at 3:55 p.m. in the Unit B medication room refrigerator revealed a multi-dose vial of Tubersol with an expiration date of 3/22/26. During an interview at that time Licensed Practical Nurse (LPN) Employee E1 confirmed that the vial of Tubersol was expired and should have been discarded. Observation on 3/24/26, at 4:30 p.m. of Unit A-1 medication cart revealed a multi-dose vial of Humalog (fast-acting insulin) with an expiration date of 3/18/26. During an interview at that time, LPN Employee E4 confirmed that the Humalog insulin was expired and should have been discarded. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1)(5) Nursing 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 review of facility policy, clinical records and staff interview, it was determined that the facility failed to maintain complete and accurate clinical records regarding a gastrostomy tube [g-tube (feeding tube inserted through the abdomen directly into the stomach to provide nutrition, fluids, and medications when oral intake is insufficient)] per physician's order for one of 15 residents (Resident R49).Findings include: A facility policy entitled, Transcribing Physician's Orders dated 2/19/26, revealed the purpose is to ensure accurate recording of physician's orders on resident clinical record, enteral feeding orders include the amount of delivery to the resident and the amount of water in a 24-hour period, if indicated by the physician. Resident R49's clinical record revealed an initial admission date of 1/09/24, with diagnoses that included dementia, pneumonitis (lungs are irritated or inflamed by various factors, such as medications, molds, chemicals, or infections), and gastrostomy status. A physician's order dated 3/09/26, revealed for enteral nutrition via pump at 80 cc/hr., hang at 6:00 p.m. and take down at 6:00 a.m. two times a day and document input. A physician's order dated 2/11/26, revealed to flush the feeding tube with (140 cc) of water q (#4 of hours) hours and with (30 cc) of water before and after each medication administration. Resident R49's medication administration record (MAR) revealed staff documented feeding hung at 6:00 p.m. and removed at 6:00 a.m. and failed to document the amount of feeding Resident R49 received. Resident R49's MAR revealed staff documented every shift flush feeding tube with (140 cc) of water q (#4 of hours) hours and with (30 cc) of water before and after each medication administration and failed to record the amount of water administered in a 24-hour period. Review of a departmental progress note dated 2/8/2026, revealed the Registered Dietitian recommended nutritional feeding at 80 cc/hour running 6 pm - 6 am, 12 hours via pump and to run to complete 1000 cc bag. Water flush 140cc q 4 hours. Feeding provides 1500 calories, 69 gm protein and 764 cc free water, plus 744 cc from water flush, for a total of 1573 cc water. Estimated needs = 1200-1500 calories, 55-65 gm protein and 1200-1500 cc fluids. Feeding is meeting 100% of estimated needs for calories, protein, and fluid. Resident R49's clinical record lacked evidence that the nutritional needs outlined by the Registered Dietitian were being met and lacked evidence that staff were recording the amount of nutritional feeding and water provided. During an interview on 3/26/26, at 3:12 p.m. the Director of Nursing confirmed Resident R49's clinical record contained incomplete and inaccurate documentation regarding tube feeding amounts and flushes. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services28 Pa. Code 211.5(f)(viii) Medical records28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1)(3) Management