

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Northern Dauphin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 990 Medical Road Millersburg, PA 17061	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on facility policy review, observations, clinical record review, and staff interviews, it was determined that the facility failed to review and revise the resident plan of care for four of 36 residents reviewed (Residents 1, 12, 43, and 103). Findings include: Review of facility policy, titled Care Plans, Comprehensive Person-Centered, dated March 2022, with a last review date of June 2, 2026, revealed 11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. Review of Resident 1's clinical record revealed diagnoses that included hypertension (high blood pressure) and cerebral infarction (a stroke-damage to the brain from interruption of its blood supply). Review of Resident 1's care plan revealed a care plan focus for resident has a respiratory infection, aspiration pneumonitis (occurs when substances such as food, liquid, or stomach contents are inhaled into the lungs, leading to inflammation), and sepsis (potentially life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs) dated April 23, 2026. Further review of Resident 1's clinical record failed to reveal any current active infections. During a staff interview with the Nursing Home Administrator (NHA), Director of Nursing (DON), and Assistant Director of Nursing (ADON) on July 8, 2026, at 2:06 PM, the ADON indicated that the care plan should have been revised when Resident 1's infection was determined to be resolved. She further indicated that Resident 1's care plan has been updated. Review of Resident 12's clinical record revealed diagnoses that included urinary retention (inability to fully empty the bladder) and chronic obstructive pulmonary disease (COPD-a type of progressive lung disease characterized by long term respiratory symptoms and airflow limitations). Review of Resident 12's care plan revealed a care plan focus for resident has an infection related to positive lab results; cystitis (inflammation of the bladder) bacteremia (presence of bacteria in the bloodstream dated April 13, 2026. Further review of Resident 12's clinical record failed to reveal any current active infections. During a staff interview with the NHA, DON, and ADON on July 8, 2026, at 2:05 PM, the ADON indicated that the care plan should have been revised when Resident 12's infection was determined to be resolved. She further indicated that Resident 12's care plan has been updated. Review of Resident 43's clinical record revealed diagnosis that included anxiety (occasional worry or fear) and hypertension. Observation of Resident 43 on July 6, 2026, at 12:49 PM, 1:02 PM, and 2:42 PM, revealed the Resident was lying in bed with her call bell wrapped underneath, out of reach of the Resident. Review of Resident 43's care plan revealed a focus area for the resident has a communication problem related to cognitive deficit, hearing deficit as evidenced by needs increased volume, needs time to finish thoughts and misses part of message intent dated January 31, 2024; with an intervention for call bell within reach, encourage resident to call for assistance, answer promptly dated January 31, 2024. Electronic mail correspondence with the NHA on July 7, 2026, at 3:33 PM, revealed that due to Resident 43's cognition, she cannot utilize her call bell. Interview (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 395428	If continuation sheet Page 1 of 13

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to ensure that the residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice for two of five residents reviewed with PTSD (Post Traumatic Stress Disorder) (Residents 8 and 90). Findings include: Review of facility policy, titled Trauma Informed Care and Culturally Competent Care, revised August 2022, revealed, Purpose: To guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice. To Address the needs of trauma survivors by minimizing triggers and/or re-traumatization. Review of Resident 8's clinical record revealed diagnoses that included PTSD, dementia (a condition characterized by progressive loss of intellectual functioning, impairment of memory and abstract thinking), cerebral ischemia, and bipolar (a mental health condition alternating period of elation and depression). Review of Resident 8's care plan, revised on April 9, 2021, revealed a care plan focus area of the Resident has a potential behavior problem related to bipolar and PTSD (nothing regarding triggers followed). Further review failed to reveal that Resident 8's triggers were identified anywhere else on the plan of care. Review of Resident 8's Social Services Quarterly Assessments dated May 18, 2026; February 19, 2026; January 29, 2026; and October 20, 2025, all failed to document PTSD. Review of Resident 8's Minimum Data Sets (MDS- periodic assessment of resident needs), dated May 21, 2026; February 19, 2026; January 29, 2026; and October 31, 2025, documented in section I, Diagnoses, PTSD. Review of Resident 8's clinical record revealed Resident 8 was also followed by a psychiatrist for psychotropic medication management, which included Depakote utilized to treat bipolar and prazosin utilized to treat PTSD (no triggers noted). Interview with Employee 16 (Social Services Director) on July 9, 2026, at 11:00 AM, she stated she didn't complete the Social Services Evaluations, however, PTSD should've been marked. Email communication with the Nursing Home administrator (NHA) on July 9, 2026, at 8:25 AM, the surveyor informed the NHA of the concern that the Social Services Assessment failed to document a diagnosis of PTSD, and that triggers weren't addressed on the care plan or noted triggers unknown. No additional information was provided. Also, the surveyor requested a copy of the Trauma and Informed Care Assessment tool kit (was referenced in the Trauma informed Care and Culturally Competent Care policy), but it wasn't provided. Review of Resident 90's clinical record revealed diagnoses that included PTSD and depression (a group of conditions associated with the elevation or lowering of a person's mood). Review of Resident 90's care plan, revised on May 14, 2024, revealed a care plan focus area of: The Resident has a psychosocial well-being problem (actual or potential) related to history of personal trauma or PTSD with behaviors triggers by i.e. (nothing followed). Further review failed to reveal that Resident 90's triggers were identified anywhere else on the plan of care. Review of Resident 90's Social Services Evaluations dated November 13, 2025; February 12, 2026; March 9, 2026; and May 29, 2026, revealed that Resident 90 had a history of personal trauma. Further review revealed that the nature of the trauma was physical and sexual abuse/violence and that Resident 90's triggers include gaslighting, emotional abuse, and victim blaming. Interview with the NHA on July 9, 2026, at 10:45 AM, revealed that Resident 90's triggers, identified on the Social Services Evaluations, were not put on the care plan or in any place where they could be acted upon and thereby failed to address the needs of the Resident and minimize triggers and chances of re-traumatization. 28 Pa. Code 201.14 (a) Responsibility of licensee		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, observations, review of resident council minutes, and resident and staff interviews, it was determined that the facility failed to ensure sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident on one of two nursing units observed (1st floor). Findings include: Review of facility policy, titled Answering the Call Light, last reviewed June 2, 2026, read, in part, The purpose of this procedure is to ensure timely responses to the resident's requests and needs. Answer the call system immediately. If a resident needs assistance, indicate the approximate time it will take for you to respond. During an interview with Resident 69 on July 6, 2026, at 11:02 AM, she revealed that staff are slow to answer call bells and are always short staffed. During an interview with Resident 72 on July 6, 2026, at 1:21 PM, he revealed the facility is often short staffed, and sometimes he waits so long for someone to respond to his call bell that he starts to bang on his bed enabler bar and yells out until someone comes. During a resident group meeting on July 7, 2026, at 10:00 AM, there were concerns with call bell response times, especially on night shift. It was also revealed that staff will respond to the call bell and turn it off without providing assistance, and they don't return. During an interview with Employee 9 on July 8, 2026, at 12:59 PM, she revealed residents often don't get up out of bed because there are not enough staff to get everyone up and out of bed. During an interview with Resident 154 on July 8, 2026, at 1:03 PM, he revealed the building is extremely short staffed and call bell responses are too long. Review of Resident Council meeting minutes for June 4, 2026, documented new business, call bells are often responded to by nursing staff turning of the bell without addressing the issue. The July 2, 2026, meeting documented under old business that the call bell concern [NAME] up in the June 2026 meeting was unresolved. Observation at the 1st floor nurses station on July 6, 2026, at 1:45 PM, revealed Residents 90 and 153 had their call lights activated down the 400 hallway. The call light system at the nurses' station was sounding. Employee 7 (Nurse Aide) was sitting at the nurses station on a tablet with her back to the 400 hall, while the call lights were illuminated and ringing. Observation on July 6, 2026, at 1:55 PM, revealed Resident 90's and 153's call bells remained activated and Employee 7 remained sitting at the nurses station on the tablet. Employee 5 (Nurse Aide) walked out of the 300 hallway in view of the 400 hallway and stated, I am going to go outside and smoke some cigarettes to Employee 6 (Nurse Aide). Employee 6 then stated, I will go with you. They exited the nursing unit approximately 2 minutes later. Further observation on July 6, 2026, at 2:02 PM, revealed Resident 90's and 153's call bells remained activated. Employee 8 (Nurse Aide) then approached Employee 7 and stated, you have a call light on. Observation of Employee 7 revealed she was playing a game on the tablet and was sitting with her back to her assigned hallway. Employee 7 then got up to answer Resident 153's call bell at 2:03 PM, 18 minutes after it had been observed to be active. Resident 90's call bell was answered by Employee 18 (Nurse Aide) at that time. Employees 6 and 7 returned to the floor at the same time at 2:19 PM. Observation of the 1st floor nurse's station call bell system on July 6, 2026, at 2:15 PM, revealed Resident 3's call bell had been on for 20 minutes before it was answered by a staff member. Observation of the 1st floor nurses' station call bell system on July 6, 2026, at 2:43 PM, revealed Resident 173's call bell had been on for 21 minutes and 20 seconds. Further observation at 2:49 PM, revealed staff going into the Resident's room and turning the call bell off, exiting the room and (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	proceeded to get the Resident ice. The call bell had been on for 25 minutes and 41 seconds. During an interview with the Assistant Director of Nursing, in the presence of the Nursing Home Administrator and the Director of Nursing (DON), on July 7, 2026, at 2:08 PM, she revealed that the Residents came up with their own call bell expectations on an adequate time for staff to respond to them, which was not to exceed 15 minutes. During an interview with the DON on July 8, 2026, at 1:47 PM, she revealed it is the facility process on day shift to assign two nurse aides to either side of a hallway, depending on staffing needs. She stated staff should help each other if they aren't busy to answer call bells on each other's assignment, and staff members can help answer call bells on any assignment. She revealed nurse aides assigned to the same hallway should never go on break together, and they should always report to a nurse to request to go on break, to ensure their assignment is covered while they are away. She further revealed that the employees observed leaving to smoke together, as well as the employee playing a game on the tablet, are employed by a contracted company, and she will request that they do not return to the facility. During a follow up interview with the DON on July 9, 2026, at 10:40 AM, she revealed she is making changes to nurse management, and she thinks that will help with staffing concerns. No further information was provided. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management. 28 Pa code 211.12(d)(1)(4)(5) Nursing services		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on document review and staff interview, it was determined that the facility failed to ensure an annual performance review is completed for each nurse aide for five of five nurse aide performance evaluations reviewed (Employees 10, 11, 12, 13, and 14). Findings Include: Review of the facility's list of nurse aide staff revealed Employee 10 had a hire date of February 24, 2025; Employee 11 had a hire date of March 4, 2024; Employee 12 had a hire date of May 8, 2023; Employee 13 had a hire date of January 18, 2021; and Employee 14 had a hire date of March 18, 2009. Requests for the most recent yearly performance reviews revealed Employees 10, 11, 12, 13, and 14 did not have an annual performance review completed within the previous 12 months. During an interview conducted with the Nursing Home Administrator on July 8, 2026, at 2:21 PM, he confirmed the nurse aide performance evaluations had not been completed in the past year on the aforementioned nurse aides. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.19 Personnel policies and procedures		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on facility policy review, observations, and staff interviews, it was determined that the facility failed to store food and utilize kitchen equipment in accordance with professional standards for food service safety in the main kitchen and two of two nourishment areas. Findings include: Based on facility policy, titled Food from Outside Sources last reviewed June 2, 2026, read, in part, Visitors/family members will label food and beverages with the resident's name, room number, and date. All food is to be stored in a suitable container. Perishable foods with a use by date which is 3 days from the date that it was brought into the facility. Food or beverage items without manufacturers expiration date that have written dates should be thrown away 3 days after the date marked. Observation in the main kitchen on July 6, 2026, at 9:54 AM, revealed the ice machine had a line of dust clear across the top of the ice machine under the lid, and the top of the lid was dirty. Interview with Employee 4 (Director of Dining Services) on July 6, 2026, at 9:55 AM, revealed he was not aware of a formal cleaning schedule of the ice machine or when it was last cleaned. Observation of the June 2026 Dish Machine Temperature Log in the main kitchen on July 6, 2026, at 10:04 AM, revealed wash and rinse temperatures failed to be logged at breakfast and lunch on June 27-30, 2026. Observation of the July 2026 Dish Machine Temperature Log in the main kitchen on July 6, 2026, at 10:05 AM, revealed wash and rinse temperatures failed to be logged at breakfast and lunch on July 1-5, 2026; and dinner on July 2, 2026. Review of the January 2026 Dish Machine Temperature Log revealed wash and rinse temperatures failed to be recorded at breakfast on January 1-10, 12-16, and 19-30; at lunch on January 1-12, 14-17, and 19-30; and at dinner on 1-4, 6-11, 13, 15, 16, 18, 22, 23, 25, and 28-30. Observation in the 2nd floor pantry area ice machine on July 6, 2026, at 10:14 AM, revealed it was soiled with an orange substance and a spotty black substance on the white section directly above the ice. Observation in the 2nd floor pantry freezer on July 6, 2026, at 10:16 AM, revealed a Styrofoam cup of soft serve ice cream that was not dated; and two breakfast sandwiches from an outside source not dated. Observation in the 2nd floor pantry refrigerator on July 6, 2026, at 10:16 AM, revealed one container of perishable food from an outside source not dated. Observation in the 1st floor pantry freezer on July 6, 2026, at 10:28 AM, revealed one Styrofoam cup from an outside source with a red substance inside not labeled or dated; and soft serve ice cream in a plastic cup with a spoon inside not dated. Observation in the 1st floor pantry refrigerator on July 6, 2026, at 10:32 AM, revealed one container of perishable food from an outside source dated June 26, 2026; one container of perishable food from an outside source with a resident's name and date not legible; one bag with a resident's name containing three containers of perishable food, not dated; one container of perishable food from an outside source with a resident's name, dated June 29, 2026; and one bag with six containers of perishable food from outside sources with a resident's name, dated June 20, 2026. Review of email correspondence between the Nursing Home Administrator (NHA) and Employee 15 (Maintenance Director) on July 6, 2026, at 2:52 PM, revealed Kitchen ice machine was dumped by us and cleaned by housekeeping. Other two ice machines were checked an ok'd by housekeeping. Observation of the 2nd floor pantry area ice machine on July 7, 2026, at 9:38 AM, revealed it was soiled with the same orange substance and a spotty black substance on the white section directly above the ice. Interview with the NHA on July 7, 2026, at 1:42 PM, revealed it was the facility's expectation that expired items are discarded, foods items are labeled and dated per facility policy, and kitchen equipment is utilized in accordance with professional standards. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.6(f) Dietary services.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on clinical record review and staff interviews, it was determined that the facility failed to notify the resident's representative of a medication change for one of six residents reviewed for unnecessary medications (Resident 179). Findings Include: Review of Resident 179's clinical record revealed diagnoses that included Alzheimer's Disease and hypertensive heart disease (complications of the heart caused by long-term, unmanaged high blood pressure). Review of Resident 179's pharmacy recommendation, dated February 27, 2026, revealed a recommendation for a gradual dose reduction (GDR) of the Resident's Memantine (also known as Namenda; a medication used to treat moderate to severe dementia associated with Alzheimer's Disease). Further review of the recommendation revealed that on March 6, 2026, the provider agreed with the GDR of Memantine, and wrote orders for the GDR. Review of a nursing progress note written by Employee 17 (Licensed Practical Nurse [LPN]), on March 8, 2026, revealed Medication Managers recommending d/c [discontinue] of Namenda [Memantine] as medication is no longer effective during end stage dementia. The note further stated that the provider agreed and new orders were received to titrate the Resident off of the medication. The note did not indicate that the Resident's Responsible Party was made aware of the GDR of the medication. There was no additional evidence in Resident 179's clinical record that Resident 179's Responsible Party was notified of the GDR and discontinuation of the Memantine. During an interview with Employee 17 on July 8, 2026, at 11:27 AM, she stated that she cannot recall if she made Resident 179's Responsible Party aware of the GDR. She stated that the facility should alert a resident's responsible party with any medication changes. During an interview with the Nursing Home Administrator and Director of Nursing (DON) on July 8, 2026, at 1:50 PM, the DON stated she would expect the Resident's Representative to be made aware of any medication changes. 211.12(d)(1)(3)(5) Nursing services		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on facility policy review, clinical record reviews, observations, and resident and staff interviews, it was determined that the facility failed to follow physician orders for wound care for one of four residents reviewed (Resident 15); and failed to follow physician orders for obtaining weights and medication administration for one of 36 residents reviewed (Resident 100). Findings include: Review of facility policy, titled Wound Care, dated October 2010, and a last review date of June 2, 2026, revealed, in part, The following information should be recorded in the resident's medical record: 2. The date and time the wound care was given. 4. The name and title of the individual performing the wound care. 9. If the resident refused the treatment and the reason(s) why. 10. The signature and title of the person recording the data. Review of Resident 15's clinical record revealed diagnoses that included Diabetes Mellitus Type II (disease that occurs when your blood glucose, also called blood sugar, is too high) with a foot ulcer and hemiplegia (paralysis of one side of body) and hemiparesis (muscle weakness on one side of the body) following a cerebral infarction (a stroke-damage to the brain from interruption of its blood supply) affecting right dominant side. Review of Resident 15's physician orders revealed orders for wound care to right lateral foot diabetic ulcer, cleanse with wound cleanser; do wet to dry with gauze; secure with dry dressing; change every day and evening shift and as needed, dated July 1, 2026. Review of Resident 15's clinical record revealed that he originally developed the current diabetic foot ulcer on April 11, 2026. Review of Resident 15's care plan revealed a care plan focus for has potential for skin impairment related to right hemiparesis, limited mobility to reposition self, diabetes, incontinence, and presence of diabetic ulcer to right lateral foot last revised on July 1, 2026. Interventions included, but were not limited to, administer treatment to right plantar foot as ordered and observe for effectiveness with a revision date of April 21, 2026. In addition, he had a care plan focus for activities of daily living self-care deficit related to right hemiparesis, weakness, and lack of coordination, last revised on October 31, 2025. Interventions included, but were not limited to, transfer with platform walker and two-person assist, and the Resident is an early riser at 6:00 AM to be dressed and groomed, both dated October 26, 2025. Observation of Resident 15 on July 7, 2026, at 10:26 AM, revealed that he was sitting in his wheelchair in the hallway with no dressing on his right foot. His bare foot was resting on the footrest. During an immediate interview with Resident 15, he indicated that he did not know why staff had not put a dressing on his foot. Observation of Resident 15 on July 7, 2026, at 2:39 PM, revealed that he was sitting in his wheelchair in the downstairs activity /dining room with no dressing on his right foot. His bare foot was resting on the footrest. Resident 15 lifted his foot up off the footrest and a small amount yellowish drainage was noted to be oozing from the wound. During an immediate interview with Resident 15, he again indicated that he did not know why staff had not yet put a dressing on his foot. Follow-up observation of Resident 15 with the Assistant Director of Nursing (ADON) on July 7, 2026, at 2:48 PM, revealed that he was sitting in his wheelchair in the downstairs activity /dining room with no dressing on his right foot. His bare foot was resting on the footrest. During an immediate interview with the ADON, she confirmed that Resident 15 should have a dressing on his right foot. She said that the facility wound consultant saw Resident 15 that morning, and that typically she accompanies the wound consultant but did not do so today. The ADON further indicated that the wound consultant starts rounds at the facility at approximately 6:00 AM. She said that the nurse assigned to Resident 15 usually works night shift and that she would follow-up with Resident 15's assigned nurse. She directed a nurse to perform wound care for Resident 15. During a follow-up staff interview with the ADON on July 8, 2026, at 9:15 AM, she indicated that she followed up with the (continued on next page)		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(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	Licensed Practical Nurse the prior day who was assigned to Resident 15. She said that the nurse shared that she had not had time to do the dressing change yet. She indicated that she still needed to follow up with the aides who got him out of bed without a dressing on his foot. During a staff interview with the Nursing Home Administrator (NHA), Director of Nursing (DON), and the ADON on July 8, 2026, at 2:08 PM, the ADON confirmed that Resident 15's wound care should have been provided prior to staff transferring him out of bed to his chair. No additional information was provided regarding the nurse aides transferring Resident 15 out of bed without a dressing in place. Review of Resident 15's Treatment Administration Records for May 2026 and June 2026 revealed that his wound care was not documented as being completed (box was blank) on May 30, 2026, or June 30, 2026, evening shifts. Review of Resident 15's progress notes failed to reveal any documentation as to why the wound care was not performed as ordered. Email communication received from the NHA on July 9, 2026, at 11:41 AM, revealed that he had no additional information to provide as to why Resident 15's wound care was not completed as ordered on May 30, 2026, or June 30, 2026. The NHA further indicated that he would have expected Resident 15's wound care to have been completed as ordered. Review of Resident 100's clinical record revealed diagnoses that included hyperlipidemia (abnormally high levels of fats) and depression (a mood disorder characterized by persistent feelings of sadness, emptiness, and lack of interest in activities). Review of Resident 100's physician orders revealed an order for daily weights per hospice, give as needed (PRN) Lasix for weight gain of 3 pounds one time a day related to heart failure, with a start date of May 25, 2026. Review of Resident 100's June 2026 Medication Administration Record (MAR), revealed there were no weights taken on the Resident from June 1 through 25, 2026. Further review of Resident 100's June 2026 MAR revealed that the Resident weighed 191.2 pounds on June 29, 2026, and 194.6 pounds on June 30, 2026, and was not administered PRN Lasix on that day. During an interview conducted with the DON on July 8, 2026, at 12:51 PM, she confirmed that Resident 100 did not receive his PRN Lasix and he should have been administered it on June 30, 2026, after his 3-pound weight gain. Further interview conducted with the DON, NHA, and ADON on July 9, 2026, at 10:28 AM, the DON revealed that Resident 100's weight order was not put into the system correctly and confirmed that no weights were obtained from June 1 to 25, 2026. 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)(2)(3)(5) Nursing services.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on facility policy review, product packaging review, clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure that the medication error rate was not five percent or greater, based on three medication errors out of 29 opportunities. Findings include: Review of facility policy, titled Administering Medications, dated April 2019, with a last review date of June 2, 2026, revealed, in part, Medications are administered in accordance with prescriber orders; and the individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. Observation of Employee 2 (Licensed Practical Nurse) on July 8, 2026, at 9:25 AM, revealed that she was preparing medications to administer to Resident 62. Review of the medication packaging for the ordered medication donepezil indicated Do Not Crush. Employee 2 was observed to crush the medication and administer it to Resident 62. Observation of Employee 2 on July 8, 2026, at 9:41 AM, revealed that she was preparing medications to administer to Resident 50. Review of the medication label on a bottle of Biotene Dry Mouth Moisturizing Spray indicated to give 15 milliliters by mouth one time a day swoosh and spit. Employee 2 was observed to administer two sprays of the Biotene into the mouth of Resident 50. During a staff interview with Employee 2 on July 8, 2026, at 10:03 AM, Employee 2 confirmed that she had crushed the donepezil and administered it to Resident 62 and said that she did not see the instruction on the packet to not crush the medication. In addition, Employee 2 confirmed that she had administered the two sprays of the Biotene spray since it was what the pharmacy had provided and confirmed that there were no directions on how many sprays should have been administered. Observation of Employee 3 (Licensed Practical Nursing) on July 8, 2026, at 10:20 AM, revealed that she was preparing medications to administer to Resident 160. Review of the medication packaging for the ordered medication mirabegron extended-release tablet indicated Do Not Crush. Employee 3 was observed to crush the medication and administer it to Resident 160. During a staff interview with Employee 3 on July 8, 2026, at 10:03 AM, Employee 3 confirmed that she had crushed the mirabegron and administered it to Resident 160. Employee 3 further indicated that Resident 160 will spit out pills that are too big. During medication administration observations, there were 3 errors and 29 opportunities, resulting in a medication error rate of 10.34%. During a staff interview with the Nursing Home Administrator and Director of Nursing (DON) on July 9, 2026, at 10:44 AM, the DON confirmed that she would expect nursing staff to administer medications as ordered and to follow all special instructions for safe medication administration. 28 Pa. Code 211.9(a)(1) Pharmacy services. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on facility policy review, Centers for Disease Control and Prevention (CDC) guidelines, observations, and resident and staff interviews, it was determined that the facility failed to provide a safe and sanitary environment to prevent the development and spread of communicable diseases and infections by not covering a wound known to be infected by a multi-drug resistant organism for one of four residents reviewed (Resident 15). Findings include: Review of facility policy, titled Transmission Based Precautions, dated June 14, 2019, with a last review date of June 2, 2026, revealed, in part, Part of routine infection control practices, standard precautions include wearing gloves for situations involving known or anticipated contact with blood, body fluids, tissue, mucous membranes, or nonintact skin. You should combine standard precautions with transmission-based precautions for patients with confirmed or suspected infection with highly transmissible pathogens. Transmission-Based Precautions Contact: To prevent the spread of epidemiologically important infectious organisms through direct patient contact or indirect contact with the patient's environment. According to the Centers for Disease Control and Prevention (CDC), contact precautions are transmission-based isolation measures used to prevent the spread of pathogens that are transmitted by direct or indirect contact with contaminated surfaces or objects and are indicated for patients with infections or conditions that can be spread through direct contact (e.g., skin-to-skin, wound-to-skin) or indirect contact (e.g., touching contaminated surfaces). Contact precautions should be used for patients with known or suspected infections that represent an increased risk for contact transmission; and limit transport and movement of patients outside of the room to medically-necessary purposes. When transport or movement is necessary, cover or contain the infected or colonized areas of the patient's body. Review of Resident 15's clinical record revealed diagnoses that included Diabetes Mellitus Type II (disease that occurs when your blood glucose, also called blood sugar, is too high) with a foot ulcer, local infection of the skin and subcutaneous tissue (the body's deepest skin layer, stores fat, contains larger blood vessels and nerves), and hemiplegia (paralysis of one side of body) and hemiparesis (muscle weakness on one side of the body) following a cerebral infarction (a stroke-damage to the brain from interruption of its blood supply) affecting right dominant side. Review of Resident 15's physician orders revealed orders for wound care to right lateral foot diabetic ulcer, cleanse with wound cleanser; do wet to dry with gauze; secure with dry dressing; change every day and evening shift and as needed, dated July 1, 2026; and contact precautions every shift, dated June 22, 2026. Review of Resident 15's clinical record revealed that he originally developed the diabetic foot ulcer on April 11, 2026. In addition, he was currently being treated for an infection to his diabetic foot ulcer by an infectious diseases specialist, the facility wound consultant, and his primary care provider, which started around May 20, 2026. Review of Resident 15's care plan revealed a care plan focus for: has potential for skin impairment related to right hemiparesis, limited mobility to reposition self, diabetes, incontinence, and presence of diabetic ulcer to right lateral foot, last revised on July 1, 2026. Interventions included, but were not limited to, administer treatment to right plantar foot as ordered and observe for effectiveness, with a revision date of April 21, 2026; and contact precautions, dated May 18, 2026. In addition, he had a care plan focus for activities of daily living self-care deficit related to right hemiparesis, weakness, and lack of coordination, last revised on October 31, 2025. Interventions included, but were not limited to, transfer with platform walker and two-person assist, and the Resident was an early riser at 6:00 AM to be dressed and groomed, both dated October 26, 2025. Observation of Resident 15 on July 7, 2026, at 10:26 AM, revealed that he was sitting in his wheelchair in the hallway with no dressing on his right (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	foot. His bare foot was resting on the footrest. During an immediate interview with Resident 15, he indicated that he did not know why staff had not put a dressing on his foot. Observation of Resident 15 on July 7, 2026, at 2:39 PM, revealed that he was sitting in his wheelchair in the downstairs activity/dining room with no dressing on his right foot. His bare foot was resting on the footrest. Resident 15 lifted his foot up off the footrest and a small amount yellowish drainage was noted to be oozing from the wound. During an immediate interview with Resident 15, he again indicated that he did not know why staff had not yet put a dressing on his foot. There were approximately 20 other residents noted to be in the room. Follow-up observation of Resident 15 with the Assistant Director of Nursing (ADON) on July 7, 2026, at 2:48 PM, revealed that he was sitting in his wheelchair in the downstairs activity /dining room with no dressing on his right foot. His bare foot was resting on the footrest. During an immediate interview with the ADON, she confirmed that Resident 15 should have a dressing on his right foot and that contact precautions were not being followed. She said that the facility wound consultant saw Resident 15 that morning, and that typically she accompanies the wound consultant but did not do so today. The ADON further indicated that the wound consultant starts rounds at the facility at approximately 6:00 AM. She said that the nurse assigned to Resident 15 usually works night shift and that she would follow up with Resident 15's assigned nurse. She directed a nurse to perform wound care for Resident 15. During a follow-up staff interview with the ADON on July 8, 2026, at 9:15 AM, she indicated that she followed up with the Licensed Practical Nurse the prior day who was assigned to Resident 15. She said that the nurse shared that she had not had time to do the dressing change yet. She indicated that she still needed to follow up with the aides who got him out of bed without a dressing on his foot. During a staff interview with the Nursing Home Administrator, Director of Nursing, and the ADON on July 8, 2026, at 2:08 PM, the ADON confirmed that Resident 15's wound care should have been provided prior to staff transferring him out of bed to his chair and that contact precautions should have been followed. No additional information was provided regarding the nurse aides transferring Resident 15 out of bed without a dressing in place. 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)(2)(3)(5) Nursing services.		