STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395423	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Champion City Nursing and Rehabilitation Center	6655 Frankstown Avenue Pittsburgh, PA 15206

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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 interview, it was determined that the facility failed to properly store food products and maintain proper infection control practices in the main kitchen and dish room which created the potential for cross contamination in the designated main kitchen, dish room. The facility policy entitled Food Preparation and Service dated 10/29/25, indicated Food and nutrition employees prepare, distribute, and serve food in a manner, that complies with safe food handling practices. During an observation of the main designated kitchen on 3/23/26, at 9:45 a.m. the following was observed: -(2) cups were stored in the flour bin -(2) packages uncooked ground pork stored improperly -(1)open bag of hashbrowns in the freezer, open, not dated -(2) cases ice cream stored on walk in freezer floor -(5) individual ice cream, open, walk in freezer During tray line observation of the main designated kitchen on 3/24/2026 at 11:42 a.m. -11:49 a.m. server observed picking up Salisbury steaks with gloved hands, opened warming cart door, did not change gloves -lid covers for plates were still wet from being washed from breakfast During dish room observation 3/26/26 at 9:37 a.m. the following was observed: -dietary staff loading dirty dishes, when wash cycle was complete, he proceeded to clean side and unloaded without washing hands. This was observed x 5. During an interview on 3/26/26 at 10:00 a.m., Dietary Manager Employee E21 confirmed that the facility failed to properly label and date food products and maintain sanitary conditions which created the potential for cross contamination.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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on review of the facility policy and staff interview, it was determined that the facility failed to implement an antibiotic stewardship program for 12 of 12 months (March 2025, through February 2026) Findings include: Review of facility Antibiotic Stewardship policy dated 10/29/25, indicated that antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. Review of the facility's Infection Control Program from March 2025, through February 2026, failed to include documented evidence that antibiotic (medications used to treat infections) monitoring and ensuring appropriate usage was completed. During an interview on 3/25/26, at 10:51 a.m. Director of Nursing reviewed the facilities infection control documents with State Agency (SA) and was unable to provide the facilities antibiotic stewardship program and stated, I haven't been here that long. We just hired a new infection preventionist, and we will be working to get all the infection control in order. During an interview on 3/26/26, at 9:00 a.m. Director of Nursing stated, I did find an antibiotic stewardship binder in one of the offices and confirmed that it just had reports from the lab in it and failed to include any facility tracking of antibiotics. During an interview on 3/26/26, at 9:09 a.m. the Director of Nursing confirmed that the facility failed to implement an antibiotic stewardship program for 12 of 12 months (March 2025, through February 2026). 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, closed clinical records, resident fund account statements and staff interview it was determined that the facility failed to convey resident funds and close accounts upon discharge within 30 days for three out of three closed resident records (Closed Resident Records CR186, CR187, and CR188).Findings include:Review of facility policy Conveyance of Resident Funds dated 10/29/25, indicated the resident's personal funds and a final accounting of funds are returned to the resident, the resident's representative or to the resident's estate (individual or probate jurisdiction per state law), as applicable, within thirty (30) days from the date of the resident's discharge or eviction from the facility, or death. Review of the clinical record revealed Closed Resident Record CR186 was admitted to the facility on [DATE], with diagnoses of high blood pressure, hyperlipidemia (high levels of fats in the blood), and unsteadiness on feet. Review of documentation indicated Closed Resident Record CR186 ceased to breath (CTB) at the facility on 2/5/26. Review of the clinical record revealed Closed Resident Record CR187 was admitted to the facility on [DATE], with diagnoses of high blood pressure, muscle weakness, and dysphagia (difficulty swallowing). Review of documentation indicated Closed Resident Record CR187 was transferred to the hospital on 9/24/25, and ceased to breathe at the hospital on 9/25/25. Review of the clinical record revealed Closed Resident Record CR188 was admitted to the facility on [DATE], with diagnoses of hyperlipidemia, anxiety, and high blood pressure. Review of documentation indicated Closed Resident Record CR188 ceased to breathe at the facility on 8/19/25. Review of the facility trust fund account (resident funds account with current accounts open and holding resident monies) dated 3/23/26, indicated the following:Closed Resident Record CR186 had a balance of $3778.30Closed Resident Record CR187 had a balance of $240.54Closed Resident Record CR188 had a balance of $517.07 During an interview on 3/26/26, at 1:14 p.m. Regional Business Office Manager Employee E14 confirmed that the facility failed to convey resident funds and close resident accounts within 30 days upon discharge for three out of three closed resident records (Closed Residents CR186, CR187, and CR188). 28 Pa. Code: 201.14(a)Responsibility of licensee.28 Pa. Code: 201.18(b)(2)(e)(1) Management.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 review of facility policies, clinical record review, and staff interview, it was determined that the facility failed to make certain resident medication regimens were free from potentially unnecessary psychotropic (substances that act on the brain to alter cognition, perception, and mood) medications for four of five residents (Residents R13, R16, R37, and R139).Findings include: Review of facility policy Psychotropic Medication Use dated 10/29/25, indicated residents do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record. Medications in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: anti-psychotics, anti-depressants, anti-anxiety medications, and hypnotics/sedatives. Review of facility policy Medication Regimen Reviews dated 10/29/25, indicated a licensed pharmacist reviews the medication regimen of each resident at least monthly. The consultant pharmacist provides the director of nursing services and medical director with copy of all medication regimen reports. Upon receiving the MRR report from the pharmacist, the director of nursing reviews the recommendations with the attending physician, responds to the report, and documents what (if any) actions were taken to address them. Review of the clinical record indicated Resident R13 was admitted to the facility on [DATE]. Review of Resident R13's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/11/26, indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life) , cerebral infarction (necrotic tissue in the brain resulting in loss of blood and oxygen to the brain), and high blood pressure. Review of Resident R13's MRR dated 3/31/25, indicated the following recommendation from the pharmacist to the physician: Recommendation: The resident is receiving the antipsychotic agent Quetiapine (a mind-altering medication) but lacks an allowable diagnosis to support its use. Please consider an appropriate diagnosis. Review of Resident R13's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 3/31/25. Review of Resident R13's MRR dated 8/30/25, indicated the following recommendation from the pharmacist to the physician: Recommendation: Escitalopram Oxalate (a medication used to treat depression) 15 milligrams (mg) by mouth once a day. If an antidepressant is used for sleep or to manage behavior, stabilize mood, or treat a psychiatric disorder, it must be reviewed for a possible gradual dose reduction (GDR) in an effort to find the lowest effective dose. Review of Resident R13's clinical record failed to include a response from the resident's attending (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician regarding the recommendation made on 8/30/25. On 9/4/25, a CRNP addressed the MRR, stating, Depression ongoing-any further GDR would likely exacerbate underlying symptoms. Review of Resident R13's MRR dated 9/29/25, indicated the following recommendation from the pharmacist to the physician: Recommendation: Quetiapine 100 milligrams by mouth two times a day. The resident is receiving the antipsychotic agent Quetiapine but lacks an allowable diagnosis to support its use. Please consider an appropriate diagnosis. Review of Resident R13's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 9/29/25. On 10/9/25, a CRNP addressed the MRR, stating, Please add schizoaffective disorder (a mental disorder in which a person experiences a combination of schizophrenia and mood disorder symptoms); refer to psych notes. Review of Resident R13's MRR dated 1/31/26, indicated the following recommendation from the pharmacist to the physician: Recommendation: Quetiapine 100 milligrams by mouth two times a day. Resident is due for a GDR in an attempt to find the lowest effective dose. Please consider a trail dose reduction. Review of Resident R13's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 1/31/26. Review of the clinical record indicated Resident R16 was admitted to the facility on [DATE]. Review of Resident R16's MDS dated [DATE], indicated diagnoses of depression, dementia, and insomnia (difficult sleeping). Review of Resident R16's MRR dated 3/31/25, indicated the following recommendation from the pharmacist to the physician: Recommendation: Zyprexa (a mind-altering medication) 2.5 milligrams by mouth two times a day. The resident is receiving the antipsychotic agent, but lacks an allowable diagnosis to support its use. Please consider an appropriate diagnosis. Review of Resident R16's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 3/31/25. Review of Resident R16's MRR dated 7/31/25, indicated the following recommendation from the pharmacist to the physician: Recommendation: Zyprexa 2.5 milligrams by mouth two times a day. The resident is receiving the antipsychotic agent, but lacks an allowable diagnosis to support its use. Please consider an appropriate diagnosis. Review of Resident R16's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 7/31/25. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R16's MRR dated 9/29/25, indicated the following recommendation from the pharmacist to the physician: Recommendation: Zyprexa 2.5 milligrams by mouth two times a day. The resident is due for a GDR in an attempt to find the lowest effective dose. Please consider a trial dose reduction. Review of Resident R16's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 9/29/25. Review of Resident R16's MRR dated 11/26/25, indicated the following recommendation from the pharmacist to the physician: Recommendation: Remeron (a medication used to treat depression) 15 milligrams by mouth once a day. If an antidepressant is used for sleep or to manage behavior, stabilize mood, or treat a psychiatric disorder, it must be reviewed for a possible GDR in an effort to find the lowest effective dose. Review of Resident R16's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 11/26/25. Review of Resident R16's MRR dated 2/28/26, indicated the following recommendation from the pharmacist to the physician: Recommendation: Zyprexa 2.5 milligrams by mouth two times a day. The resident is due for a GDR in an attempt to find the lowest effective dose. Please consider a trial dose reduction. Review of Resident R16's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 2/28/26. Review of the clinical record revealed Resident R37 was admitted to the facility on [DATE]. Review of Resident R37's MDS dated [DATE], indicated diagnoses of high blood pressure, anxiety, and depression. Review of a physician order dated 8/29/24, through 5/26/25, indicated to administer Xanax (an anti-anxiety medication) 0.5 mg give one tablet by mouth two times a day for anxiety. Review of a physician order dated 5/26/25, indicated to administer Xanax 0.5 mg give one tablet by mouth three times a day for anxiety. Review of Resident R37's clinical record failed to reveal documentation that a MRR had been completed by the consultant pharmacist for March 2025, April 2025, May 2025, June 2025, and July 2025. Review of the clinical record revealed Resident R139 was admitted to the facility on [DATE]. Review of Resident R139's MDS dated [DATE], indicated diagnoses of depression, schizoaffective disorder (a mental disorder in which a person experiences a combination of schizophrenia and mood disorder symptoms), and muscle weakness. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a physician order dated 3/27/24, through 5/5/25, indicated to administer Remeron (an anti-depressant medication) 15 mg by mouth at bedtime for depression. Review of a physician order dated 2/14/25, through 6/30/25, indicated to administer Abilify (an antipsychotic) 10 mg by mouth twice a day for mood. Review of a physician order dated 6/6/25, through 8/10/25, indicated to administer Ativan (an anti-anxiety medication) 0.5 mg by mouth twice a day for anxiety. Review of Resident R139's clinical record failed to reveal documentation that a MRR had been completed by the consultant pharmacist for March 2025, April 2025, May 2025, June 2025, and July 2025. During an interview on 3/25/26, at 3:05 p.m. the Director of Nursing (DON) stated, I don't have any [MRRs] from before August 2025. The completed MRRs I gave you is all I have. During this interview, the DON confirmed that the facility failed to provide documentation that medication regimens were free from potentially unnecessary medications for four of five residents (Residents R13, R16, R37, and R139). 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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for five of six residents sampled with facility-initiated transfers (Residents R8, R12, R35, R180 and R184), failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for four of six resident hospital transfers (Residents R12, R35, R180 and R184), and failed to notify the Office of the State Long-Term Care Ombudsman upon transfer to the hospital for five of six resident hospital transfers (Residents R12, R35, R168, R180, and R184).Findings include: Review of facility policy Transfer or Discharge Documentation last reviewed 10/29/25, indicated when a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care provider. When a resident is transferred or discharged from the facility, the following information will be documented in the medical record that includes but not inclusive to: The basis for the transfer or discharge That appropriate notice was provided to the resident and/or legal representative The date and time of the discharge The new location of the resident The mode of transportation A summary of the residents' overall medical, physical, and mental condition Disposition of personal effects Disposition of medications Others as appropriate or as necessary The signature of the person recording the date in the medical record When a resident is transferred or discharged from the facility, the following information will be communicated to the receiving facility or provider that includes but not inclusive to: The basis for the transfer or discharge Contact information of the practitioner responsible for the care of the resident Resident representative information including contact information Advanced directives information (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	All special instructions or precautions for ongoing care Comprehensive care plan goals All other necessary information, including a copy of the resident's discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care. Review of the facility policy Bed -Holds and Returns last reviewed 10/29/25, indicated residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed hold policies. Review of the admission record indicated 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 2/6/26, indicated the diagnosis of anemia (low iron in the blood), high blood pressure and diabetes (high sugar in the blood). Review of Resident R8's nursing progress notes dated 12/31/25, at 1:12 p.m. indicated resident in bathroom on first floor with uncontrollable nosebleed. Several attempts were made to stop the bleeding to no effect. Resident requests to be sent to local emergency room at this point. Physician and emergency services notified. Resident sent to local hospital. Family notified. Resident returned to facility at 5: 25 p.m. Review of Resident R8's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected return, which included the resident's care plan goals and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R12 was admitted to the facility on [DATE]. Review of Resident R12's MDS dated [DATE], indicated diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain), and multiple sclerosis (a disease that affects central nervous system). Review of the clinical record indicated Resident R12 was transferred to the hospital on [DATE], and returned to the facility on [DATE]. Review of Resident R12's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of Resident R12's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on [DATE]. Review of the admission record indicated Resident R35 was admitted to the facility on [DATE]. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 35's MDS indicated the diagnosis of anemia (low iron in the blood), high blood pressure and hyperlipidemia (high fat in the blood). Review of Resident R35's nursing progress notes dated 2/24/25, at 12:36 p.m. indicated physician present in facility and assessed area to back of resident's neck. Upon assessment physician ordered for resident to be sent out to the hospital for evaluation of cyst no other issues at this time called brother to notify, no answer. Left voice mail. Review of Resident R35's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected return, which included the resident's care plan goals and all information necessary to meet the resident's specific needs at the receiving facility, the clinical record also failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer and failed to notify the Office of the State Long-Term Care Ombudsman upon transfer. Review of the clinical record revealed Resident R168 was admitted to the facility on [DATE]. Review of Resident R168's MDS dated [DATE], indicated diagnoses of high blood pressure, Bipolar disorder (a mental condition marked by alternating periods of elation and depression), and muscle weakness. Review of the clinical record indicated Resident R168 was transferred to the hospital on 1/14/26, and did not return to the facility. Review of Resident R168's clinical record, the facility failed to include documented evidence that the facility provided a written transfer notification to the Office of Long-Term Care Ombudsman for the hospitalization on 1/14/26. Review of the clinical record indicated that Resident R180 was admitted to the facility on [DATE]. Review of Resident R180's MDS dated [DATE], indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), dysphagia (difficult swallowing), and muscle weakness. Review of the clinical record indicated Resident R180 was transferred to the hospital on 3/6/26, and returned to the facility on 3/15/26. Review of Resident R180's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of Resident R180's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 3/6/26. Review of the clinical record indicated that Resident R184 was admitted to the facility on [DATE]. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R184's MDS dated [DATE], indicated diagnoses of neurogenic bladder (bladder problems due to disease or injury of the nervous system involved in the control of urination), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and multiple sclerosis. Review of the clinical record indicated Resident R184 was transferred to the hospital on 2/9/26, and did not return to facility. Review of Resident R184's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of Resident R184's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 2/9/26. During an interview on 3/26/26, at 9:13 a.m. Regional Director of Clinical Services Employee E33 confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider and failed to notify the resident or resident's representative of the facility bed-hold policy for Residents R12, R25, R180, and R184. During an interview on 3/27/26, at 9:39 a.m. the Nursing Home Administrator confirmed that there was no evidence that the State Ombudsman office was notified for transfer to the hospital for and the facility failed to notify the Office of the State Long-Term Care Ombudsman upon transfer to the hospital for five of six resident hospital transfers (Resident R12, R35, R168, R180, and R184). 28 Pa. Code: 201.14(a)Responsibility of licensee. 28 Pa. Code: 201.29 (a)(c.3)(2) Resident rights.

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Champion City Nursing and Rehabilitation Center	6655 Frankstown Avenue Pittsburgh, PA 15206

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on review of the Resident Assessment Instrument User's Manual, clinical records, and staff interview, it was determined that the facility failed to make certain that comprehensive Minimum Data Set assessments were completed in the required time frame for three of seven residents (Residents R28, R36, and R48).Findings include: Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2025, indicated that an admission MDS assessment was to be completed no later than 14 calendar days following admission (admission date plus 13 calendar days). Resident R28 had an admission date of 1/17/26, with an MDS completion date of 1/30/26. The MDS was signed off as completed 2/4/26, five days after the due date.Resident R36 had an admission date of 1/21/26, with an MDS completion date of 2/3/26. The MDS was signed off as completed 2/4/26, one day after the due date. Resident R48 had an admission date of 1/19/26, with an MDS completion date of 2/1/26. The MDS was signed off as completed 2/4/26, three days after the due date.During an interview on 3/27/26, at 10:08 a.m. Registered Nurse Assessment Coordinator (RNAC) Employee E15 stated, I just started in February, the previous position was vacant from about November 2025 through January 2026. During an interview on 3/27/26, at 10:08 a.m. RNAC Employee E15 confirmed that the facility failed to make certain that comprehensive MDS assessments were completed in the required time frame for three of seven residents (Residents R28, R36, and R48). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code 211.5(f) Medical records.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and staff interviews, it was determined that the facility failed to develop and implement a baseline care plan to include instructions needed to provide effective and person-centered care of the residents for three of four residents reviewed (Resident R6, R24, and R147).Findings include: Review of the facility policy Baseline Care Plan last reviewed 10/29/25, indicated a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight hours of admission. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including but not limited to the following:Initial goals based on admission orders and discussion with the resident/representative.Physician ordersDietary ordersTherapy servicesSocial service The baseline care plan is used until the staff can conduct a comprehensive assessment and develop an interdisciplinary person-centered care plan. A comprehensive care plan may be used in place of the baseline care plan providing the comprehensive care plan is developed within 48 hours of the resident's admission. Review of the clinical record indicated Resident R6 admitted to the facility on [DATE]. Review of the Resident R6's Minimum Data Set (MDS- a periodic assessment of care needs) dated 2/9/26, indicated the diagnoses of high blood pressure, depression and Post Traumatic Stress Disorder (PTSD- a mental disorder that develops after a traumatic event) Review of Resident R6's baseline care plan failed to include care management for Resident R6's dietary, social service and initial goals. Review of the clinical record indicated Resident R24 admitted to the facility on [DATE]. Review of the Resident R24s Minimum Data Set (MDS- a periodic assessment of care needs) dated 3/3/26, indicated the diagnoses of high blood pressure, diabetes (high sugar in the blood) and hyperlipidemia (high fat in the blood) Review of Resident R24's physician orders dated 11/27/25, at 4:00 p.m. indicated Insulin Lispro Injection Solution 100 UNIT/Milliliter (ML) Inject as per sliding scale. Review of Resident R24's baseline care plan failed to include care management for Resident R24's diabetes management, dietary, social service and initial goals. Review of the clinical record indicated Resident R147 admitted to the facility on [DATE]. Review of the Resident R147s MDS dated [DATE], indicated the diagnoses of high blood pressure, Human Immunodeficiency Virus Disease (HIV-chronic condition caused by a virus that damages the immune system) and viral hepatitis (inflammation of the liver due to a viral infection). Review of Resident R147's baseline care plan failed to include care management for Resident R147's dietary, social service and initial goals. During an interview completed on 3/25/26, at 1:33 p.m. Registered Nurse (RN) Employee E16 confirmed that the facility failed to complete baseline care plans for Resident R6, R24, and R147. During an interview completed on 3/26/26, at 12:35 p.m. the Director of Nursing stated that the baseline care plans were not done for Residents R6, R24, and R147. During an interview completed on 3/23/26, at 1:25 p.m. [NAME] President of Clinical Services Employee E27 stated the baseline care plan is within the comprehensive care plan upon review of the comprehensive care plan it was discovered that the care plans failed to include the information necessary to properly care for the residents and confirmed that the facility failed to develop and implement a baseline care plan to include the minimum healthcare instructions needed to provide effective and person-centered care of the resident for three of four residents reviewed (Resident R6, R24, and R147). 28 Pa Code 211.10(a) Resident care policies.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 perform timely and accurate post-fall documentation and failed to make certain that residents were provided appropriate treatment and care in accordance with professional standards of practice for two of five residents (Residents R10 and R13), and failed to provide 1:1 supervision during a suicidal ideation for one of two residents (Resident R181). indings include: Review of facility policy Assessing Falls and Their Causes dated 10/29/25, indicated staff are to observe for delayed complications of a fall for approximately forty-eight (48) hours after an observed or suspected fall, and will document findings in the medical record. Review of the facility Registered Nurse (RN) job description indicated major duties and responsibilities include assesses for changes in residents' status, notifying the physician and resident's family or representative and documenting accordingly. Review of facility policy Suicide Threats dated 10/29/25, indicated resident suicide threats shall be taken seriously and addressed appropriately. A staff member shall remain with resident. Review of the clinical record indicated 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 12/31/25, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and anxiety. Review of a nursing progress note dated 3/22/26, at 2:10 a.m. completed by Licensed Practical Nurse (LPN) Employee E32 stated, Writer heard resident yelling out for help from inside her room. Upon entering the room, resident observed laying on her back with her legs flexed. Alert and oriented. Able to make needs known. Denied hitting her head denied pain. Vital signs obtained. BP (blood pressure) 160/100. Neuro checks stable at baseline. Moving all extremities, bilateral (both sides) hips equal, no shortening noted. Assisted off the floor x 2 assist and toileted, returned back to bed, safety measures maintained, call light within reach. bed in lowest position.Review of Resident R10's clinical record failed to include documentation that the resident was assessed by a Registered Nurse after being found on the floor on 3/22/26, at 2:10 a.m.Review of a nursing progress note dated 3/22/26, at 7:15 a.m. completed by RN Employee E3 stated, Upon arrival to the unit, I heard someone yelling out that they are on the floor. I went into Resident R10's room and noted her on the bathroom floor. She denied hitting her head on the floor nor did she have any open injuries. The night nurse stated that she had fallen earlier that night around 2am and stated that she her vital signs at the time they were she was fine. Physician was called along with the family members and was made aware of her falling outta the bed. Physician's on called doctor was also made aware and decided not to take any action, just continue to monitor her. So far the resident has stayed in her chair. Review of Resident R10's clinical record failed to include documentation that the resident was monitored for delayed complications after a suspected fall on 3/22/26, at 2:10 a.m. and 7:15 a.m. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/25/26, at 11:15 a.m. LPN Employee E1 stated, After a resident falls, we do neuro assessments on paper and once they're done, the supervisor collects them. We're supposed to do an incident report, fall assessment, skin assessment, pain assessment. There are four assessments we do. We check vital signs, assess for injuries. We're supposed to chart every shift for 72 hours. Sometimes the LPNs are allowed to do the incident report, sometimes it has to be the RNs. It depends on who management is at the time. During an interview on 3/26/26, at 12:25 p.m. the Director of Nursing (DON) confirmed there was no documented evidence that a Registered Nurse assessed Resident R10 after a fall on 3/22/26 at 2:10 a.m. and staff failed to document that the resident was monitored for delayed complications after a suspected fall on 3/22/26, at 2:10 a.m. and 7:15 a.m. Review of the clinical record indicated Resident R13 was admitted to the facility on [DATE]. Review of Resident R13's MDS dated [DATE], indicated diagnoses of dementia, cerebral infarction (necrotic tissue in the brain resulting in loss of blood and oxygen to the brain), and high blood pressure. Review of a nursing progress note dated 2/6/26, at 11:59 a.m. completed by LPN Employee E8 stated, Resident wandering in another resident's room and found lying backwards in bathtub. Fall was unwitnessed and reported by other resident.Review of Resident R13's clinical record failed to include documentation that the resident was assessed by a RN after being found on the floor on 2/6/26, at 11:59 a.m. During an interview on 3/25/26, at 2:27 p.m. LPN Employee E11 stated, We make sure they are okay and call the RN supervisor. RN supervisor then comes to assess the resident and lets us know if it's okay to get resident up. Then she calls the doctor and follows their orders. We either send them to the hospital or treat them at the facility, and confirmed that there was no documented evidence that a RN assessed Resident R13 after a fall on 2/6/26, at 11:59 a.m. Review of the clinical record indicated Resident R181 was admitted to the facility on [DATE]. Review of Resident R181's MDS dated [DATE], indicated diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), anxiety, and schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized speech and behavior). Review of a nursing note dated 3/26/26, at 10:33 p.m. indicated Resident R181 called crisis center to speak with them. The crisis center notified facility, and they reported that the resident stated she was having thoughts of suicide. Resident 1:1. Did not state to staff she was having these thoughts. Remains 1:1. Resting quietly in bed at present time. During an observation on 3/27/26, at 11:03 a.m. Resident R181 was sitting in the hallway coloring with another resident. Resident R181 stated, I'm going to go see where my sitter is. During an observation on 3/27/26, at 11:05 a.m. the assigned 1:1 Nursing Assistant (NA) Employee E34 was behind the nurse's station talking to other staff members and Resident R181 was not with in sight. During an interview on 3/27/26, at 12:29 p.m. Social Worker Employee E24 stated, If someone is 1:1, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	it is to keep eyes on them. I would contact someone to take my position if I needed to leave for some reason. During an interview on 3/27/26, at 12:38 p.m. NA Employee E23 stated, If they are 1:1, then they need to be 1:1 all day. If I needed to leave for some reason, someone else must come. There should be eyes on that person at all times. During an interview on 3/27/26, at 1:13 p.m. the Nursing Home Administrator and Director of Nursing confirmed that crisis was notified and the facility is waiting on transportation to pick up resident and Resident R181 was not being supervised 1:1 to ensure the safety of the resident. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and clinical records and staff interview, it was determined that the facility failed to obtain physician order for a urinary catheter (insertion of a tube into the bladder to remove urine) for three of four residents (Resident R4, R9, and R125), failed to make certain that appropriate treatments and services were provided for the use of a urinary catheter as required for three of four residents (Resident R9, R125, and R180), and failed to ensure that care was provided in a manner which maintained resident dignity for two of four residents (Resident R125, and R180). The facility policy entitled Foley Catheter Insertion, male resident dated 10/29/25, indicated that the physician's order should be verified. Review of facility policy Care Plans, Comprehensive Person-Centered dated 10/29/25, indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Review of the clinical record indicated Resident R4 was admitted [DATE]. Review of Resident R4's MDS (minimum data set a periodic review of assessment needs) dated 2/18/26, indicated diagnosis of fracture left femur, chronic obstructive pulmonary disease (common lung disease causing restricted airflow and breathing problems) and dysphasia (difficulty swallowing). Review of a physician's order dated 8/14/25, indicated Resident R4 orders did not include the catheter, balloon size or the valid medical diagnosis for the catheter. During an interview on 3/26/26, at 1:30 p.m. Director of Nursing confirmed there were no orders for Resident R4's catheter as required. Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident R9's MDS dated [DATE], indicated diagnoses of muscle weakness, aphasia (a disorder that causes a loss of ability to produce or understand spoken and written language, often following a stroke or head injury), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Section H0100- Appliances A, indwelling catheter is marked to indicate that resident has a catheter. Review of clinical record conducted on 3/23/26, revealed that Resident R9 did not reveal a physician's order for a catheter, or a care plan for catheter care. Review of Resident R9's treatment record revealed that staff was to provide catheter care every shift beginning on 3/4/26. Review of the treatment record indicated that Resident R9 did not receive catheter care on the evening shift of 3/12/26, and 3/16/26, and on night shift of 3/20/26. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/25/26, at 12:45 p.m. the Director of Nursing (DON) confirmed that Resident R9 did not have a current order for a catheter, a care plan for a catheter, and that catheter care was not obtained on the evening shift of 3/12/26, and 3/16/26, and on night shift of 3/20/26. Review of the clinical record indicated Resident R125 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of clinical record revealed a progress note dated 3/12/26, that Resident R125 has a foley catheter that is intact/patent and draining yellowish in color urine. Review of Resident R125's MDS dated [DATE], indicated diagnoses of muscle weakness, kidney failure, and high blood pressure. Section H0100- Appliances A, indwelling catheter is marked to indicate that resident has a catheter. During an observation on 3/23/26, at 10:39 a.m. Resident R125 was resting in bed with a catheter bag hanging on her bedframe without a privacy cover applied. During an interview on 3/23/26, at 10:51 a.m. Nurse Aide (NA) Employee E31 confirmed that Resident R125's catheter draining bag did not have a privacy cover and that the facility failed to ensure that care was provided in a way that maintained Resident R9's dignity. Review of Resident R125's clinical record conducted on 3/23/26, did not reveal a physician's order for a catheter. Review of the treatment record indicated that Resident R125 revealed that staff was to provide catheter care every shift starting 3/18/26. Note that resident did not receive catheter care from her 3/11/26, readmission until 3/18/26 During an interview on 3/25/26, the DON confirmed that the facility failed to obtain an order for Resident R125's catheter, and ensure that catheter care was provided every shift from 3/11/26 through 3/17/26. Review of Resident R180's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R180's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/6/26, indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), dysphagia (difficult swallowing), and muscle weakness. Section H-Bladder and Bowel, H0100- Appliances A, indwelling catheter is marked. Resident R180 was admitted to facility with a foley catheter. During an observation on 3/23/26, at 9:30 a.m. Resident R180 was sitting by the nurse's station with a foley catheter bag hanging on the wheelchair without a privacy cover applied. During an interview on 3/23/26, at 10:44 a.m. Licensed Practical Nurse (LPN) Employee E8 confirmed Resident R180's catheter draining bag did not have a privacy cover and that the facility failed to ensure that care was provided in a way that maintained Resident R180's dignity. Review of the clinical record revealed that Resident R180 had a physician's order for a foley catheter (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	but failed to have a diagnosis for the foley catheter in place and failed to have a diagnosis in Resident R180's care plan. During an interview on 3/25/26, at 1:15 p.m. the Director of Nursing confirmed that Resident R180 did not have a current diagnosis for a foley catheter, and no foley catheter diagnosis care planned. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, and staff interview it was determined that the facility failed to provide appropriate respiratory care relating to CPAP/BIPAP (a continuous positive airway pressure machine used to keep airways open while you sleep/a positive airway pressure machine when breathing in and breathing out) for one of three residents (Residents R36), and that the facility failed to maintain oxygen equipment for two of three sampled residents (Residents R122 and R157). Findings include: Review of the facility policy Oxygen Administration last reviewed 10/29/25, indicated dated 1/2/25, indicated the purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure. Review the physician orders of facility protocol for oxygen administration. Review the residents' care plan to assess any special needs of the residents. Review of the facility policy Fire safety and prevention last reviewed 10/29/25, indicated oxygen safety: store oxygen in clean dry locations away from direct sunlight. Use plugs, caps and plastic bags to protect equipment in use from dust and dirt. Review of the admission record indicated Resident R36 was admitted on [DATE]. Review of Resident R36s Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/27/26 indicated the diagnosis of high blood pressure, anxiety and obstructive sleep apnea (breath pauses while sleeping). During an observation completed on 3/23/26, at 10:43 a.m. Resident R36's bedside stand had a BI-PAP machine with the mask lying on the top of the stand not stored in a bag as required. During an interview completed on 3/23/26, at 12:34 p.m. Licensed Practical Nurse (LPN) Employee E17 confirmed Resident R36's bedside stand had a BI-PAP machine with the mask lying on the top of the stand not stored in a bag as required. Review of Resident R36's current physician orders failed to include instructions for the BI-PAP machine. Review of Resident R36's current care plan failed to include interventions for the BI-PAP machine Interview completed on 3/25/26, at 1:33 p.m. Registered Nurse (RN) Employee E16 confirmed that Resident R36 did not have current physician orders or a care plan intervention for the BI-PAP machine and that the facility failed to provide appropriate respiratory care relating to CPAP/BIPAP for one of three residents (Residents R36). Review of the clinical record indicated Resident R122 was admitted to the facility on [DATE]. Review of Resident R122's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/4/26, indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), high blood pressure, and chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness). Section O Special (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Treatments, Procedure and Programs O0110, C1 Oxygen Therapy is marked as while a resident. Review of physician orders dated 1/29/26, indicated to administer oxygen via nasal cannula (a thin tubing that delivers oxygen from the oxygen concentrator to the nose) four liters per minute every shift for COPD. Review of physician orders dated 1/29/26, indicated to change oxygen tubing and filter weekly, one time a day every Monday. Review of physician orders dated 1/29/26, indicated Ipratropium-Albuterol Solution (a medication used to treat lung diseases) inhale orally every four hours as needed via nebulizer (a machine used to deliver medication) for shortness of breath. During an observation on 3/23/26, at 10:03 a.m. Resident R122 was lying in bed with oxygen in use. The oxygen concentrator was located beside the bed. Oxygen tubing was dated 3/9/26, and the nebulizer tubing was dated 2/28/26, and was not stored in a bag when not in use. During an interview on 3/23/26, at 10:47 a.m. Licensed Practical Nurse (LPN) Employee E8 stated that the tubing should get changed weekly and confirmed the dates on the oxygen and nebulizer tubing and that the nebulizer mask was not stored in a bag when not in use. Review of the clinical record indicated Resident R157 was admitted to the facility on [DATE]. Review of Resident R157's MDS dated [DATE] indicated diagnoses of hyperlipidemia (high fat in the blood), diabetes (high sugar in the blood) and chronic obstructive pulmonary disease (COPD- causes restricted airflow and breathing problems). Review of Resident R157 physician orders dated 10/13/25, indicated Nebusal Inhalation Nebulization Solution 6 % (helps to improve lung function by using a nebulizer machine that changes a solution into a mist that is inhaled) 1.5 milliliter (ml) inhale orally two times a day. During an observation completed on 3/23/26, at 10:04 a.m. Resident R157's nebulizer was hanging on the nightstand drawer wrapped around the pull handle not stored in a bag as required During an interview completed on 3/23/26, at 10:15 a.m. LPN Employee E17 confirmed the nebulizer was hanging on the nightstand drawer wrapped around the pull handle not stored in a bag as required. During an interview on 3/23/26, at 2:45 p.m. the Director of Nursing confirmed that the facility failed to provide appropriate respiratory care for two of three residents (Resident R122 and R157). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(d) Resident care policies.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of resident clinical records, facility policy and staff interview it was determined the facility failed to provide consistent and complete communication with the dialysis (treatment that helps body remove extra fluid and waste products) center for one of four residents (Resident R171), and failed to ensure that monitoring of residents' access site was completed for three of four residents (Resident R11, R47, and R171). Findings include: Review of the facility policy Hemodialysis dated 10/29/25, indicated that the facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include the ongoing assessments of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility. Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. The facility will monitor and document the status of the resident's access site(s) upon return from the dialysis treatment and observe for bleeding or other complications. Review of the clinical record revealed Resident R11 was admitted to the facility on [DATE]. Review of Resident R11's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/21/26, indicated diagnoses of high blood pressure, End Stage Renal Disease (ESRD - an inability of the kidneys to filter the blood), and hemiplegia (paralysis on one side of the body). Review of a physician order dated 1/11/26, indicated dialysis: site - check right chest tunneled dialysis catheter for bleeding or symptoms of infection every shift.Review of Resident R11's March 2026 Treatment Administrator Record (TAR) revealed the treatment was not signed off as completed or refused on the following shifts: 3/16/25, 7 a.m. - 3 p.m. shift 3/22/26, 7 a.m. - 3 p.m. shift 3/24/26, 3 p.m. - 11 p.m. shift Review of the clinical record revealed Resident R47 was admitted to the facility on [DATE]. Review of Resident R47's MDS dated [DATE], indicated diagnoses of high blood pressure, ESRD, and muscle weakness. Review of a physician order dated 1/16/26, indicated hemodialysis: observe dialysis left chest site for s/sx (signs and symptoms) of infection such as redness, edema (swelling from trapped fluid), bleeding, and drainage. Report abnormal findings to the provider every shift. Review of Resident R47's March 2026 TAR revealed the treatment was not signed off as completed or refused on the following shifts: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/2/26, 7 a.m. - 3 p.m. shift 3/16/26, 7 a.m. - 3 p.m. shift 3/17/26, 7 a.m. - 3 p.m. shift 3/22/26, 7 a.m. - 3 p.m. shift 3/23/26, 3 p.m. - 11 p.m. shift During an interview on 3/26/26, at 12:30 p.m. the Director of Nursing (DON) confirmed that the facility failed to ensure that monitoring of residents' access site was completed for Residents R11 and R47. Review of the admission record indicated Resident R171 was admitted to the facility on [DATE], with diagnoses of end-stage kidney disease, dependence on dialysis, and muscle weakness. Review of Resident R171's clinical record revealed a physician's order dated 3/20/26, to go to dialysis, and also to monitor right subclavian dialysis catheter every shift. State Agency was provided with Resident R171's communication binder upon request, however there was no communication in the binder. During an interview on 3/25/26, at 10:12 a.m. Licensed Practical Nurse (LPN) Employee E12 stated that Resident R171 goes to dialysis every Tuesday, Thursday, and Saturday, and that she has been to dialysis two times she was admitted . Once on 3/21/26, and the other on 3/24/26. When LPN Employee E12 was asked where the communication sheets were for Resident R171, she replied We couldn't find the binder so we sent her without it. Review of Resident R171's medical record conducted on 3/25/26, revealed that staff had not documented that the access site was being monitored since admission on [DATE]. During an interview on 3/25/26, at 12:48 p.m. the Director of Nursing confirmed that the facility failed to complete communication with the dialysis center and failed to monitor the access site for Resident R171. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1) Management.28 Pa. Code: 211.10(c)(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(3)(5) Nursing 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 the clinical records and staff interview, it was determined that the facility failed to provide documentation that medication regimen reviews (MRR) were completed and reviewed by the resident's attending physician monthly for five of five residents (Residents R13, R16, R24, R37, and R139).Findings include: Review of facility policy Medication Regimen Reviews dated 10/29/25, indicated a licensed pharmacist reviews the medication regimen of each resident at least monthly. The consultant pharmacist provides the director of nursing services and medical director with copy of all medication regimen reports. Upon receiving the MRR report from the pharmacist, the director of nursing reviews the recommendations with the attending physician, responds to the report, and documents what (if any) actions were taken to address them. Review of the clinical record indicated Resident R13 was admitted to the facility on [DATE]. Review of Resident R13's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/11/26, indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life) , cerebral infarction (necrotic tissue in the brain resulting in loss of blood and oxygen to the brain), and high blood pressure. Review of Resident R13's MRR dated 3/31/25, indicated the following recommendation from the pharmacist to the physician: Recommendation: The resident is receiving the antipsychotic agent Quetiapine (a mind-altering medication), but lacks an allowable diagnosis to support its use. Please consider an appropriate diagnosis. Review of Resident R13's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 3/31/25. Review of Resident R13's MRR dated 8/30/25, indicated the following recommendation from the pharmacist to the physician: Recommendation: Escitalopram Oxalate (a medication used to treat depression) 15 milligrams by mouth once a day. If an antidepressant is used for sleep or to manage behavior, stabilize mood, or treat a psychiatric disorder, it must be reviewed for a possible gradual dose reduction (GDR) in an effort to find the lowest effective dose. Review of Resident R13's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 8/30/25. On 9/4/25, a CRNP addressed the MRR, stating, Depression ongoing-any further GDR would likely exacerbate underlying symptoms. Review of Resident R13's MRR dated 9/29/25, indicated the following recommendation from the pharmacist to the physician: Recommendation: Quetiapine 100 milligrams by mouth two times a day. The resident is receiving the (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	antipsychotic agent Quetiapine but lacks an allowable diagnosis to support its use. Please consider an appropriate diagnosis. Review of Resident R13's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 9/29/25. On 10/9/25, a CRNP addressed the MRR, stating, Please add schizoaffective disorder (a mental disorder in which a person experiences a combination of schizophrenia and mood disorder symptoms); refer to psych notes. Review of Resident R13's MRR dated 1/31/26, indicated the following recommendation from the pharmacist to the physician: Recommendation: Quetiapine 100 milligrams by mouth two times a day. Resident is due for a GDR in an attempt to find the lowest effective dose. Please consider a trail dose reduction. Review of Resident R13's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 1/31/26. Review of the clinical record indicated Resident R16 was admitted to the facility on [DATE]. Review of Resident R16's MDS dated [DATE], indicated diagnoses of depression, dementia, and insomnia (difficult sleeping). Review of Resident R16's MRR dated 3/31/25, indicated the following recommendation from the pharmacist to the physician: Recommendation: Zyprexa (a mind-altering medication) 2.5 milligrams by mouth two times a day. The resident is receiving the antipsychotic agent, but lacks an allowable diagnosis to support its use. Please consider an appropriate diagnosis. Review of Resident R16's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 3/31/25. Review of Resident R16's MRR dated 7/31/25, indicated the following recommendation from the pharmacist to the physician: Recommendation: Zyprexa 2.5 milligrams by mouth two times a day. The resident is receiving the antipsychotic agent, but lacks an allowable diagnosis to support its use. Please consider an appropriate diagnosis. Review of Resident R16's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 7/31/25. Review of Resident R16's MRR dated 9/29/25, indicated the following recommendation from the pharmacist to the physician: Recommendation: Zyprexa 2.5 milligrams by mouth two times a day. The resident is due for a GDR in an attempt to find the lowest effective dose. Please consider a trial dose reduction. Review of Resident R16's clinical record failed to include a response from the resident's attending (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R37's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 8/30/25. On 9/5/25, a Certified Registered Nurse Practitioner (CRNP) addressed the MRR, stating, Continue Omeprazole - chronic acid reflux. Review of Resident R37's MRR dated 9/29/25, indicated the following recommendation from the pharmacist to the physician: Recommendation: Duloxetine HCL Oral Capsule Delayed Release, give 120 mg by mouth one time a day for depression. If an antidepressant is used for sleep or to manage behavior, stabilize mood, or treat psychiatric disorder, it must have reviewed for a possible gradual dose reduction in an effort to find the lowest effective dose. If a dose reduction is deemed clinically contraindicated at this time, please state the rationale below and the risk vs. benefit of continuing the drug at the current dose. Review of Resident R37's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 9/29/25. On 10/9/25, a Certified Registered Nurse Practitioner (CRNP) addressed the MRR, stating, Disagree - moods unstable and GDR (gradual dose reduction) will likely exacerbate underlying etiology. Review of Resident R37's MRR dated 10/31/25, indicated the following recommendation from the pharmacist to the physician: Recommendation: Xanax Oral Tablet 0.5 mg give 1 tablet by mouth three times a day for anxiety related to anxiety disorder. Resident is due for a gradual dose reduction in an attempt to find the lowest effective dose. Please consider a trial dose reduction. If the medication cannot be reduced at this time, please check the appropriate response below related to the gradual dose reduction being clinically contraindicated at this time. Review of Resident R37's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 10/31/25. On 11/25/25, a Certified Registered Nurse Practitioner (CRNP) addressed the MRR, stating, Disagree - anxiety chronic and ongoing, further GDR would exacerbate symptoms. Review of Resident R37's clinical record failed to include documentation that a MRR was performed monthly for March 2025, April 2025, May 2025, June 2025, and July 2025. Review of the clinical record revealed Resident R139 was admitted to the facility on [DATE]. Review of Resident R139's MDS dated [DATE], indicated diagnoses of depression, schizoaffective disorder (a mental disorder in which a person experiences a combination of schizophrenia and mood disorder symptoms), and muscle weakness. Review of Resident R139's MRR dated 9/29/25, indicated the following recommendation from the pharmacist to the physician: Recommendation: Abilify Oral Tablet 10 mg, give 1 tablet by mouth two times a day for mood. The resident is receiving the antipsychotic agent Abilify, but lacks an allowable diagnosis to support its use. Review of Resident 139's clinical record failed to include a response from the resident's attending (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician regarding the recommendation made on 9/29/25. On 10/9/25, a Certified Registered Nurse Practitioner (CRNP) addressed the MRR, stating, Please add schizoaffective diagnosis; refer to psych notes. Review of Resident R139's MRR dated 12/31/25, indicated the following recommendation from the pharmacist to the physician: Recommendation: Ativan Oral Tablet 0.5 mg, give 1 tablet by mouth two times a day for anxiety. Resident is due for a gradual dose reduction in an attempt to find the lowest effective dose. Please consider a trial dose reduction. If the medication cannot be reduced at this time, please check the appropriate response below related to the gradual dose reduction being clinically contraindicated at this time. Review of Resident 139's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 12/31/25. On 1/20/26, a Certified Registered Nurse Practitioner (CRNP) addressed the MRR, stating, Further GDR would likely exacerbate underlying psychotic symptoms. During an interview on 3/25/26, at 3:05 p.m. the Director of Nursing (DON) stated, I don't have any [MRRs] from before August 2025. The completed MRRs I gave you is all I have. During this interview, the DON confirmed that the facility failed to provide documentation that medication regimen reviews were completed monthly for five of five residents (Residents R13, R16, R24, R37, and R139). During an interview on 3/26/26, at 9:30 a.m. the DON confirmed that the monthly medication regimen reviews are addressed by the facility and Psych services CRNPs and not the resident's attending physician for Residents R13, R16, R37, and R139. 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to properly store medications in four of five medication carts (Second Floor Medication Cart, Third Floor Medication Cart, Fourth Floor Front Medication Cart, and Sixth Floor Back Medication Cart) and one of three medication rooms (Sixth Floor Medication Room), and failed to properly secure a medication cart while not in use for one of five medication carts (Fifth Floor East Front Medication Cart). Findings include: Review of the facility policy Medication Storage last reviewed [DATE], indicated medications will be stored in a manner that maintains the integrity of the product, ensures the safety of the resident's and is in accordance with the Department of Health guidelines. Medications will be stored in the original, labeled containers received from the pharmacy. Expired, discontinued and/or contaminated medications will be removed from the medication storage area and disposed of in accordance with the facility policy. With the exception of Emergency Drug Kits, all medications will be stored in a locked cabinet, cart or medication room that is accessible only to authorized personnel, as defined by facility policy. During an observation completed on [DATE], at 12:21 p.m. the Fourth Floor Front Medication Cart contained the following: A medication cup stored in the top right drawer labeled 128 that contained 4 white round pills, 1 oval pink pill, 1 yellow oblong pill and 1 green oblong pill. 1 bottle of lactulose solution that failed to be labeled with a date opened as required. 1 opened vial of lispro insulin, that failed to be labeled with a name or date opened as required. 1 bottle of artificial tears that failed to be labeled with a date opened as required. 2 Breo Ellipta inhalers that failed to be labeled with a date opened as required. 1 fluticasone diskus inhaler that failed to be labeled with a date opened as required, 2 trelegy inhalers that failed to be labeled with a date opened as required. During an interview completed on [DATE], 12:25 p.m. Licensed Practical Nurse (LPN) E17 confirmed the above observations and that the facility failed to properly store medications in the Fourth Floor Front Medication Cart.During a medication cart review completed on [DATE], at 11:17 a.m. the Third Floor Medication Cart contained the following: Lantus Insulin Pen (used to treat high blood sugar) - no open date and no expiration date Lispro Insulin Pen (used to treat high blood sugar) - no open date and no expiration date (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE], at 11:21 a.m. LPN Employee E11 confirmed the above observations and that the facility failed to properly store medications in the Third Floor Medication Cart. During a medication cart review completed on [DATE], at 11:34 a.m. the Second Floor Medication Cart contained the following: Humalog Insulin Cartridge (used to treat high blood sugar) - no open date and no expiration date During an interview on [DATE], at 11:42 a.m. LPN Employee E12 confirmed the above observations and that the facility failed to properly store medications in the Second Floor Medication Cart. During an observation on [DATE], at 11:22 a.m. the following were observed in the Sixth Floor Medication Room in a drawer labeled IV (Intravenous) Supplies: Three (3) vanilla pudding cups Eight (8) unsweetened applesauce cups During an interview on [DATE], at 11:24 a.m. LPN Employee E1 confirmed the above observation and that the facility failed to properly store medications in the Sixth Floor Medication Room. During an observation on [DATE], at 8:34 a.m. the Fifth Floor East Front Medication Cart was in the hallway outside of a resident room unlocked and unattended. During an interview on [DATE], at 8:35 a.m. LPN Employee E13 confirmed the above observation and that the facility failed to properly secure a medication cart while not in use. During an observation completed on [DATE], at 9:35 a.m. the Sixth Floor Back Hall Medication Cart contained the following: 1 bottle of pro-stat liquid protein that failed to be labeled with a date opened as required. During an interview completed on [DATE], at 9:44 a.m. LPN Employee E19 confirmed the above observation and that the facility failed to properly store medications in the Sixth Floor Back Hall Medication 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.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on facility policy, menu, observations, and staff interviews, it was determined that the facility failed to follow the menu for two of two lunch meal (lunch meal Monday 3/23/26, and Tuesday 3/24/26). The facility policy entitled Food and Nutrition Services dated 10/29/25, indicated each resident is provided with a nourishing, palatable, well-balanced diet that meets hir or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Review of facility policy Tray Identification dated 10/29/25, indicated that appropriate identification shall be used to identify various diets. A review of the menu indicated that the menu for lunch on 3/23/26, was as follows:Chicken and biscuits, carrots, cranberries, gelatin, and juiceDuring an observation of lunch on 3/23/26, the third floor failed to include the following:Resident R71 was missing finger food items, magic cup, peanut butter and jelly sandwich, and milk were missing from trayResident R180 was missing magic cup on trayResident R127 was missing magic cup on trayResident R29 was missing gelatin on trayResident R66 was missing gelatin on trayResident R100 was missing gelatin on trayDuring an interview on 3/23/26, at 12:44 p.m. Licensed Practical Nurse (LPN) Employee E8 confirmed the missing food items above. A review of the menu indicated that the menu for lunch on 3/24/26, was as follows:Salisbury steak, carrots, mashed chive potatoes, gravy, soup, bread pudding During an observation of lunch meal trayline service in the main kitchen on 3/24/26, at 12:34 p.m., it was revealed residents (14) had the following instead: Hamburger or grilled cheese, mashed chive potatoes, california vegetables During an interview on 3/24/26, at 12:45 p.m. Dietary [NAME] Employee E26 confirmed that she was serving a different menu. She stated Our morning cook called off, we had carrots two days in a row and we didn't give the right food to PC (personal care). During an interview on 3/24/36, at 1:05 p.m. Dietary Manager Employee E21 confirmed that the facility failed to serve what was on the menu and to reflect menu changes. During an observation of lunch on 3/24/26, the third floor failed to include the following:Resident R86 was served blended vegetables, no soup on tray, and no onions and mushroomsResident R28 was missing vegetables and bread puddingResident R136 was missing soup and bread puddingResident R180 was missing magic cup and soup, no bread puddingResident R71 was served grilled cheese, no magic cup, no soup, no bread puddingResident R100 was missing soup and bread puddingResident R46 was missing soup and bread puddingResident R29 was missing bread puddingResident R14 was missing soup and bread puddingDuring an interview on 3/24/26, at 1:15 p.m. Licensed Practical Nurse (LPN) Employee E11 confirmed the missing food items above. 28 Pa. Code: 211.6(a)(b) Dietary services

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on review of facility policy, Quality Assurance attendance records, and staff interview, it was determined that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all of the required committee members for three of four quarters (April 2025 through June 2025, July 2025 through September 2025, and October 2025 through December 2025).Findings include: A review of the QAA Committee meeting sign-in sheets from the period of April 2025 through June 2025, did not reveal that the Director of Nursing or Infection Preventionist were in attendance. A review of the QAA Committee meeting sign-in sheets from the period of July 2025 through September 2025, did not reveal that the Director of Nursing was in attendance. A review of the QAA Committee meeting sign-in sheets from the period of October 2025 through December 2025, did not reveal that the Director of Nursing was in attendance. During an interview on 3/27/26, at 12:55 p.m. Regional Nursing Home Administrator Employee E25 confirmed that the facility failed to conduct QAA meetings at least quarterly with all of the required committee members for three of four quarters (April 2025 through June 2025, July 2025 through September 2025, and October 2025 through December 2025). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(e)(1)(2)(3)(4) Management.

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	395423	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Champion City Nursing and Rehabilitation Center	6655 Frankstown Avenue Pittsburgh, PA 15206

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, observations, and staff interviews, it was determined that the facility failed to implement enhanced barrier precautions for one of four residents (Residents R180), failed to implement an infection control program that included a system of surveillance to identify possible communicable diseases or infections for nine of twelve months (March, April, May, September, October, November, and December 2025, and January and February 2026), and failed to prevent cross contamination during a dressing change for one of three residents (Resident R2).Findings include: Review of the facility policy Enhanced Barrier Precautions (EBP) dated 10/29/25, indicated EBP's are utilized to prevent the spread of multi-drug-resistant organisms for residents. EBP refers to infection prevention and control interventions designed to reduce the transmission of organisms during high contact resident care activities. Review of facility policy Surveillance for Infections dated 10/29/25, indicated the Infection Preventionist will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcomes and that may require transmission-based precautions and other preventative interventions. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and HAIs, to guide appropriate interventions, and to prevent future infections. Review of facility policy Infection Prevention and Control Program dated 10/29/25, indicated an infection prevention and control program is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Review of facility policy Wound Care dated 10/29/25, indicated the purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Wipe reusable supplies, such as scissor blades. Review of the clinical record indicated that Resident R180 was admitted to the facility on [DATE]. Review of Resident R180's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/6/26, indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), dysphagia (difficult swallowing), and muscle weakness. Section H-Bladder and Bowel, H0100- Appliances A, indwelling catheter (a flexible tube inserted into the bladder to drain urine) is marked. Resident R180 was admitted to facility with a foley catheter. During an observation on 3/23/26, at 9:30 a.m. Resident R180 was sitting by the nurse's station with a foley catheter bag hanging on the wheelchair. During an observation on 3/23/26, at 9:44 a.m. Resident R180's room failed to have EBP signage on the door. During a review of Resident R180's physician orders on 3/23/26, at 9:57 a.m. failed to include orders for EBP relating to the indwelling catheter upon admission. During an interview on 3/23/26, at 10:40 a.m. Licensed Practical Nurse (LPN) Employee E8 confirmed Resident R180's door was missing EBP signage and failed to have an order for EBP related to having a foley catheter in a timely manner. During an interview on 3/23/26, at 2:30 p.m. Director of Nursing confirmed that the facility failed to implement enhanced barrier precautions for one of four residents (Residents R180). During a review of the facilities infection control program on 3/25/26, at 9:15 a.m. the facility failed to provide documented evidence of infection surveillance for the facility for nine of twelve months (March, April, May, September, October, November, and December 2025, and January and February 2026. During an interview on 3/25/26, at 10:51 a.m. Director of Nursing reviewed the facilities infection control documents with State Agency (SA) and was unable to provide the facilities infection surveillance and stated, I haven't been here that long. We just hired a new infection preventionist, and we will be working at getting all the infection control in order. We need to track infections to see if we can find a trend to reduce infection rates in the facility and confirmed that the facility failed to implement an infection control program that included a system of surveillance to identify possible communicable diseases or infections for nine of twelve months (March, April, May, September, October, November, and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	December 2025, and January and February 2026). Review of the clinical record indicated that Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's MDS dated [DATE], indicated diagnoses of wound infection, depression, and paraplegia (a form of paralysis affecting the lower half of the body). During a review of Resident R2's physician orders dated 3/26/26, indicated wound care- cleanse left heel with normal saline solution, pat dry, apply Santyl (a chemical agents for removing dead skin cells), calcium alginate (a highly absorptive dressing that creates a protective gel and maintains a moist wound environment) cut to fit, dry dressing daily and as needed for soilage/dislodgement. During a wound dressing change observation on 3/26/26, at 12:00 p.m. LPN Employee E13 failed to clean scissor blades prior to cutting the calcium alginate for Resident R2. During an interview on 3/26/26, at 12:21 p.m. LPN Employee E13 confirmed that she failed to clean the scissors prior to use for the dressing change and the facility failed to prevent cross contamination during a dressing change for one of three residents (Resident R2). 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1)(e)(1) Management. 28 Pa. Code: 211.10 (d) Resident care policies. 28 Pa. Code: 211.12 (d)(1)(2)(5) Nursing services.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on a review of facility policy, facility provided documentation, and staff interviews, it was determined the facility failed to designate a consistent qualified individual(s) onsite, who is responsible for implementing programs and activities to prevent and control infections for seven of 12 months (February 2025, through September 2026).Findings included: Review of facility Infection Preventionist policy dated 10/29/25, indicated the infection preventionist is responsible for coordinating, implementing, and updating the infection prevention and control program. The infection preventionist is scheduled with enough time to properly assess, develop, implement, monitor, and manage the infection prevention and control program, address training requirements, and participate in required committees. Evidence of training is provided through a certification. During entrance meeting on 3/23/26, at 9:00 a.m. Nursing Home Administrator stated a new Infection Preventionist was hired and was identified as the facilities Infection Preventionist (IP). During a review of the facilities Infection Control Program on 3/25/26, the Infection Preventionist (IP) Employee E29's IP certificate was dated 3/24/26. During a review of IP certificates reveal the facility failed to have a certified IP on the following dates: March 2025, through September 12, 2025. During an interview on 3/25/26, at 10:57 a.m. the Director of Nursing confirmed that the facility failed to designate a qualified individual(s) onsite, who is responsible for implementing programs and activities to prevent and control infections for the above dates. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 201.19(3) Personnel records. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on documents and observations and staff interviews it was determined the facility failed to maintain an effective pest control program related to fruit flies in the dish room (Main Kitchen). During an observation on 3/26/26 at approximately 9:35 a.m. in the dish room of the Main Kitchen there were three gold fly sticky traps full of fruit flies. As staff were doing dishes several fruit flies were observed in the area. Review of facility provided documentation included pest-control logs dated from 9/17/25-2/11/26. The following treatments to the kitchen area were provided on the following dates: 9/17/25 crack/crevice spray to baseboards in kitchen10/29/25 crack/crevice spray to kitchen, dining room, maintenance hall11/19/25 crack/crevice spray to baseboards, kitchen, maintenance hall, front lobby12/3/25 crack/crevice spray to kitchen, maintenance hall1/21/26 crack/crevice spray to baseboards in kitchen, dish room, maintenance hall2/11/26 crack/crevice spray to baseboards in kitchen During an interview on 3/26/26 at 10:00 a.m. Dietary Manager Employee E21 confirmed the facility failed to maintain an effective pest control program in the main kitchen. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 207.2(a) Administrator's responsibility

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility documents, clinical record review, and staff interview, it was determined that the facility failed to ensure resident rights to make informed decisions and choices about important aspects of residents' health, safety and welfare by making certain residents understand the Notice of Medicare Non-Coverage (NOMNC) form and failed to ensure the agreement is explained to the resident and his or her representative in a form and manner that he or she understands for one of three residents (Resident R77).Findings include: Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019 indicated that a Brief Interview for Mental Status (BIMS), is a screening test that aides in detecting cognitive impairment. A BIMS total score of 0-7: suggests severe cognitive impairment. Review of Resident R77's admission record indicated the resident was admitted to the facility on [DATE]. Review of Resident R77's demographic information available in the electronic medical record indicated that Resident R77's son was designated as the responsible party, and power of attorney. Review of clinical record revealed that Resident R77 had a Cognitive Screen completed on 7/8/25, and received a BIMS score of 5. Review of the NOMNC form dated 9/29/25, revealed that it was signed by Resident 77. During an interview on 3/26/26, at 12:45 p.m. Regional Business Office Manager Employee E14 stated that a resident with a low BIMS score, should not be signing their own paper work if they have family or a representative to do so, and confirmed that the facility failed to ensure the NOMNC is explained to the resident and his or her representative in a form and manner that he or she understands for one of three residents. 28 Pa. Code 201.14(a) Responsibility of Licensee.28 Pa. Code 201.18(b)(2) Management.28 Pa. Code 201.24 (b) admission Policy.28 Pa. Code 201.29(a) Resident Rights.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on review of facility policy, observation, and staff interview it was determined that the facility failed to maintain the confidentiality of residents' medical information on one of five nursing units (Fifth Floor Nursing Unit).Findings include: Review of facility policy Confidentiality of Information and Personal Privacy dated 10/29/25, indicated the facility will safeguard the personal privacy and confidentiality of all resident personal and medical records. During an observation on 3/26/26, at 8:34 a.m. the 5 East Front Medication Cart outside of a resident room was left unattended with the computer screen open with identifiable information any passerby could see resident personal and confidential information. During an interview on 3/26/26, at 8:35 a.m. Licensed Practical Nurse Employee E13 confirmed the above observation and that the facility failed to maintain the confidentiality of residents' medical information as required. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.29(c.3) Resident rights.28 Pa. code: 211.5(b) Medical records.28 Pa. Code: 211.12(d)(1) 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations and staff interviews it was determined that the facility failed to provide a clean, safe, comfortable, and homelike environment for one of five floors (Third floor).Findings include: Review of the facility policy Homelike Environment dated 10/29/25, indicated the residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. During a tour with the Director of Operations Employee E9 on 3/23/26, from 1:38 p.m. to 2:07 p.m. of the Third floor, the following were observed: room [ROOM NUMBER] had unpainted plaster on the bathroom wallroom [ROOM NUMBER]'s vent cover was missing and the bathroom doorknob was missingroom [ROOM NUMBER] was missing four ceiling tiles in the room, vent cover was loose, and had two brown ceiling tiles in the bathroomroom [ROOM NUMBER] was missing a piece of the vent coverroom [ROOM NUMBER] was missing a piece of the vent coverroom [ROOM NUMBER] had unpainted plaster on the bathroom wallroom [ROOM NUMBER]'s window blind was brokenroom [ROOM NUMBER] was missing ceiling tile in the room, had brown ceiling tile in the bathroom, and unpainted plaster under sinkroom [ROOM NUMBER] had brown ceiling tiles in the bathroomroom [ROOM NUMBER] had brown ceiling tiles in the bathroomroom [ROOM NUMBER] had a baseboard heater mounted on the wall behind the bed that exposed sharp objectsroom [ROOM NUMBER] had brown ceiling tiles in the corner of ceilingHallway ceiling tile tracks had brown rusty color throughout the hallwayResident common room by exit door had unpainted plaster on wallsHallway walls throughout the unit were chipped, marked up, and not paintedCeiling tiles throughout the hallway had brown ceiling tiles During an interview on 3/23/26, at 2:07 p.m. Director of Operations Employee E9 confirmed the above findings, and that the facility failed to provide a clean, safe, comfortable, and homelike environment for one of five floors (Third floor). 28 Pa. Code 201.18(b)(3)(e)(2) Management. 28 Pa code 211.12(d)(1) Nursing services.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on review of facility policy, review of personnel files, and staff interview, it was determined that the facility failed to properly screen an employee by failing to conduct a criminal background check prior to the start of employment for one of five personnel files reviewed (Nurse Aide (NA) Employee E6).Findings include: Review of facility policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated 10/29/25, indicated the facility will conduct employee background checks and not knowingly employ or otherwise engage any individual who has: been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; had a finding entered into the state nurse aide registry concern abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or a disciplinary action in effect against his or her professional license by a state licensure body as a result of finding abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. Review of NA Employee E6's personnel file revealed a hire date of 1/9/26. Review of the personnel file did not include a completed state criminal background check prior to their date of hire. During an interview on 3/25/26, at 1:48 p.m. Human Resources Director Employee E2 confirmed that the facility failed to properly screen an employee by failing to conduct a criminal background check prior to the start of employment for one of five personnel files reviewed (NA Employee E6). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.19(8) Personnel records.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the RAI (Resident Assessment Instrument), clinical records, and staff interviews it was determined that the facility failed to make certain that resident assessments were accurate for one of three residents (Residents R9).Findings include: The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (periodic assessments of resident care needs), dated October 2025, indicated the following: Section K0310; Discharge Status: Weight Gain of 5% or more in the last month or gain of 10% or more in last 6 months. Code 0, no or unknown: if the resident has not experienced weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available Code 1, yes on physician-prescribed weight-gain regimen: if the resident has experienced a weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight gain was planned and pursuant to a physician's order. In cases where a resident has a weight gain of 5% or more in 30 days or 10% or more in 180 days as a result of any physician ordered diet plan, K0310 can be coded as 1. Code 2, yes, not on physician-prescribed weight-gain regimen: if the resident has experienced a weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight gain was not planned and prescribed by a physician. Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE]. Review of Resident R9's MDS dated [DATE], indicated diagnoses of muscle weakness, aphasia (a disorder that causes a loss of ability to produce or understand spoken and written language, often following a stroke or head injury), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Section K0310 was marked 0. Review of Resident R9's weight record revealed the following weights:9/6/25: 140.7 poundsOctober 2025: no weight obtainedNovember 2025: no weight obtained12/21/26: 142.9 pounds1/10/26: 141.7 pounds2/5/26: 170.2 pounds3/3/26: 170.5 pounds. This is an increase of 21.2% in six months. During an interview on 3/27/26, at 11:16 a.m. Registered Nurse Assessment Coordinator (RNAC) Employee E15, confirmed that the facility failed to indicate that Resident R9 had a significant weight gain on the MDS dated [DATE], and stated Yes. I just noticed that they haven't been marking weight changes. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing Services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical records and staff interviews, it was determined that the facility failed to develop a care plan for one of four residents (Resident R6) to accurately reflect the current status of the resident.Findings include: Review of the facility policy Care Plan, Comprehensive Person-Centered last reviewed 10/29/25, indicated a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive care plan will include but not inclusive of:Measurable objectives and timeframesDescribes services that are to be furnished to attain or maintain the residents' highest practicable physical, mental and psychosocial well-being.Identify problem areas and their causes and develop interventions that are targeted and meaningful to the residents. Review of the clinical record indicated Resident R6 admitted to the facility on [DATE]. Review of the Resident R6's Minimum Data Set (MDS- a periodic assessment of care needs) dated 2/9/26, indicated the diagnoses of high blood pressure, depression and Post Traumatic Stress Disorder (PTSD- a mental disorder that develops after a traumatic event) Review of Resident R6's physician orders dated 6/4/25, indicate bilateral upper side rails as enablers for bed mobility and repositioning. During an observation completed on 3/23/26, at 10:08 a.m. Resident R6 was in bed, her bed had enablers bars to both sides. Review of Resident R6's current care plan failed to include interventions for Resident R6's bilateral upper side rails. During an interview completed on 3/25/26, at 1:43 p.m. Registered Nurse (RN) Employee E16 confirmed Resident R6's care plan did not include interventions for the bilateral upper side rails as enablers for bed mobility and repositioning and that the facility failed to develop a care plan for one of four residents (Resident R6) to accurately reflect the current status of the resident. 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and resident and staff interview, it was determined that the facility failed to promote a multidisciplinary approach with care conferences for two of six resident's reviewed (Resident R4, R159).Review of the clinical record indicated Resident R4 was admitted [DATE]. Review of Resident R4's MDS (minimum data set a periodic review of assessment needs) dated 2/18/26, indicated diagnosis of fracture left femur, chronic obstructive pulmonary disease (common lung disease causing restricted airflow and breathing problems) and dysphasia (difficulty swallowing). Review of Resident R4's Multidisciplinary Care Conference sign in sheet dated 3/12/26, included the following disciplinary: social worker, dietary and activities. Review of clinical record indicated Resident R159 was admitted to the facility on [DATE]. Review of Resident R159's Minimum Data Set (MDS-a mandated assessment of a resident's abilities and care needs) assessment, dated 1/3/26, indicated the diagnoses end stage renal disease, dependance on renal dialysis and diabetes mellitus. Review of Resident R159's Multidisciplinary Care Conference sign in sheet dated 2/26/26, included the following disciplinary: social worker, dietary and activities. During an interview on 3/26/26 at 11:15 a.m. Director of Social Services Employee E22 confirmed nursing was unavailable during care conference meetings dated 2/26/26 and 3/12/26 as required. 28 Pa. Code 211.12(d)(3) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to make certain that residents were provided appropriate treatment and care in accordance with professional standards of practice for one of four residents (Resident R169).Findings include: Review of the facility Registered Nurse (RN) job description indicated major duties and responsibilities include assesses for changes in residents' status, notifying the physician and resident's family or representative and documenting accordingly. Review of the clinical record revealed Resident R169 was admitted to the facility on [DATE]. Review of Resident R169's Minimum Data Set (MDS - a periodic assessment of care needs) dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fats in the blood), and cognitive communication deficit. Review of a nursing progress note dated [DATE], completed by Licensed Practical Nurse (LPN) Employee E30 stated, Around 1705 (5:05 p.m.) Caregiver informed writer that resident needed a nurse, when writer went into resident room resident breathing was labored and was mouth breathing mucus membranes were dry, BP (blood pressure) was low and could not get a O2 (oxygen saturation) on resident, writer notified supervisor and she came to assess resident and instructed me to call 911, writer notified sister and on call provider, resident was breathing and had a faint pulse when EMT's (Emergency Medical Technicians) arrived, as they were preparing to put resident on the stretcher resident stop breathing and CPR (cardiopulmonary resuscitation) was performed after a couple of hours to CPR EMT's pronounced resident expired, writer called sister back and informed her that her brother had expired and she stated that there was need for her to come say good bye and that no other family members will come in because she was the only family in the area, writer call the on call provider back to inform them that the resident had expired and the body will be picked up by the funeral home service listed in chart. Review of Resident R169's clinical record failed to include documentation that the resident was assessed by a Registered Nurse after a change in condition was identified. During an interview on [DATE], at 9:32 a.m. the Director of Nursing confirmed that the facility failed to make certain that residents were provided appropriate treatment and care in accordance with professional standards of practice for one of four residents (Resident R169). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395423	A. Building B. Wing	03/27/2026

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **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 properly monitor weight and nutrition status by failing to obtain weights for one of three residents (Resident R9).Findings include: Review of facility policy Weight Assessment and Intervention dated 10/29/25, indicated that resident weights are monitored for undesirable or unintended weight loss or gain. Residents are to weighed upon admission and at intervals established by the interdisciplinary team. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. If the weight is verified nursing will immediately notify the dietitian in writing. Unless notified of significant weight change, the dietitian will review the unit weight record monthly to follow individual weight trends over time. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a) 1 month: 5% weight loss is significant; greater than 5% is severe.b) 3 months: 7.5% weight loss is significant; greater than 7.5% is severe.c) 6 months: 10% weight loss is significant greater than 10% is severe. If the weight change is desirable, this is documented. Undesirable weight change is evaluated by the treatment team whether or not the criteria for significant weight change has been met. Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE]. Review of Resident R9's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/18/26, indicated diagnoses of muscle weakness, aphasia (a disorder that causes a loss of ability to produce or understand spoken and written language, often following a stroke or head injury), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Section K0710 A, indicated that resident received 51% or more proportion of total calories through a tube feeding (nutrition is provided through a tube inserted directly into the digestive system). Review of Resident R9's weight record revealed the following weights:9/6/25: 140.7 poundsOctober 2025: no weight obtainedNovember 2025: no weight obtained12/21/26: 142.9 pounds1/10/26: 141.7 pounds2/5/26: 170.2 pounds Review of clinical record revealed that Resident R9 was out to the hospital on 1/21/26, and returned on 2/5/26 with a weight of 170.2 pounds. Review of the above data indicated that Resident R9 had a significant weight increase of 20.1% from January 2026 to February 2026. Review of Resident R9's clinical record revealed a Nutrition note dated 2/11/26, that resident had a significant weight gain from last month Review of clinical record revealed that Resident R9 was out to the hospital on 2/15/26, and returned on 3/3/26 with a weight of 170.5 pounds. Review of the above data indicated that Resident R9 had an significant weight increase of 21.2% in six months. Review of Resident R9's clinical record revealed a Nutrition note dated 3/7/26, that stated that resident had a significant weight gain in February, and weekly weights for four weeks on readmission to monitor Review of Resident R9's clinical record revealed a physician's order dated 3/7/26 to weigh weekly for four weeks. Review of clinical record revealed that no weights were obtained for Resident R9 after 3/3/26. During an interview on 3/27/26, at 9:46 a.m. Registered Dietitian (RD) Employee E28 confirmed that the facility failed to obtain monthly weights as required in October, and November 2025, and weekly weights as ordered on 3/3/26, to properly monitor weight and nutrition status for Resident R9. 28 Pa. Code 201.18(b)(1)(Management.28 Pa. Code 211.10(c) Resident care policies.28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, and staff interviews it was determined that the facility failed to provide a resident special eating equipment for one of five residents (Resident R35).Based on observations, and staff interviews it was determined that the facility failed to provide a resident special eating equipment for one of five residents (Resident R35). Findings Include: Review of the admission record indicated Resident R35 was admitted to the facility on [DATE]. Review of Resident 35 's MDS indicated the diagnosis of anemia (low iron in the blood), high blood pressure and hyperlipidemia (high fat in the blood). Review of Resident R35's physician orders dated 7/4/25 indicated Resident to use scoop dish for all meals. During an observation completed on 3/23/26, at 12:40 p.m. Resident R35 was observed with a regular white plate on his lunch tray. During an interview completed on 3/23/26 at 12:40 p.m. Nurse Aid (NA) Employee E6 confirmed Resident R35's meal ticket indicated the use of a scoop dish and confirmed the facility failed to provide a scoop dish as ordered for Resident 35. During an observation completed on 3/24/26, at 12:48 p.m. Resident R35 was observed with a regular white plate on his lunch tray. During an interview completed on 3/24/26 at 12:48p.m. NA Employee E18 confirmed Resident R35's meal ticket indicated the use of a scoop dish and confirmed the facility failed to provide a scoop dish as ordered for Resident 35. Pa Code: 201.14(a) Responsibility of licensee.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on facility policy, observation, and staff interview it was determined that the facility failed to properly contain garbage in two of four outside dumpsters to prevent the potential for rodent and insect infestation (dumpster one, three). The facility policy entitled Food-Related Garbage and Refuse disposal dated 10/29/25, indicated all garbage and refuse containers are provided with tight-fitting lids or covers and must be kept covered when stored or not in continuous use. During an observation of the facility's outdoor trash receptacles on 3/23/26, at 9:30 a.m. Dietary Manager Employee E21 confirmed that the lid/covers were not closed on dumpster one and three. During an interview on 3/24/26, at 12:30 p.m. Dietary Manager Employee E21 confirmed that the facility failed to properly contain garbage in the outside trash receptacles to prevent the potential for rodent and insect infestation. 28 Pa. Code 201.18(b)(3) Management.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical record review and staff interview, it was determined that the facility failed to provide accurate and timely documentation related to the COVID-19 (a respiratory disease) vaccine for one of five residents (Resident R16).Findings include: Review of facility policy Coronavirus Disease(COVID-19)- Vaccination of Residents dated 10/29/25, indicated that each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident is fully vaccinated. The resident or representative can accept or refuse a COVID-19 vaccine. The vaccine can be provided at the facility. Review of Resident R16's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R16's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/17/26, indicated diagnoses of depression, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and insomnia (difficult sleeping). MDS Section O- Special treatment, Procedures, and Programs O0350 indicated COVID-19 vaccine was coded a 0- resident not up to date. During a review of clinical records indicated that Resident R16 last received a COVID-19 vaccination on 10/19/24. During a review of Resident R16's clinical documentation labeled, COVID-19 Vaccine Consent Form-Resident indicated that on 10/29/25, consent for vaccine was obtained and resident did not receive it. During an interview on 3/25/26, at 10:26 a.m. Director of Nursing confirmed that the facility failed to provide accurate and timely documentation related to the COVID-19 vaccine one of five residents (Resident R16). 28 Pa. Code 211.5(f) Clinical records