STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395454	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkhouse Rehabilitation and Nursing Center	1600 Black Rock Road Royersford, PA 19468

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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 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. Based on observations and staff interviews, it was determined that the facility failed to ensure the resident environment remained as free of accident hazards as possible by failing to ensure that the door leading to the trash chute on the memory care unit remained locked at all times.Findings include:Observations conducted on the memory care unit located on the 8th floor on June 9, 2026, at approximately 7:47 a.m. revealed a sign affixed to a door stating, TRASH CHUTE - This door must be kept locked at all times. THANK YOU. Further observation revealed the door was unlocked and located out of view of the nurses' station. A laundry cart had been placed in front of the trash chute, requiring the cart to be moved in order to gain access to the chute.Subsequent observations conducted on June 10 and June 11, 2026, revealed the door leading to the trash chute remained unlocked. The laundry cart remained positioned in front of the trash chute; however, the chute remained accessible once the cart was moved.An interview conducted with the Nursing Home Administrator (NHA) and Assistant Nursing Home Administrator (ANHA) on June 11, 2026, at approximately 11:38 a.m. confirmed that the door leading to the trash chute is required to remain locked at all times. 28 PA. Code 201.14(a) Responsibility of licensee28 PA. Code 211.12(d)(1)(2)(3)(5) Nursing services28 PA, Code 201.18(b)(1)(3)(e)(1) Management

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 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 interview, observation, and facility policy review, it was determined the facility failed to implement enhanced barrier precautions (an infection control strategy to prevent the spread of multi-drug-resistant organisms in long term care facilities) for two out of four hallways reviewed on Unit 2 West. Findings include: A review of facility policy titled, Isolation Steps: Categories of Transmission-Based Precautions, reviewed August 2025 revealed: All residents with any of the following should use enhanced barrier precautions.open wounds, and/or indwelling medical devices (e.g. central line, urinary catheter, feeding tube, tracheostomy) . wear a gown and gloves for all interactions that may involve contact with a resident or the resident's environment. Donning PPE (personal protective equipment) upon room entry and properly discarding before exiting the patient room is done to contain pathogens (germs that cause disease). Observation of room [ROOM NUMBER] on June 9, 2026, at approximately 6:58 a.m. revealed a urinary drainage bag hanging from the bed frame and no sign on the door for enhanced barrier precautions. Further observation of room [ROOM NUMBER], revealed a sign for enhanced barrier precautions for residents in bed 2 and bed 4, however there was no PPE bin in the hallway for two out of the 3 rooms where enhanced barrier precautions were in place. Subsequent observations on June 10, 2026, at approximately 1:39 pm and June 11, 2026, at approximately 8:43 a.m. revealed there was no sign on the door of room [ROOM NUMBER] for enhanced barrier precautions and no bin containing PPE for that hallway. Observation of rooms 211, 214, 215, and 217 on the 2 [NAME] hallway on June 11, 2026 at approximately 9:00 a.m., revealed signs for enhanced barrier precautions, but no bin for PPE for any room on this hallway. Interview with nursing employee E5 on June 11, 2026 at approximately 9:30 a.m. revealed that E5 did not know what enhanced barrier precautions were, What is that? I've never heard of that. Interview with nursing employee E4 on June 12, 2026 at approximately 9:45 a.m. revealed that there should have been a sign on the door of room [ROOM NUMBER] and that there were not enough bins for all the rooms that were on enhanced barrier precautions, but they were on order. Interview with nursing employee E3 on June 12, 2026 at approximately 3:00 p.m. revealed that the facility struggled with having PPE binds outside each room because of clutter in the hallway, but that there should be bins for PPE that are convenient for staff to use. Review of Resident 9's care plan revealed a care plan for Enhanced Barrier Precautions (EBP) r/t (related to) (Contained RLE (right lower extremity- the right leg) wound. Observations of Resident 9's room on June 10, 2026, at 11:57 am; on June 11, 2026, at 10:56am and June 12, 2026, at 8:22am revealed no EBP sign on door and no PPE (personal protective equipment) outside door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Employee E7 on June 12, 2026, at 8:24am confirmed the above findings. 28 Pa Code 201.18(b)(1)(3) Management 28 Pa Code 207.2(a) Administrator's responsibility 28 Pa. Code 211.10(c) Resident care policies 28 Pa Code 211.12(d)(1)(5) Nursing services

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, and staff interviews, it was determined that the facility failed to protect the residents' rights for one of thirty-five residents reviewed (Resident 99)Findings include:Resident 99 was admitted to the facility on [DATE], with medical diagnoses that include Parkinsons's Disease (movement disorder of the nervous system), difficulty walking, need for assistance with personal care, unsteadiness on feet, and abnormality of gait (deviation from normal walking pattern.)A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 99, dated May 14, 2026, revealed that the resident utilizes a wheelchair, requires partial to moderate assistance with toileting hygiene, and substantial to maximum assistance with sit to stand and toilet transfers. Review of Resident 99's care plan revealed a focus dated November 11, 2025, noting the resident exhibits toileting deficits, putting them at risk for reduced independence with activities of daily living (adls). Further review of Resident 99's care plan revealed a focus dated November 24, 2025, noting the resident has an ADL self-care performance deficit related to depression, Parkinson's Disease, and asthma. Interventions included Resident 99 requires the assistance of one staff for personal hygiene, transfers and toilet use.Observations made on June 9, 2026, at 6:30 a.m. revealed Nurse Aide Employee E9, and Unit Manager Licensed Practical Nurse Employee E10 sitting behind the nurses station with Resident 93. Observations made on June 9, 2026, at 6:50 a.m., revealed Resident 99 sitting in his/her room, in their wheelchair, a clear liquid was observed pooling on the floor. Closer observation revealed the resident's clothes and wheelchair were wet. Resident 99 stated he/she needed assistance with continence care, and no staff came to assist him/her during the entire night shift. Observation was made of Resident 99 activating his/her call bell at 6:52a.m.At 6:54 a.m., Employee E9 was observed leaving the nurses' station and walking towards Resident 99's room. Employee E9 immediately returned to the nurses' station. At 6:55 a.m. Resident 99's call bell was observed to be turned off. During interview Resident 99 stated Employee E9 came in the room, turned the call bell off, and told Resident 99 he/she had to wait for assistance with continence care.During interview at 6:58 a.m. Employee E9 confirmed he/she went into Resident 99's room, observed the resident required continence care, turned the call bell off, and told the resident he/she had to wait for assistance. Employee E9 stated he/she could not leave Resident 93 because he/she was a fall risk. Employee E10 was observed sitting behind the nurses' station with Employee E9 since this Surveyor's 6:30 a.m. arrival on the unit. During interview conducted at 10:15 a.m. Resident 99 confirmed that Employee E9 never returned to assistant the resident. Resident 99 stated he/she did not receive continence care until the dayshift started. During interview with Resident 99 on June 10, 2026, at 12:10 p.m. the resident stated he/she did not receive continence care during the entire night shift again.Review of resident 99's 30-day toileting task form revealed no documentation of the resident receiving overnight toileting care for June 9, 2026, and June 10, 2026. Interview conducted with Nursing Home Administrator (NHA) and Director of Nursing (DON) on June 5, 2026, at 2:05 p.m., when the above information was presented, the NHA and DON stated they would investigate the matter.Employee E9 turning off Resident 99's call bell, telling him/her they had to wait for care, and not providing continence care when required violated Resident 99's right to dignified treatment.28 Pa. Code 201.29(j) Resident Rights.

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F 0579 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide information about how to apply for and use Medicare and Medicaid benefits. Based on record review and staff interview, it was determined that the facility failed to provide the Notice of Medicare Non-Coverage (NOMNC) within the required timeframe for one out of one residents reviewed (Resident #335).Findings include:Review of Resident 335's medical record revealed a Notice of Medicare Non-Coverage (NOMNC) indicating Medicare-covered skilled services were ending on May 14, 2026. The notice was signed and dated by the resident on May 13, 2026, at 9:00 a.m., which was 1 day prior to the end of Medicare-covered services.An Interview conducted on June 12, 2025, at 12:05 p.m., with the Nursing Home Administrator (NHA) confirmed the NOMNC was not provided within the required 2-day (48-hour) timeframe.The facility failed to provide the NOMNC within the required 2-day advance timeframe from which it should have been provided.28 Pa. Code 201.18(b)(1) Management28 Pa. Code 201.29(a) Resident Rights

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on a review of the facility's policy, clinical records review, and staff interview, it was determined that the facility failed to monitor the resident's behaviors, and medication side effects, for residents receiving a psychotropic medication for three of the five residents reviewed (Resident 15, 17, and 327). Findings: A review of the facility's policy titled Antipsychotic/Anxiolytic Utilization, last review in April 2025, revealed that documentation is necessary to assist in assessing whether the resident's behavioral symptom needs some form of intervention, determining whether the behavioral symptom is transitory or permanent. A review of Resident 15's physician order dated June 2, 2026, revealed an order Quetiapine Fumarate (Atypical anti-psychotic) Oral Tablet 25 mg 1 tablet by mouth at bedtime for anxiety A review of Resident 15's Medication Administration Records and progress notes medication revealed side effects were not monitored since the Quetiapine Fumarate medication started on March 12, 2026. A review of Resident 17's physician order dated August 28, 2025, revealed an order Risperdal (atypical antipsychotic) Oral Tablet 1 MG Give 1 tablet by mouth at bedtime related to psychotic disorder with delusions due to known physiological condition A review of Resident 17's Medication Administration Records and progress notes medication revealed side effects were not monitored since the Quetiapine Fumarate medication started on August 28, 2025. An interview with the Director of Nursing on June 12, 2025, at 10:10am confirmed the above findings. A review of Resident 327's physician order dated March 12, 2026, revealed an order Seroquel (Anti-psychotic medication) oral tablet 25 mg Give 25mgby mouth two times a day for psychotic disorder with delusion (A mental health condition where a person experiences persistent, fixed false beliefs that are unshakeable even when presented with factual evidence), please monitor for sedation and increase in falls. A review of Resident 327's Medication Administration Records and progress notes revealed the resident's behaviors and medication side effects were not monitored since the Seroquel medication started on March 12, 2026. An interview with the Director of Nursing on June 12, 2026, at 10:00 a.m., confirmed that Resident 327's behavior and medication side effects were not monitored. The facility failed to ensure Residents 15, 17, and 327's behaviors and medication side effects were monitored. 28 Pa Code 211.10(c) Patient care policies (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(c)(1)(3)(5) Nursing services 28 Pa Code 211.5 (f) Clinical 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 clinical records review and staff interview, it was determined that the facility failed to ensure that assessments accurately reflected the resident's status for three of the 35 residents reviewed (Residents 2,3, and 283). Findings Include: Review of Resident 2 progress note on 4/15/2026 at 12:47 nursing note stated Resident 2 sustained a witnessed fall after breakfast at 9:2am. [NAME] did strike her head, and she landed on her L hip after the fall. Further review of Resident 2 progress note on 4/18/2026 at 11:38 nurses note stated: Resident Xray results received after rereading DX:Acute left sub capital femur fracture with impaction (broken left side of your thighbone). Md notified and recommended for resident to be sent to hospital. Resident sent to Phoenixville Hospital. Daughter contacted but no answer. Brother contacted and aware of situation. A review of Resident 2's Quarterly Minimum Data Set (MDS- A standardized assessment tool that measures health status in long-term care residents) MDS is dated 5/18/2026 revealed that under section J1900-Number of Falls Since Admission/Entry or Reentry or Prior Assessment did not indicate that residents had a fall with major injury. Interview with Employee E6 on June 11, 2026, at 12:07pm confirmed the above findings. A review of Resident 3's nursing progress notes dated December 6, 2025, at 7:43 a.m., revealed the resident was observed on the floor next to the bed. The resident denied pain. The family and the physician were notified. A review of Resident 3's nursing progress notes dated December 8, 2026, at 1:46 p.m., revealed new order for Xray three views left foot regarding s/p (status post) fall. A review of the Xray report dated December 8, 2026, revealed Acute fracture at base of 1st metatarsal (A break on the shortest, thickest, and strongest bone in the human foot) noted. A review of Resident 3's Quarterly Minimum Data Set (MDS- A standardized assessment tool that measures health status in long-term care residents) dated December 26, 2025, did not indicate that resident had a fall with major injury. A review of Resident 283's nursing progress notes dated May 3, 2026, at 12:35 p.m., revealed an x ray was done post unwitnessed fall on May 1, 2026. The Xray result was nondisplaced fracture of the nasal bone (A break in the nasal bone but stays aligned without moving). The physician and the guardian were notified. A review of Resident 283's Quarterly MDS dated [DATE], did not indicate that residents had a fall with major injury. An interview with licensed nurse Employee E6 was conducted on June 11, 2026, at 12:23 p.m. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employee E6 confirmed that Resident 3 and 283's falls with major injury were not accurately reflected on their MDS' The facility failed to ensure Resident 3 and 283's falls with major injury were not accurately reflected on their MDS assessments. 28 Pa Code 211.5 (f) Clinical records 28 Pa. 211.12(c)(d)(1)(3)(5) Nursing services

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, resident and staff interviews and review of resident clinical records it was determined that the facility failed to provide assistance with activities of daily living for 1 of thirty-five residents reviewed (Resident 99).Findings include:Facility policy titled Activities of Daily Living (ADLs), last reviewed December 2024, notes it is the policy of the facility to understand the principals of quality of life, and honor and support these principals for each resident, and that the care and services provided are person centered, and honor and support each resident's preferences, choices, values and beliefs. The facility will provide care and services for hygiene-bathing, and toileting care.Resident 99 was admitted to the facility on [DATE], with medical diagnoses that include Parkinsons's Disease (movement disorder of the nervous system), difficulty walking, need for assistance with personal care, unsteadiness on feet, and abnormality of gait (deviation from normal walking pattern.)A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 99, dated May 14, 2026, revealed that the resident utilizes a wheelchair, requires partial to moderate assistance with toileting hygiene, and substantial to maximum assistance with sit to stand and toilet transfers. Review of Resident 99's care plan revealed a focus dated November 11, 2025, noting the resident exhibits toileting deficits, putting them at risk for reduced independence with activities of daily living (adls). Further review of Resident 99's care plan revealed a focus dated November 24, 2025, noting the resident has an ADL self-care performance deficit related to depression, Parkinson's Disease, and asthma. Interventions included Resident 99 requires the assistance of 1 staff for personal hygiene, transfers and toilet use.Observations made on June 9, 2026, at 6:30 a.m. revealed Nurse Aide Employee E9, and Unit Manager Licensed Practical Nurse Employee E10 sitting behind the nurses station with Resident 93. Observations made on June 9, 2026, at 6:50 a.m., revealed Resident 99 sitting in his/her room, in their wheelchair, a clear liquid was observed pooling on the floor. Closer observation revealed the resident's clothes and wheelchair were wet. Resident 99 stated he/she needed assistance with continence care and no staff came to assist him/her during the entire night shift. Observation was made of Resident 99 activating his/her call bell at 6:52a.m.At 6:54 a.m., Employee E9 was observed leaving the nurses' station and walking towards Resident 99's room. Employee E9 immediately returned to the nurses' station. At 6:55 a.m. Resident 99's call bell was observed to be turned off. During interview Resident 99 stated Employee E9 came in the room, turned the call bell off, and told Resident 99 he/she had to wait for assistance with continence care.During interview at 6:58 a.m. Employee E9 confirmed he/she went into Resident 99's room, observed the resident required continence care, turned the call bell off, and told the resident he/she had to wait for assistance. Employee E9 stated he/she could not leave Resident 93 because he/she was a fall risk. Unit Manager Licensed Practical Nurse Employee E10 was observed sitting behind the nurses' station with Employee E9 since this Surveyor's 6:30 a.m. arrival on the unit. During interview conducted at 10:15 a.m. Resident 99 confirmed that Employee E9 never returned to assistant the resident. Resident 99 stated he/she did not receive continence care until the dayshift started. During interview with Resident 99 on June 10, 2026, at 12:10 p.m. the resident stated he/she did not receive continence care during the entire night shift again.Review of resident 99's 30-day toileting task form revealed no documentation of the resident receiving overnight toileting care for June 9, 2026, and June 10, 2026. Interview conducted with Nursing Home Administrator (NHA) and Director of Nursing (DON) on June 5, 2026, at 2:05 p.m., when the above information was presented, the NHA and DON stated they would investigate the matter.Quality of Care 483.24(b)(1)28 Pa. Code 211.5(f) Clinical Records 28 Pa. Code 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 clinical record review, observations, and staff interview, it was determined that the facility failed to implement physicians' orders for three of 24 sampled residents (Residents R1, R16, R56 and R262). Findings include: Review of Resident R1's clinical record revealed an admission date of April 27, 2026. Clinical record review revealed that Resident R1's had diagnoses that included chronic obstructive pulmonary disease, unspecified (COPD, a condition caused by damage to the lungs resulting in swelling and irritation, also called inflammation, inside the airways that limit airflow into and out of the lungs), dependence on supplemental oxygen, psychosis (collection of symptoms that disrupt a person's thoughts and perceptions, making it difficult to distinguish what is real from what is not), and major depressive disorder, recurrent, moderate (a mood disorder that causes a persistent feeling of sadness and loss of interest). Review of Resident R1's clinical record revealed a physician order stating, Ear mates to oxygen tubing at all times to help relieve pressure, with a start date of June 1, 2026. Observations conducted on June 10, 2026, at approximately 1:17 p.m. revealed Resident R1 resting in bed while receiving supplemental oxygen via nasal cannula (a device used to deliver oxygen through two small prongs inserted into the nostrils). Further observation revealed the oxygen tubing was not fitted with ear mates (foam protectors) as ordered. An interview conducted with Resident R1 on June 10, 2026, at approximately 1:20 p.m. revealed he/she could not recall the last time ear mates had been attached to the oxygen tubing. An interview conducted with the Nursing Home Administrator (NHA) and Assistant Nursing Home Administrator (ANHA) on June 11, 2026, at approximately 11:38 a.m. confirmed the above findings. A review of Resident 16's diagnosis list includes End Stage Renal Disease (ESRD – the final, permanent stage of chronic kidney disease where kidneys have lost most of their function, making them unable to sustain life), Hemodialysis (A process of purifying the blood of a person whose kidneys are not working normally), and hypertension (high blood pressure). An interview was conducted with Resident 16 on June 10, 2026, at 9:30 a.m., while on dialysis. The residents reported that their dialysis days are Mondays, Wednesdays, and Friday's morning. A review of Resident 16's physician order dated March 30, 2026, revealed an order for Hydralazine (A medication to lower blood pressure), HCL 25 mg tablet. Give one tablet by mouth every 12 hours for hypertension, hold for SBP (Systolic Blood Pressure) below 120mm Hg. The medication was scheduled at 9:00 a.m. and 9:00 p.m. A review of Resident16's April 2026, Medication Administration Record (MAR) revealed Hydralazine was not administered on the following days: April 1, 3, 6, 8, 10, 13, 15, 17, 202, 22, 24, and 27. The record indicated that medication was not administered because the resident was on dialysis. Further review revealed that from April 1, 2026, until April 30, 2026, the medication Hydralazine was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered to the resident five times with systolic blood pressure below 120 mm Hg (out of ordered parameters). Resident 56 was admitted into the facility on February 9, 2026, with medical diagnoses that include encounter for attention to colostomy (a surgical procedure that creates an opening in the abdomen to allow stool to exit the body) Review of Resident 56's physician orders revealed an order dated February 9, 2026, for colostomy care every shift, empty and document changes. Further review of Resident 56's physician orders revealed an order dated April 21, 2026, for Enhanced Barrier Precautions for Colostomy every shift for infection control. Review of Resident 56's care plan revealed a focus noting the resident is on Enhanced Barrier Precautions (EBP) related to colostomy. Review of Resident 56's May and June 2026 Medication Administration Reports revealed documentation of EBP being followed related to colostomy care but no documentation of colostomy care being provided. Resident 56's 14-day bowel continence task form notes the resident did not have a bowel movement for 14 of the 14 days. Interview conducted with Nursing Home Administrator (NHA) and Director of Nursing (DON) on June 5, 2026, at 2:05 p.m., when the above information was presented, the NHA and DON confirmed that the resident utilizes a colostomy, The DON stated Resident 56 had a follow up visit with a Gastrointestinal physician who recommended they wait until the resident's colonoscopy, scheduled for July 7, 2026, to determine whether the colostomy can be reversed or not. The DON and NHA confirmed there were no documentation of colostomy care being provided. A review of Resident 262's diagnosis list includes ESRD, Hemodialysis, and Hypertension. A review of Resident 262's physician order dated April 18, 2026, revealed Dialysis Care: Receives Dialysis at bedside on Monday, Wednesday, and Friday. An observation on June 10, 2026, at 9:30 a.m., revealed the resident was receiving Dialysis on the facility's dialysis rooms. A review of Resident 262's physician order dated April 24, 2026, revealed an order for Sevelamar Carbonate 0.8 packet GM. Give one packet by mouth three times daily for ESRD. The medication administration was scheduled at 9:00 a.m., 2:00 p.m., and 9:00 p.m. A review of Resident 262's physician order dated April 19, 2026, revealed an order for Lisinopril (A medication to lower blood pressure). Give 1 tablet by mouth one time a day for hypertension. The medication administration was scheduled for 9:00 a.m. An additional order was Hydralazine (A medication to lower blood pressure) HCL 50 mg, one tablet by mouth every eight hours. The medication administration was scheduled for 12:00 a.m., 8:00 a.m., and 4:00 p.m. A review of Resident 262's June 2026 MAR revealed Sevelamer, and Lisinopril were not administered (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 9:00 a.m. on June 3, 5, 8, and 10, 2026. Hydralazine was not administered at 8:00 on June 3, 5, 8, and 10, 2026. The records indicated medications were not administered because the resident was on dialysis. An interview with the Director of Nursing (DON) on June 12, 2026, at 10:00 a.m., confirmed Resident 16, and medications were not administered due to residents being on dialysis. A review of Resident 262's physician order dated April 19, 2026, revealed an order Clonidine (A medication used to treat high blood pressure) HCL Give 1 tablet by mouth every 6 hours for hypertension for systolic BP (blood pressure) greater than 180, or hold if HR (heart rate) less than 50. A review of Resident 262 May 2026, MAR revealed that from May 1, 2026, until May 28, 2026, Clonidine medication was administered to the resident 86 times with a blood pressure below 180 (outside the ordered parameter). The above was confirmed with the DON on June 12, 2026, at 2:00 p.m. The facility failed to ensure Resident 16 and 262's medication orders were followed. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing service 28 Pa Code 211.5(f) Clinical Records

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observations, clinical records review, and staff interviews, it was determined that the facility failed to follow a wound treatment order correctly and in a timely manner for one of ten residents reviewed (Resident 259).Findings: A review of Resident 259's active care plan revealed the resident was at risk for skin integrity impairment related to immobility and incontinence. The interventions, including an air mattress, repositioning, and treatment as ordered, were put in place. Additional interventions include applying Calamine-Zinc Oxide External Lotion, applied to the buttocks topically every day and evening shift for protectant (Dermaseptin ointment- A soothing skin protectant used to treat and prevent minor skin irritations by creating a protective, moisture-repelling barrier). A review of the nursing progress notes dated April 1, 2026, at 2:32 p.m., revealed the resident was observed with a new skin area of concern to the sacrum a large, (triangular bone located at the base of the spine, just below the lumbar vertebrae and between the hip bones), a DTI (Deep Tissue Injury - Persistent non-blanchable deep red, maroon or purple discoloration) to the sacrum (The triangular bone just below the lumbar vertebrae), dry, with a measurement of 2.8 x 2.0 x 0 cm. The area was deep purple. Wedge pillows are used for positioning and out of bed restrictions to four hours three times a week. A review of the wound consult dated April 7, 2026, revealed that the sacral wound progressed to a Stage II (Partial-thickness skin loss with exposed dermis). A Triade Hydrophilic wound dressing (A zinc oxide-based, containing petrolatum, carboxymethylcellulose, and dimethicone paste that manages light-to moderate wound drainage) to the sacrum was recommended. A review of Resident 259's physician's order revealed that the wound specialist recommendations on April 7, 2026, for the Triade treatment were not put in as an order and therefore was not followed. A review of the wound consult dated April 14, 2026, revealed the resident's sacral wound remained a stage II, continue Triade Hydrophilic treatment. A review of Resident 259's physician's order revealed that the wound specialist recommendations on April 14, 2026, to continue the Triade treatment to the resident's' sacral wound was not followed. A review of the wound consult dated April 21, 2026, revealed sacral wound stage III (full-thickness skin loss) measuring 1.0 x 0.5 x 0.1 cm. dry with 70% slough (A non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed. A wound treatment of honey hydrogel was recommended. A review of Resident 259's April 2026 Treatment Administration Record (TAR) revealed that recommended wound treatment for honey hydrogel was not started until April 23, 2026, two days after the sacral wound was identified as stage III. An interview was conducted with the Assistant Director of Nursing (ADON) on June 11, 2026, at 1:00 p.m. The ADON confirmed that the Triade Hydrophilic paste recommendation was not followed, and the honey hydrogel wound treatment was not followed in a timely manner. The facility failed to ensure that Resident 259's wound treatment, as recommended by the wound specialist, was followed correctly and in a timely manner. 28 Pa Code 211.5 (f) Clinical records 28 Pa. 211.12(c)(d)(1)(3)(5) Nursing services

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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. Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure proper monitoring of fluid restrictions for two of three residents reviewed for nutrition/hydration needs (Resident 108, and Resident 259). Findings: Review of facility policy, titled Restricting Fluids last revised November 11, 2025, documents the purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. A review of the facility's policy titled Weight Assessment and Intervention, last revised on March 11, 2025, revealed that weights will be measured monthly unless discontinued by the physician. Significant weight changes are defined as more or less than 5% within 30 days; more or less than 7.5% over 3 months, and more or less than 10% within 6 months. I the weight change meets the definition of Significant, the Dietitian should discuss with the IDCP team and make recommendations. The resident's physician will be made aware of the weight loss. Review of Resident 108's medical diagnoses revealed diagnoses that included mild protein-calorie malnutrition (insufficient intake of protein and calories), atherosclerotic heart disease of native coronary artery (plaque buildup in coronary arteries), end stage renal disease (chronic kidney disease where kidneys no longer function adequately to sustain life without treatment), hypertensive heart and chronic kidney disease with heart failure (when high blood pressure cause damage to both the heart and kidneys) stage 5 chronic kidney disease or end stage renal disease, (kidney failure requiring dialysis), and fluid overload (too much water, blood or lymphatic fluid in the body). Review of Resident 108's physician orders revealed an order dated May 28, 2026, for 1500 milliliters (ml) fluid restriction: nursing staff to provide a total of 540 ml per day, 180 ml during day shift, 180 ml during evening shift, and 180 ml during night shift. Dietary staff provide a total of 960 ml per day, 360 ml with breakfast, 240 ml with lunch, and 360 ml with dinner. Review of Resident 108's May and June 2026, Medication Administration Reports (MAR) and 30-day task documentation for amount of fluid intake obtained from nursing staff for the past 30 days, in addition to the amount of fluids provided with meals, revealed that the combined fluid intake either exceeded the ordered amount or failed to document the resident's fluid intake amounts. During an interview with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) on June 5, 2026, at 2:05 p.m., the DON confirmed that staff was not accurately documenting the resident's fluid intake. A review of Resident 259's weights and vitals revealed a weight of 123.2 pounds on December 2, 2025, and a weight of 110.6 pounds on April 23, 2026, a 10.23% significant weight loss in four months. Further review revealed the resident's weight was not taken in March 2026. The significant weight loss identified on April 23, 2026, was not addressed, and physicians were not notified until May 15, 2026. An interview was conducted with the Registered Dietitian Employee E13 on June 12, 2026, at 1:55 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	p.m. The RD reported that their company just started seeing residents in the facility on May 4, 2026, and therefore cannot provide an explanation why the resident's weight was not monitored in March 2026, and why significant weight loss identified on April 23, 2026, was not addressed until May 15, 2026. An interview with the Nursing Home Administrator conducted on June 12, 2026, at 1:56 p.m., confirmed that Resident 259's March 2026 weight was not monitored, and significant weight loss identified on April 23, 2026, was not timely addressed. The facility failed to ensure Resident 259's weight was consistently monitored and that significant weight loss was addressed and communicated with the physician in a timely manner. 201.18(b)(1) Management 211.10(c) Resident care policies 211.12(d)(1)(2)(5) Nursing services

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on facility policy review, clinical record review and staff interview it was determined the facility failed to provide enteral nutrition (feeding delivered through a feeding tube) as ordered by the physician for one of one resident reviewed enteral feeding care. (Resident 14)Findings include: Review of facility policy and guidelines titled Enteral Feeding last revised April 15, 2024, documents the licensed nurse is responsible to assure patency of the feeding tube, administration of nutritional products and medications per physician orders, assessment of the tube and skin site and documentation of the enteral feeding process. Per the policy, documentation of the enteral feeding orders, volume, amounts, and care will be completed on the Medication Administration Record. Review of Resident 14's medical diagnoses revealed the resident admitted from the hospital on November 17, 2025, with medical diagnoses that include Traumatic Subarachnoid Hemorrhage (bleeding into the fluid-filled space between the brain and the protective tissue covering it, caused by physical head injury), Diffuse Traumatic Brain Injury (a disruption in normal brain function caused by a bump, blow, jolt to the head, or penetrating head injury), Mild Protein Malnutrition, and Dysphagia (difficulty swallowing), Review of Resident 14's weights revealed Resident 14 lost 23 pounds between November 19, 2025, and June 12, 2026. Review of Resident 14's physician orders revealed an order dated March 5, 2026, for every evening shift give Glucerna 1.5 at 80 milliliters (ml) per hour for 12 hours via PEG tube up at 7pm and down at 7am or once total volume (TV) of 960 ml is infused and every day-shift document TV infused daily once feeding completed. Review of resident 14's Medication Administration Record (MAR) for the month of June 2026, revealed documentation of total infusions ranging between 0 ml and 960 ml. Review of resident 14's physician orders revealed an order dated March 5, 2026, for Enteral Feed every day-shift document TV infused daily once feeding is completed. Review of Resident 14's May and June 2026, MAR revealed 15 days when staff documented a total volume of NA. Total volume was noted as 0 ml for 5 days, 300 ml for one day, 100 ml for one day, and 712 ml for one day. Observations made on June 12, 2026, at 11:50 a.m. revealed Resident 14's was still connected to his/her feeding pump. The pump was flashing inactive for 10 minutes. The Glucerna bag was dated June 11, 2026. 200 ml of the 1000 ml bag remained on the pump. Interview with Unit Manager Registered Nurse Employee E8 on June 12, 2026, at 11:57, when observations were made of Resident 14's feed pump and MARS, Employee E8 confirmed Resident 14's feed pump orders weren't being followed and/or documented as prescribed. Interview with the Nursing Home Administrator and Director of Nursing on June 12, 2026, at 2:00 p.m. when the above was presented, the DON confirmed the resident's enteral feed orders were not being followed and/or documented properly. 28 Pa Code: 211.5(f) Clinical 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 - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility's policy and medication manufacturer's guidelines, observations, and interview with staff and resident, it was determined that the facility failed to secure a treatment cart for one out of two units reviewed (Two West) and failed to secure and control vials of homeopathic remedies for one out of seven residents reviewed (Resident 12), and failed to ensure medications were properly stored and labeled on two of six medication carts observed (second-floor medication cart B and third-floor medication cart A Findings: A review of the facility's policy titled Medication Storage, last reviewed on [DATE], revealed, Medications will be stored in a manner that maintains the integrity of the product, ensures the safety of the residents, and is in accordance with the Department of Health guidelines. The same policy revealed, Expired, discontinued and/or contaminated medications will be removed from the medication storage areas and disposed of in accordance with facility policy. A review of the manufacturer's storage guidelines for Novolog Insulin (fast-acting insulin), revealed that the medication must be stored at room temperature and must be discarded within 28 days after opening. A review of manufacturers' storage guidelines for Lantus Insulin (long-acting insulin) revealed that the medication may be stored at room temperature and must be discarded within 28 days after opening. A review of the manufacturer's storage guidelines for Humalog Insulin (fast-acting insulin), revealed that the medication must be stored at room temperature and must be discarded within 28 days after opening. A review of the manufacturer's storage guidelines for Insulin Lispro (Humalog-fast-acting insulin), revealed that the medication must be stored at room temperature and must be discarded within 28 days after opening. A review of the manufacturers' guidelines for Novolin N 10 ml vial (An intermediate-acting insulin), revealed that the medication must be discarded 31 days after opening (refrigerated/room temperature). An observation of the second-floor medication cart B was conducted in the presence of licensed nurse Employee E11 on [DATE], at 7:00 a.m. The following were observed: One vial of Lantus insulin, opened and undated; two Lispro pen insulin, opened and undated, and one Lantus pen insulin, opened and undated. An interview with Employee E11 on [DATE], at 7:06 a.m. was conducted. Employee E11 does not know when the above-mentioned insulin was opened. Employee E11 confirmed that the insulins should have been dated when opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of the third-floor medication cart A was conducted in the presence of licensed nurse Employee E12 on [DATE], at 7:10 a.m. The following were observed: One Novolog insulin vial, opened and undated, One Lantus vial opened on [DATE], one Humalog vial opened on [DATE], one Novolog pen opened on [DATE], one Novolin vial opened on [DATE], one Lantus vial opened on [DATE], one Lispro vial opened on [DATE], and one Lantus pen opened and undated. The above observations were conveyed to the Director of Nursing on [DATE], at 11:00 a.m. The facility failed to ensure medications on the second-floor Medication Cart B, and third-floor medication Cart A were properly stored and labeled. Observation of unit Two [NAME] on [DATE] at approximately 6:30 a.m. revealed a treatment cart standing in the 2 [NAME] hallway that was unlocked. Observation of unit Two [NAME] on [DATE] at approximately 9:30 a.m. revealed the same treatment cart in standing in the 2 [NAME] hallway that was unlocked. This observation was confirmed with Nursing Employee E4 on [DATE] at approximately 9:45 a.m. Review of facility policy entitled Self-Administration of Drugs, reviewed [DATE] revealed: If the resident is able and willing to take responsibility for documenting their self administration of medications, the resident is asked to complete a bedside record indicating the administration of the medication (if beside storage is to be used and Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. Review of Resident 12's quarterly Minimum Data Set (MDS – a mandatory assessment of a residents condition and care needs) dated [DATE] revealed Resident 12 was cognitively in-tact and independent to complete activities of daily living and mobility tasks. Resident 12 had diagnoses that included: anxiety disorder, major depressive disorder, psychotic disorder with delusions, and chronic obstructive pulmonary disease. Resident 12 received antianxiety medications (for the treatment of the mental disorder anxiety), anticoagulant medications (for the treatment of irregular heartbeat), and opioid medications (controlled substance for the treatment of moderate to severe pain). Review of Resident 12's care plan revealed Resident 12 wishes to self-medicate with homeopathic treatments (essential oils) and wishes to keep her own homeopathic treatments at the bedside. Resident 12 will safely administer homeopathic remedies and keep them locked in bedside table safely. Observation of Resident 12's room on [DATE], at approximately 9:30 a.m. revealed multiple brown dropper bottles stored on a shelf under Resident 12's television. Subsequent interview with Resident 12 revealed the bottles contain my oils. Resident 12 shares a room with a roommate. Review of Resident 12's orders revealed: May self-administer medications dated [DATE]. Review of Resident 12's medication administration record for [DATE] revealed no homeopathic remedies documented in the medication administration record. Review of provider notes dated [DATE] revealed a complaint from Resident 12 related to dry skin dermatitis; resident is using her body soap and herbal essential oil. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of invoices from the company that provides Resident 12's homeopathic remedies revealed: 20 units of homeopathic remedies order February 9, 2026 and two additional homeopathic remedies ordered [DATE]; 14 homeopathic remedies ordered [DATE]; and nine units of homeopathic remedies ordered [DATE]. Interview with nursing employee E4 on [DATE], at approximately 9:45 revealed that nursing does not track of what homeopathic remedies Resident 12 has, what they are for, or when they are taken. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(a)(d) Pharmacy Services 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing Services