STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395410	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quality Life Services - Sugar Creek	120 Lakeside Drive Worthington, PA 16262

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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 facility policy, observations and staff interviews, it was determined that the facility failed to ensure foods were not held in the danger zone temperatures which are between 41 degrees Fahrenheit (F) and 135 degree F and properly store food products.Findings: Review of the facility's Food Storage policy dated 2/12/26, revealed sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. Food is dated as it is placed on the shelves, and old stock is always used first. Date marking to indicate the date by which a ready-to-eat, potentially hazardous food should confused or discarded will be visible on all high risk food. Foods with a manufacturer use by date, must be used or discarded by the stamped date. During tray line observation of the main designated kitchen on 6/3/26, at 11:20 a.m. the following was observed:-The tomato soup was held at 89F. During an interview on 6/3/26, at 11:21 a.m. Dietary Aide, Employee E9 confirmed the tomato soup was being held at 89F. During an interview on 6/3/26, at 11:22 a.m. Director of Dietary, Employee E8 confirmed the facility failed to ensure foods were not held in the danger zone temperatures which are between 41 degree F and 135 degree F. During an observation on 6/4/26, at 10:45 a.m. of the Activity Kitchenette the following was observed: -(1) 10 oz can of pumpkin expired 4/19 -(1) 8ounce Hershey's Coca Powder Expired 8/23 -(1) box of Jell-O lime flavored expired 11/22/24-(1) Box of Jell-O orange flavored expired 2/23/25 -(1) 14 oz Pumpkin Pie Mix Expired 10/25 -(1) bottle of balsamic vinegar Expired 10/7/25 -(1) Container 8 oz Corn Meal Expired 3/7/26 Interview on 6/4/26, at 10:46 a.m. the Director of Maintenance, Employee E7 confirmed the above observations and the facility failed to properly store food products and ensure food products were discarded prior to their expiration date. During an interview on 6/4/26, at 11:16 a.m., the Nursing Home Administrator confirmed that the facility failed to properly store food products and ensure foods were not held in the danger zone temperatures which are between 41 degrees Fahrenheit (F) and 135 degree F. 28 Pa. Code: 201.18(b)(1) Management28 Pa. Code: 211.6(c) Dietary services28 Pa. Code: 201.14(a) Responsibility of licensee

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to develop and implement person-centered comprehensive care plans to meet resident care needs for three of five residents (Resident R10, R17, and R98). Findings include: Review of facility policy Behavior Monitoring dated 2/16/26, indicated the licensed nursing staff will observe resident behaviors and provide documentation regarding: what behaviors are observed and the number of episodes that occur each shift, what non-pharmacological interventions are initiated to prevent or respond to the behaviors, and the effectiveness of the non-pharmacological interventions utilized. Review of the clinical record revealed Resident R10 was admitted to the facility on [DATE]. Review of Resident R10's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/22/26, indicated diagnoses of anxiety, depression, and Post Traumatic Stress Disorder (PTSD – a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and may have triggers that can bring back memories of trauma accompanied by intense emotional and physical reactions). Review of Resident R10's care plan dated 4/6/26, indicated the resident has the potential to demonstrate verbally abusive behaviors related to ineffective coping skills, including becoming agitated towards staff and cursing at staff when agitation. Interventions include analyze key times, places, circumstances, triggers, and what de-escalates my behavior and document. Monitor my behavior and document the success of attempted interventions. Review of Resident R10's comprehensive care plan dated 5/29/26, indicated the resident has a behavior problem related to raising the height of my bed as high as it will go. I have been known to make false accusations against staff and family. Interventions include monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Review of Resident R10's behavior monitoring documentation indicated, behavior symptoms known to resident and planned interventions; flat affect, difficulty falling and staying asleep: calm environment, encourage to participate in activities and therapy. Food/fluid, TV staff to document behaviors and response to interventions each shift and as needed. Resident R10's behavior documentation failed to include the resident's behaviors of cursing, making false accusations against staff and family, and raising their bed to the highest level. During an interview on 6/3/26, at 1:41 p.m. Social Worker Employee E2 confirmed the facility failed to implement Resident R10's person-centered comprehensive care plan by failing to ensure staff are monitoring and documenting identified behaviors each shift. Review of the clinical record Resident R17 was admitted to the facility on [DATE]. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R17's MDS dated [DATE], indicated diagnosis of Alzheimer's disease (brain condition that slowly damages your memory, thinking, learning and organizing skills) and mild cognitive impairment (typical thinking skills and dementia). During a resident group on 6/3/26, at 11:00 a.m. residents reported that Resident R17 has a behavior of putting his hands down his pants. Residents agreed that he does this behavior consistently and in public, during activities, when he sits next to other residents (to include female residents), etc. Residents stated staff were aware, but this behavior has been on-going since his admit to the facility. During an interview on 6/3/26, with three employee's (Nurse Aide (NA) Employee E4, NA Employee E19, and Licensed Practical Nurse (LPN) Employee E20) confirmed that Resident R17 has the behavior of sticking his hands down his pants in public. It can occur when he is walking down the hallway, sitting in an activity, etc., and it is consistent. That when they tell him to stop he does but he may do it again in a 5 minutes or an hour and that they were unaware of any place to document or monitor his behavior. Review of Resident R17's comprehensive care plan dated 5/28/26, indicated: behavior problem related to putting my hand down the front of my pants. Assist me to develop more appropriate methods of coping and interacting. Educate me my family and caregivers on successful coping and interaction strategies. Ensure resident is wearing underwear under clothing. If observed not wearing underwear, remind/assist me in dressing. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time, day, persons involved and situations. Document behavior and potential causes. Review of Resident R17 behavior documentation for May 2026 and June 2026 failed to include documentation of monitoring of the above behaviors. During an interview on 6/3/26, at 1:42 p.m. Social Worker Employee E2 confirmed that the facility failed to implement Resident R17's person centered- comprehensive care plan by failing to ensure staff are monitoring and documenting identified behaviors each shift. Review of the clinical record indicated Resident R98 was admitted to the facility on [DATE]. Review of Resident R98's MDS dated [DATE], indicated diagnoses of high blood pressure, anxiety, and depression. Review of Resident R98's behavior monitoring documentation indicated, behavior symptoms known to resident and planned interventions: yelling without provocation, restlessness, transfer without assistance; common area for close supervision, 1:1, Tv, food/fluid, toileting. Review of Resident R98's behavior documentation for May 2026 revealed the resident displayed known behaviors during 36/94 observations. Review of Resident R98's comprehensive care plan failed to include the development of person-centered goals and interventions related to the resident's known behaviors. During an interview on 6/5/26, at 10:25 a.m. Registered Nurse Assessment Coordinator (RNAC) Employee E6 confirmed that the facility failed to develop a person-centered comprehensive care plan to meet resident care needs for Resident R98. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, job descriptions, clinical record review, and staff interview, it was determined that the facility failed to provide sufficient and timely social services for three of four residents reviewed (Residents R10, R15, and R17). Findings include: Review of the Social Work Director job description indicated the purpose of this position is to coordinate internal and external social services counseling and education services. Review of the Psychiatric Mental Health Nurse Practitioner (PMHNP/CRNP) job description indicated the PMHNP provides comprehensive mental health care needs to residents across the care continuum. The CRNP (Certified Registered Nurse Practitioner) will assess, diagnose, and manage psychiatric and mental health conditions using evidence-based treatment modalities including psychotherapy and psychopharmacology. Key responsibilities include provide psychotherapy or supportive counseling as appropriate. Review of the clinical record revealed Resident R10 was admitted to the facility on [DATE]. Review of Resident R10's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/22/26, indicated diagnoses of anxiety, depression, and Post Traumatic Stress Disorder (PTSD – a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and may have triggers that can bring back memories of trauma accompanied by intense emotional and physical reactions). Review of Resident R10's clinical record from December 2025 through May 2026 revealed the following behavior documentation: 12/11/25: This writer was approached by sister, who was visibly upset. Sister stated that she was told by resident to get the F*** out. Sister told this writer she was leaving. That she did not have to put up with his abuse. He lived with her and she will not tolerate his abuse anymore. She stated that she left his room but he did not have his call bell and she was not going back in there. This writer stated they would get the call bell and give it to the resident. This writer went into the room, got his call bell and clipped it to his shirt. This writer stated to the resident, here is your call bell clipped to your shirt. The resident then began to curse at this writer. This writer told resident that they were leaving the room now. Resident then said a few more curse words and then said no more. 1/20/26: Resident was swearing at staff during a transfer via hoyer lift. Resident was instructed to cross his arms when he was in the lift so he did not hurt his arms and he would not. When staff tried to help him cross his arms he cursed at staff. 3/16/26: Resident observed with bed a high position. Resident was educated numerous times that it was a danger to have bed that high up but resident continues to raise bed to a high position. 3/18/26: Resident rang call light to ask CNA (Certified Nurse Aide) to get him up for bingo. CNA told resident that as soon as the hoyer lift and another staff member was available she would get him into (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	his wheelchair. Resident began screaming at CNA get the fuck out of here you fucking asshole CNA removed herself from the room after telling the resident it was not appropriate and she would return when the hoyer lift was available as resident was unable to be consoled at that time. Resident had call light within reach. 2 CNAs went in and assisted resident via hoyer lift into wheelchair, during care resident was yelling at staff, one of the CNAs told resident that they were there to help, and to please stop yelling at them. Resident calmed down and was assisted down to bingo without further behaviors at this time. 4/4/26: Writer alerted at 0710 (7:10 a.m.) by nightshift CNA that resident was yelling at her to get his morning medications. Writer had just received change of shift report from nightshift, got resident's medications and asked the other LPN (Licensed Practical Nurse) on the unit to go in with this writer due to his increased behaviors. Writer and other LPN knocked and entered the resident's room, resident started screaming at staff you fucking people! writer explained that writer and LPN just came onto shift, writer realizes he is angry about nightshift not getting meds but i am here with them now. Resident continued with I don't fucking care. I am so fucking sick of you fucking people. I shouldn't be here Writer told the resident I do not appreciate the way you are talking to me, if you are going to continue, I am leaving the room and you can ring when you are cooled off resident continued screaming and cussing at writer, writer was turning to walk out of the room and resident said I'll take them resident took medications, writer asked for a finger to obtain blood glucose reading, resident put middle finger up in writer's face and said how about this one? I'm fucking pissed. This is fucking bullshit. I hate it here. I hate you people. I hate it, I shouldn't be here Writer obtained blood glucose reading and ensured call light was within reach. Resident then said, everyone just leave me the fuck alone, okay? writer explained we were there to assist him and to ring if he needs anything. 4/5/26: Resident in bed with control and put his bed high up in the air. Writer and CNA asked resident to lower his bed to a safe level. Resident stated oh fuck off and leave me the fuck alone. Resident educated on risk of falling and injury when bed is that high, resident stated No. I don't fucking care. What do you people not get? Leave me the fuck alone. Writer and CNA ensured call light within reach clipped to the resident's shirt prior to exiting the resident's room. 4/13/26: Resident yelling at staff and dumped breakfast tray this AM resident educated related he acknowledged understanding. 4/13/26: Resident yelling cuss words in common area at staff and visitors; resident taken back to room. 5/29/26: Resident has been yelling at staff and is refusing to eat out of anger. Resident refused to eat his lunch. Resident received fall mats and has been instructed to keep his bed low to the ground to prevent falls. Resident previously would keep his bed raised in the air in the highest position and would make jokes about attempting to roll out of bed. Resident is angry that he can't keep his bed in the air the way he likes it. Resident was educated that we take these precautions to keep him safe. Resident continues to yell at staff. RN (Registered Nurse) notified. Plan of care continues. 5/29/26: Resident requested to speak with SW (Social Worker). SW went to resident's room per his request accompanied by CED (Customer Experienced Director). Resident voiced he was angered regarding keeping bed in low position and having fall mats in room. SW asked if resident understood why staff were enacting these precautions. Resident stated yeah, because the head nurse thinks she knows everything. Well she don't know me. I want to know who said I was putting the bed up? SW discussed at length need for keeping resident safe at all times. Resident stated you don't know what (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	you're talking about. I like my bed the way I like it. Offered to assist resident in adjusting bed at this time. Resident became agitated and started yelling at CED and SW that you guys don't know how to do it. So stop acting like you do and just get out. SW and CED stated to resident would leave room per request, and if needing any further assistance to press call light for hall staff to assist. Review of a Medical assessment dated [DATE], completed by PMHNP Employee E17 stated, Patient was seen today due to being a new resident, history to anxiety/depression/PTSD and recent subdual hemorrhage. Patient was sitting at a table eating his breakfast. Patient had latent responses. Often thinking hard before responding to me. Patient reports he is sleeping good and has a good appetite. Patient did not understand the question how is your mood? He just looked at me and mumbled words. Patient repots some depression in that he feels sad at times. Patient is already on the maximum dose of lexapro (a medication used to treat depression). Patient denies anxiety and psychosis. Plan is to keep all psych medications the same and follow up in 1 month. Review of a Medical assessment dated [DATE], completed by PMHNP Employee E17 stated, Patient was seen today due to increased depression and poor appetite. Patient states he doesn't have much of an appetite. Patient reports sleeping good. Patient reports depression but states he doesn't want any medications or medication changes. Patient denies anxiety. Patient denies psychosis. Plan is to keep all psych medications the same and follow up in 1 month. Review of a Medical assessment dated [DATE], completed by PMHNP Employee E17 stated, Patient was seen today for a follow up. Patient was laying in his bed. Patient was pleasant. Patient has trouble articulating words and it takes a while for him to speak and get his point across. Patient reports I don't know when asked how his mood is. Patient reports good for appetite and sleep. Patient reports some depression I have been sad, lonely and depressed for seven months now. Patient denies anxiety. Patient denies psychosis. Plan is to keep all psych medications the same and follow up in 1 month. Review of clinical record from November 2025 to May 2026 failed to show additional therapy services. During an interview on 6/3/26, at 1:31 p.m. Social Worker Employee E2 stated, PMHNP Employee E17 does medication management. We currently do not have a provider for counseling. We had one previously, but they had no psychologists available, so we are to utilize PMHNP Employee E17 for mental health concerns. We currently do not have any residents going to outpatient mental health services. We haven't had a provider for a few months now. During an interview on 6/3/26, at 1:41 p.m. Social Worker Employee E2 stated, We use VA (Veterans Affairs) to coordinate transportation services for Resident R10. We should be coordinating services with them so he can see outpatient psych services. We could also schedule a telehealth appointment. During this interview, Social Worker Employee E2 confirmed that the facility failed to provide sufficient and timely social services to Resident R10. Review of the clinical record indicated Resident R15 was admitted to the facility on [DATE]. Review of Resident R15's MDS dated [DATE], indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), heart failure (a progressive heart disease that affects pumping action of the heart muscles), and cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain). (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R15's physician order dated 1/6/26, through 1/13/26, indicated to administer Zyprexa (an antipsychotic medication used to treat mental illnesses) 2.5 milligrams at bedtime for schizophrenia (a chronic and severe brain disorder that affects a person's ability to interpret reality, often diagnosed in late teens). Review of Resident R15's current diagnosis list, a new diagnosis of schizophrenia was given on 1/6/26, the day the antipsychotic medication was ordered. Review of Resident R15's clinical record on 6/4/26, at 9:41 a.m. failed to reveal that other interventions were completed to rule out an acute change of condition prior to implementation of an antipsychotic medication. Review of facility provided documentation labeled Medical Assessment completed on 1/5/26, indicated plan is to diagnose patient with schizophrenia and start her on Zyprexa 2.5 milligrams twice a day for hallucinations and delusions and was completed by PMHNP Employee E17. During an interview on 6/4/26, at 11:19 a.m. Social Worker Employee E2 stated that other tests should have been completed such as urinalysis (to check for a urinary tract infection) and blood work prior to a provider ordering new mind altering medications and confirmed that Resident R15 failed to have medical testing done prior to Zyprexa medication ordered and a new diagnosis of schizophrenia given to Resident R15. Review of the clinical record Resident R17 was admitted to the facility on [DATE]. Review of Resident R17's MDS dated [DATE], indicated diagnosis of Alzheimer's disease (brain condition that slowly damages your memory, thinking, learning and organizing skills) and mild cognitive impairment (typical thinking skills and dementia). During a resident group on 6/3/26, at 11:00 a.m. residents reported that Resident R17 has a behavior of putting his hands down his pants. Residents agreed that he does this behavior consistently and in public, during activities, when he sits next to other residents (to include female residents), etc. Residents gave example that Resident R17 had been putting his hands down his pants this past weekend at an activity was re-directed and this upset the other residents during the activity. Residents stated staff were aware, but this behavior has been on-going since his admit to the facility. Review of Resident R17's clinical record indicated: Social service note 11/10/2025: Initial care conference held this AM with resident's brother and his wife. Discussed behaviors and cognitive status with family. They requested eval by Valley Psychology to determine cognitive status r/t dx of Alzheimer's and Lewy Body Dementia to determine medical/financial decision-making ability. Reviewed referral would be sent per their request for consult. Reviewed resident was also on rounds for psych CRNP this AM as well. Family voiced appreciation for discussion. Following, SW sent referral for eval to Psychology. Health Status note: 11/11/2025: This writer spoke with resident's brother, in regard to medication changes. Resident R17's brother voiced understanding. Resident R17's brother inquired about giving resident Depo-Provera to control his urges. This writer stated that would be a decision for the MD to make but will inquire with MD if it would be a possibility. Resident R17's brother voiced understanding. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clinician order note: 11/25/2025: This order is outside of the recommended dose or frequency. Depo-Provera Intramuscular Suspension 150 MG/ML (Medroxyprogesterone Acetate (Contraceptive)) Inject 1 ml intramuscularly in the morning starting on the 28th and ending on the 28th every month for Unspecified Sexual Dysfunction - The dosing regimen of 1 mL monthly exceeds the usual dosing regimen of 0.9844 mL every 92 days to 1 mL every 90 days. - The frequency of monthly exceeds the usual frequency of every 92 days to every 90 days. Health Status note: 11/25/2025: Called Resident R17's brother and spoke with him in regard to the Depo-Provera shot. Resident R17's brother voiced understanding and was pleased that Resident R17 will be receiving the shot. Medical assessment note: 4/27/2025: Resident R17 was seen for putting his hands down his pants and upsets other residents. Resident R17 was in his room sitting in a chair. Resident R17 reports I got my Depo shot today, what does that do?. Resident R17 was educated on the purpose of the shot and Resident R17 reports it works. Resident R17 was instructed to stop putting his hands down his pants by other residents. During an interview on 6/3/26, with three employee's (NA Employee E4, NA Employee E19, and LPN Employee E20) confirmed that Resident R17 has the behavior of sticking his hands down his pants in public, it can occur when he is walking down the hallway, sitting in an activity, etc., and it is consistent. That when they tell him to stop, he does but he may do it again in 5 minutes or an hour and that they were unaware of any place to document or monitor his behavior. During an interview on 6/3/26, at 1:02 p.m. Activity Coordinator Employee E21, confirmed that Resident R17 has the behavior of sticking his hands down his pants and has done this during activities, and other residents have stated they are uncomfortable with this. Review of clinical record from January 2026 to June 2026 failed to show additional therapy services. During an interview on 6/3/26, at 1:31 p.m. Social Worker Employee E2 stated, PMHNP Employee E17 does medication management. We currently do not have a provider for counseling. We had one previously, but they had no psychologists available, so we are to utilize PMHNP Employee E17 for mental health concerns. We currently do not have any residents going to outpatient mental health services. We haven't had a provider for a few months now. During an interview on 6/3/26, at 1:33 p.m. Social Worker Employee E2 confirmed that the facility failed to provide sufficient and timely social services (counseling/therapy) for a known behavior for Resident R17. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.29(a) Resident rights. 28 Pa. Code: 211.16(a)Social services.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide evidence medication regimen reviews (MRRs) were reviewed by the resident's attending physician monthly for three of five residents (Residents R8, R56, and R98).Findings include: Review of facility policy Medication Regimen Review dated 2/16/26, indicated the consultant pharmacist performs a comprehensive review of each resident's medication regimen (MRR) at least monthly. The MRR includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. Findings and recommendations are reported to the director of nursing and the attending physician, and if appropriate, the medication director and/or the administrator. Recommendations are acted upon and documented by the facility staff or the prescriber. Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing. Review of the clinical record revealed Resident R8 was admitted to the facility on [DATE]. Review of Resident R8's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/23/26, indicated diagnoses of high blood pressure, muscle weakness, and Gastro-Esophageal Reflux Disease (GERD - a chronic condition where stomach acid flows back into the esophagus). Review of Resident R8's MRR dated 1/31/26, indicated the following recommendation from pharmacist to physician:Resident is prescribed a PRN (as needed) order for Omeprazole (a medication used to treat GERD) 20 mg (milligrams) tablets. Please consider discontinuing the PRN order for Omeprazole, and ordering PRN Calcium Carbonate (500 mg - 750 mg) tablets: 2 tablets every 6 hours, as needed for treatment of GERD symptoms. Review of Resident R8's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 1/31/26. On 2/3/26, a facility Certified Registered Nurse Practitioner (CRNP) addressed the MRR, stating, Other, has not used, d/c (discontinue) Omeprazole. Review of the clinical record revealed Resident R56 was admitted to the facility on [DATE]. Review of Resident R56's MDS dated [DATE], indicated diagnoses of depression, Bipolar disorder (a mental condition marked by alternating periods of elation and depression), and Schizoaffective disorder (a mental disorder in which a person experiences a combination of schizophrenia and mood disorder symptoms).t Review of Resident R56's MRR dated 4/20/26, indicated the following recommendation from pharmacist to physician:Please consider tapering the antipsychotic order for Olanzapine (a medication used to treat mood disorders) 10 mg to 7.5 mg (daily each morning) x 7 days, then taper further to 5 mg (daily each morning) x 7 days, then discontinue. On day 8 of taper (1st day of 5 mg Olanzapine dose), consider starting Quetiapine 12.5 mg daily each morning, then reassess treatment after 14 days (at 7 days post-discontinuation of Olanzapine). Resident has experienced increased incidence of hallucinations since starting Olanzapine, with notable increase after the dose was changed from 7.5 mg to 10 mg, on 3/31/26. Review of Resident R56's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 4/20/26. On 4/27/26, a psychiatric CRNP addressed the MRR, stating, Disagree: monitor current mental health recent med changes. Review of the clinical record indicated Resident R98 was admitted to the facility on [DATE]. Review of Resident R98's MDS dated [DATE], indicated diagnoses of high blood pressure, anxiety, and depression. Review of Resident R98's MRR dated 2/28/26, indicated the following recommendation from pharmacist to physician:Resident is prescribed a routine order for Ativan 0.5 mg (three times daily) for treatment of anxiety disorder. Prescribed PRN Ativan for treatment of resident's anxiety started on 12/8/25 and the PRN order had minimal use. Please consider decreasing the currently prescribed Ativan 0.5 mg dose to 0.25 mg. Please also consider changing the regimen back to a PRN order, due to Ativan administration history and resident's history of falls. Review of Resident R98's clinical record (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	failed to include a response from the resident's attending physician regarding the recommendation made on 2/28/26. On 3/6/26, a facility CRNP addressed the MRR, stating, Disagree with no additional explanation provided. During an interview on 6/4/26, at 2:30 p.m. the Director of Nursing confirmed that the monthly medication regimen reviews were addressed by the facility and Psych services CRNPs and not the resident's attending physician for Residents R8, R56, and R98. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.5(f) Medical records.28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy, and staff interviews, it was determined that the facility failed to ensure that residents' medication regime was free from unnecessary psychotropic (a mind-altering medication) medication for two of three residents (Resident R9 and R15). Findings include: Review of facility Antipsychotic Medication Consent Form policy dated 2/16/26, indicated it is the philosophy of this home that in cooperation with our elders, we will create and maintain an environment that fosters the minimal use of antipsychotic medications. Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE], and re-admitted on [DATE]. Review of Resident R9's Minimum Data Set (MDS - a periodic assessment of resident needs) dated 4/13/26, indicated diagnoses of Anxiety disorder (group of mental health conditions that cause fear, dread, and other symptoms that are out of proportion to the situation) Depression (mood disorder that causes persistent feeling of sadness and loss of interest) , and Bipolar disorder (mental health condition that causes extreme mood swings). Review of physician order dated 12/22/25, indicated to administer: Risperdal oral tablet 0.5mg (risperidone - an antipsychotic medication) give 1 tablet by mouth two times a day for schizoaffective disorder, depressive type. Review of the admit sheet indicated a new diagnosis of schizoaffective disorder (schizoaffective disorder - is a serious mental health condition characterized primarily by symptoms of schizophrenia. Schizoaffective disorder can be difficult to diagnosis because it has symptoms of both schizophrenia and either depression or bipolar disorder. To be diagnosed with schizoaffective disorder a person must have the following symptoms: A period during which there is a major mood disorder, either depression or mania, that occurs at the same time that symptoms of schizophrenia are present. Delusions or hallucinations for 2 or more weeks in the absence of a major mood episode) dated 11/24/25, - one year after admit. Review of Resident R9's clinical record on 6/4/26, at 11:53 a.m. failed to reveal that other interventions were completed to rule out an acute change of condition prior to implementation of an antipsychotic During an interview on 6/4/26, at 1:28 p.m. Director of Nursing confirmed that the facility failed to provide documentation that the medication regimen were free from potentially unnecessary medications for Resident R9. Review of the clinical record indicated Resident R15 was admitted to the facility on [DATE]. Review of Resident R15's MDS dated [DATE], indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), heart failure (a progressive heart disease that affects pumping action of the heart muscles), and cerebral infarction (necrotic tissue in the brain (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resulting loss of blood and oxygen to the brain). Review of Resident R15's physician order dated 5/12/26, through 11/12/26, indicated to administer Ativan (a psychotropic medication used to treat anxiety) 0.5 milligrams every 12 hours by mouth as needed for anxiety for six months. Review of Resident R15's physician order dated 1/6/26, through 1/13/26, indicated to administer Zyprexa (an antipsychotic medication used to treat mental illnesses) 2.5 milligrams at bedtime for schizophrenia (a chronic and severe brain disorder that affects a person's ability to interpret reality, often diagnosed in late teens). Review of Resident R15's current diagnosis list, a new diagnosis of schizophrenia was given on 1/6/26, the day the antipsychotic medication was ordered. Review of Resident R15's clinical record on 6/4/26, at 9:41 a.m. failed to reveal that other interventions were completed to rule out an acute change of condition prior to implementation of an antipsychotic medication. During an interview on 6/4/26, at 11:19 a.m. Social Worker Employee E2 stated that other tests should have been completed such as urinalysis (to check for a urinary tract infection) and blood work prior to a provider ordering new mind altering medications and confirmed that Resident R15 failed to have medical testing done prior to Zyprexa medication ordered and a new diagnosis of schizophrenia given to Resident R15. During an interview on 6/4/26, at 11:29 a.m. the Director of Nursing confirmed that Resident R15 was ordered Ativan for six months and the clinical record failed to provide a rationale as to why the medication was ordered past 14 days and confirmed that the facility failed to ensure that residents medication regime was free from unnecessary psychotropic medications for Resident R15. 28 Pa. Code 211.2(d)(3) Medical director 28 Pa. Code 211.10(a) Resident care policies

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, staff interviews, and observations it was determined that the facility failed to provide supervision with meals as ordered for one of three residents (Resident R6). Findings include: Review of the facility policy Restorative Nursing dated 2/16/26, indicated restorative care is an ongoing process, provided by all staff at all times for resident. Formal Restorative Nursing Programs will be initiated for residents who demonstrate a need for this service. Review of the facility policy Physician Orders dated 2/16/26, indicated physician orders are followed in accordance with good nursing principles and practices and are transcribed and carried out by persons legally authorized to do so. Review of the facility policy Activities of Daily Living (ADL) dated 2/16/26, indicated a program of ADL is provided for residents. A program of assistance is implemented. Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/8/26, indicated diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and anxiety. Review of Resident R6's physician order dated 12/2/25, indicated staff to have all foods cut into small bite size pieces when setting up resident for meals, resident to be out of bed for meals and supervised by staff. Review of Resident R6's care plan dated 10/5/2023, indicated the resident has an ADL self-performance deficit related to limited mobility. Interventions include staff having all foods cut into small bite size pieces when setting up resident at meals times, resident to be out of bed for meals, and supervised by staff. During an observation on 6/2/25, at 12:35 p.m. Resident R6 was observed sitting in bed while being served lunch. Nurse Aide Employee E4 set lunch tray up and cut up food for Resident R6 and then left the room. Resident R6 failed to be out of bed for lunch and was not being supervised for lunch. During an interview on 6/2/25, at 12:47 p.m. Licensed Practical Nurse (LPN) Employee E5 stated restorative dining is to promote independence and offer assistance to residents. LPN Employee E5 confirmed that Resident R6 should have been out of bed and should have been supervised during lunch while eating in the room, per physician's orders. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(c)(d)(1) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, staff and resident interview, and observations, it was determined that the facility failed to provide appropriate respiratory care for one of five residents (R8).Findings Include: Review of the RESmart CPAP and Auto-CPAP User Manual dated 8/3/16, revealed it is recommended that the air filter be changed every 30 days. Remove the filter cap by gently pressing on its bottom. Remove the foam filter by gently pulling around the edges of the filter. Remove filter and replace with blue side facing out. Replace filter cap so that the small opening on the cap is facing down. Insert the cap's tabs into the filter area opening. Opering a RESmart CPAP and Auto-CPAP with a dirty filter may keep the system from working properly and may cause damage to the device. Review of the facility CPAP/BIPAP policy dated 2/12/26, revealed the CPAP will be set up and monitored by a licensed nurse or respiratory therapist, as appropriate. Review of the clinical record indicated Resident R46 was admitted to the facility on [DATE], with diagnoses of dysphagia (difficulty swallowing), morbid obesity, and depression. Review of Resident R46's care plan dated 10/16/25, revealed the resident had altered respiratory status and difficulty breathing related to sleep apnea, shortness of breath and uses a C-Pap. A further review of the care plan failed to include an intervention to change the CPAP's filter. Review of Resident R46's physician order dated 12/5/25, revealed the resident utilizes the Resmed Airsense 10 CPAP Settings: 4-20cm h2o, every evening and night shift. Review of Resident R46's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/23/26, indicated diagnoses were current. Section O- Special Treatments, Procedures, and Programs revealed the resident required non-invasive mechanical ventilation while a resident. During an interview on 6/3/26, at 1:02 p.m. Resident R46 indicated the facility does not clean his CPAP machine or change the filter. Resident R46 stated he has been using the CPAP for 20 years and he can't sleep without it. During an observation on 6/3/26, at 1:03 p.m. Resident R46's CPAP filter was observed to be unclean with built up fuzzy white debris visualized on it. During an interview on 6/3/26, at 1:06 p.m. Hospitality Aide, Employee E11 confirmed Resident R46's CPAP filter was unclean. During an interview on 6/3/26, at 1:09 p.m. Licensed Practical Nurse, Employee E12 confirmed Resident R46's CPAP filter was unclean with built up debris visualized on the filter. LPN, Employee E12 stated Resident R46's CPAP filter should be cleaned once a week. During an interview on 6/3/26, at 1:12 p.m. the Nursing Home Administrator confirmed the facility failed to provide appropriate respiratory care for one of five residents (Resident R46). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to ensure a resident with dementia receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being for one of three residents reviewed (Resident R15), and failed to develop and implement individualized person-centered care plans to address dementia and cognitive loss displayed by one of three residents reviewed (Resident R98). Findings include: Review of facility policy Behavior Monitoring dated 2/16/26, indicated the licensed nursing staff will observe resident behaviors and provide documentation regarding: what behaviors are observed and the number of episodes that occur each shift, what non-pharmacological interventions are initiated to prevent or respond to the behaviors, and the effectiveness of the non-pharmacological interventions utilized. Review of the clinical record indicated Resident R15 was admitted to the facility on [DATE]. Review of Resident R15's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/5/26, indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), heart failure (a progressive heart disease that affects pumping action of the heart muscles), and cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain). Review of Resident R15's physician order dated 1/6/26, through 1/13/26, indicated to administer Zyprexa (an antipsychotic medication used to treat mental illnesses) 2.5 milligrams at bedtime for schizophrenia (a chronic and severe brain disorder that affects a person's ability to interpret reality, often diagnosed in late teens). Review of Resident R15's current diagnosis list, a new diagnosis of schizophrenia was given on 1/6/26, the day the antipsychotic medication was ordered. Review of Resident R15's clinical record on 6/4/26, at 9:41 a.m. failed to reveal that other interventions were completed to rule out an acute change of condition prior to implementation of an antipsychotic medication. Review of facility provided documentation labeled Medical Assessment completed on 1/5/26, indicated plan is to diagnose patient with schizophrenia and start her on Zyprexa 2.5 milligrams twice a day for hallucinations and delusions and was completed by Psychiatric Mental Health Nurse Practitioner (PMHNP) Employee E17. During an interview on 6/4/26, at 11:19 a.m. Social Worker Employee E2 stated that other tests should have been completed such as urinalysis (to check for a urinary tract infection) and blood work prior to a provider ordering new mind altering medications and confirmed that Resident R15 failed to have medical testing done prior to Zyprexa medication ordered and a new diagnosis of schizophrenia given to Resident R15 who is diagnosed with Dementia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record indicated Resident R98 was admitted to the facility on [DATE]. Review of Resident R98's MDS dated [DATE], indicated diagnoses of high blood pressure, anxiety, and depression. Review of Resident R98's active diagnosis list indicated the resident received a diagnosis of dementia in other diseases classified elsewhere, mild, with agitation on 5/11/26. Review of Resident R98's care plan on 6/3/26, failed to indicate the facility had developed and implemented an individualized person-centered care plan to address Resident R98's dementia and cognitive loss. During an interview on 6/5/26, at 10:25 a.m. Registered Nurse Assessment Coordinator (RNAC) Employee E6 confirmed that the facility failed to develop and implement individualized person-centered care plans to address dementia and cognitive loss for Resident R98. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(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 review of facility policies, observations, and staff interviews, it was determined that the facility failed to properly secure a treatment cart while not in use for one of three treatment carts (Willow Hall Treatment Cart).Findings include: Review of the facility policy Administering Medications last reviewed 1/6 /26, indicated during administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse. When opening a multi-dose container, the date opened shall be recorded on the container. Review of the facility policy Storage of Medications last reviewed 1/6/26, indicated the nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Compartments containing drugs and biologicals shall be locked when not in use. Medications must be stored separately from food and must be labeled accordingly. During an observation completed on 6/3/26, at 12:59 p.m. the [NAME] treatment cart was sitting in the hallway near the nursing station. The treatment cart was unlocked and unattended. During an interview completed on 6/3/26, 1:02 a.m. Licensed Practical Nurse (LPN) Employee E10 confirmed the treatment cart was left unlocked and unattended. During an interview on 6/3/26, at 1:12 p.m. the Nursing Home Administrator confirmed the facility failed to properly secure a treatment cart while not in use for one of three treatment carts (Willow Hall Treatment Cart). 28 Pa. Code: 201(a) Responsibility of licensee.28 Pa. Code: 211.9(a)(1) Pharmacy services.28 Pa. Code: 211.12(d)(1)(2)(5) Nursing services.