STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395466	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milford Healthcare and Rehabilitation Center	264 Route 6 & 209 Milford, PA 18337

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policy, and staff interviews, it was determined the facility failed to implement procedures to ensure the timely acquisition and administration of prescribed medications for one of 18 sampled residents (Resident 15). Findings include: A review of facility policy labeled Administering Medications last reviewed April 23, 2025, revealed medication are administered in accordance with prescriber orders including any required time frame. A review of Resident 15's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included Dementia (the loss of cognitive functioning that affects a person's ability to perform everyday activities). A review of physician's orders dated May 13, 2024, revealed the physician prescribed Lactaid Fast oral Tablet 9000 units (an enzyme used to help break down lactose the natural sugar in milk and dairy products). Give one by mouth with meals for lactose intolerance (inability of the body to digest lactose). A review of the June 2025 medication administration record (MAR) showed that the Lactaid was not administered on June 3,2025 at 8:00 AM. The MAR was coded with a 7 to indicate other/see progress note. Further review of the clinical record revealed no documented evidence to indicate why the medication was not administered. Continued review of the MAR revealed the medication was not administered thirty-three times between the dates of June 3,2025, to June 25,2025, with no documented evidence to indicate why the medication was not administered to the resident. A nursing progress note dated June 28,2025 at 1:20 PM indicated the Director of Nursing (DON) made the MD aware the Lactaid was unavailable for several weeks. Resident only has intolerance to milk and doesn't receive milk on any of his trays. An interview was conducted with the Director of Nursing on Monday June 30,2025 at approximately 10:00 AM to review the above findings related to failure to ensure the timely acquisition and administration of the prescribed medications for this resident. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services. (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.9 (f)(2) Pharmacy 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 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 a review of clinical records, select facility policy and staff interview it was determined the facility failed to ensure the pharmacist conducted medication regimen reviews at least monthly for two residents out of five sampled.(Resident 48 and 42). Findings include: A review of a facility policy entitled Medication Regime Reviews last reviewed by the facility on April 23, 2025, indicated the facility's consultant pharmacist conducts monthly medication regime reviews (MRR) for each resident at least monthly. The MRR involves a thorough review of the resident's medical record to prevent, identify, report and re-solve medication related problems, medication errors and other irregularities, for example medications ordered in excessive doses or without clinical indication, medication regimens that appear inconsistent with the resident's stated preferences, duplicative therapies or omissions of ordered medications, inadequate monitoring for adverse consequences, potentially significant drug-drug or drug-food interactions, potentially significant medication-related adverse consequences or actual signs and symptoms that could represent adverse consequences, incorrect medications, administration times or dosage forms, or other medication errors, including those related to documentation. A review of Resident 42's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include dementia (the loss of cognitive functioning that affects a person's ability to perform everyday activities) and anxiety (a feeling of fear or dread often triggered by stressful situations). A review of Resident 42' s clinical record conducted at the time of the survey July 1, 2025, revealed no evidence the pharmacist had conducted drug regimen reviews at least once a month between February 2025, and March 2025. A review of Resident 48's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses to include post-traumatic stress disorder (PTSD is a disabling disorder that develops after exposure to a traumatic event. It is characterized by intrusive thoughts, nightmares, and flashbacks; avoidance of reminders of the trauma; negative cognitions and mood; hypervigilance and sleep disturbance) and dementia. A review of Resident 48's clinical record conducted at the time of the survey ending July 1, 2025, revealed no evidence the pharmacist had conducted drug regimen reviews at least once a month between February 2025 and March 2025. During an interview with the Director of Nursing (DON) on July 1, 2025, at approximately 11:35 AM, it was confirmed that there was no evidence the pharmacist conducted monthly medication regimen reviews as required for Residents 48 and 42. 28 Pa. Code 211.12(d)(3)(5) 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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, it was determined the facility failed to ensure that residents' drug regimens were free from unnecessary medications by failing to discontinue an unnecessary antibiotic for one resident (Resident 22); failing to provide clinical justification for the use of duplicate antidepressant medications for one resident (Resident 42); and failing to ensure that one resident's (Resident 48) medication regimen was free from unnecessary psychoactive medication, including administering an as-needed antianxiety medication beyond 14 days without adequate clinical justification and without documentation of attempted non-pharmacological interventions, for three of eighteen sampled residents. Findings include: A review of Resident 22's clinical record revealed the resident was admitted to the facility on [DATE], with a diagnosis to include dementia (a decline in memory, thinking, and other cognitive abilities, significantly impacting daily life) and chronic kidney disease (a condition where kidneys are damaged and lose their ability to filter waste and fluids from the blood). A review of a physician order dated May 4, 2025, for Bactrim DS 800-160mg tablets- Give 1 tablet by mouth every morning and at bedtime for Urinary tract infection (an infection in any part of the urinary system, usually caused by bacteria.) for 10 days. A review of a facility policy Antibiotic Stewardship last reviewed by the facility on April 23, 2025, revealed appropriate indications for antibiotic include minimum criterial met for clinical definition of active infection by utilizing McGreer Criterial (a set of definitions used in long-term care facilities to standardize the identification and classification of infections) A review of Resident 22's clinical record revealed a McGreer Criteria Checklist completed on May 5, 2025. The checklist indicated it was reviewed by the medical doctor, director of nursing, and infection control preventionist. The checklist documented that Resident 22 had no urinary tract-related symptoms and did not meet criteria for antibiotic use. A progress note dated May 9, 2025, at 6:08 PM, documented the resident was still receiving oral antibiotic therapy for a urinary tract infection while denying any symptoms. No evidence was found that a urinary specimen was obtained to confirm infection. A review of the Medication Administration Record (MAR) for May 2025 confirmed Resident 22 received twenty (20) doses of Bactrim DS without documentation of a culture or other evidence indicating infection. During an interview with the Director of Nursing on July 1, 2025, at approximately 11:00 AM, the DON confirmed the facility could not provide any additional documentation to support the antibiotic use for Resident 22. A clinical record review revealed that Resident 42 was admitted to the facility on [DATE], with diagnosis to include dementia the loss of cognitive functioning that affects a person's ability to perform everyday activities) and anxiety (a feeling of fear or dread often triggered by stressful situations). (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician orders included Trazodone HCL, 25 mg (antidepressant) by mouth at bedtime for increased depression (initiated February 2, 2025), and Remeron, 7.5 mg (antidepressant) by mouth at bedtime for appetite/depression (initiated January 17, 2025). The clinical record did not include documentation justifying the concurrent use of duplicate antidepressant medications. An interview was conducted with the Director of Nursing (DON) on July 1,2025, to review the above findings related to antidepressant therapy, the DON confirmed there was no clinical justification available for the duplicate antidepressant medications. A review of Resident 48's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include post-traumatic stress disorder (PTSD a disabling disorder that develops after exposure to a traumatic event. It is characterized by intrusive thoughts, nightmares, and flashbacks; avoidance of reminders of the trauma; negative cognitions and mood; hypervigilance and sleep disturbance) and dementia (the impaired ability to remember, think, or make decisions that interferes with doing everyday activities). A review of Resident 48's physician orders revealed an order dated February 5, 2025, for Ativan (a benzodiazepine that work by enhancing the activity of certain neurotransmitters in the brain and used to treat anxiety disorders) 0.5 mg by mouth every twenty-four hours as needed (PRN) for agitation during care. Review of Resident 48's electronic medication administration record (eMAR a technology that automates data entry for the administration of medication to patients in healthcare settings and the digital records contain details about the prescribed medication regimen, dosage, timing, and administering staff) dated February 5, 2025, through May 22, 2025, revealed that Ativan was administered on the following dates and times on February 8, 2025, at 1:26 PM, on March 29, 2025, at 5:52 PM, on April 12, 2025, at 6:48 AM, on April 21, 2025, at 10:01 PM, on April 23, 2025, at 10:01 PM, and on May 21, 2025, at 6:02 PM, without documentation that non-pharmacological interventions were attempted before administration. The facility failed to ensure the PRN antianxiety medication order was limited to 14 days and failed to provide documented evidence that the attending physician assessed and justified its continued use. Additionally, the facility could not provide document evidence that licensed nursing staff attempted non-pharmacological interventions prior to administration of a PRN antianxiety/benzodiazepine medication, Ativan. Further review of Resident 48's clinical record revealed a monthly pharmacy review completed by the consultant pharmacist dated April 6, 2025, indicated that the resident had been receiving Prazosin 2 mg by mouth daily (a medication used to treat high blood pressure, symptoms of an enlarged prostate, and nightmares related to post-traumatic stress disorder), Remeron15 mg, give one tablet daily (medication used to treat a certain type of depression called Major Depressive Disorder in adults), Seroquel50 mg by mouth daily (a psychotropic medication used to treat certain mental/mood disorders such as schizophrenia, bipolar disorder, sudden episodes of mania or depression associated with bipolar disorder), Risperdal 25 mg by mouth daily (atypical antipsychotic used to treat schizophrenia and bipolar disorder, as well as aggressive and self-injurious behaviors associated with autism spectrum disorder) and Ativan 0.5 mg, one tablet every twenty-four hours. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The consultant pharmacist made the request to the attending physician to review the resident's psychoactive medications and consider an attempted gradual dose reduction (GDR) or trial discontinuation, as deemed appropriate, and if deemed clinically contraindicated to please document the clinical rationale. The clinical rationale must address the reason(s) why an attempted GDR would likely impair the resident's function or cause psychiatric instability, by exacerbating an underlying medical or psychiatric disorder. A review of the physician signed response dated April 22, 2025, revealed to disagree with the consultant pharmacist recommendation and the noted clinical rationale was, depression, PTSD, anxiety will be impaired with a gradual dose reduction. The facility could not provide documented evidence the resident's physician provided sufficient clinical justifications for the continued use of the psychoactive medications. These findings were reviewed with the Director of Nursing on July 1, 2025, at 11:15 AM. The facility could not provide documented evidence to support PRN use of Ativan beyond 14 days, that non-pharmacological interventions were attempted prior to administration, or sufficient clinical justification for the continued use of multiple psychoactive medications. 28 Pa. Code 211.2(d)(3)(5) Medical Director 28 Pa. Code 211.12(d)(3)(5) Nursing services

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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 observation and staff interview, it was determined the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in the dietary department. Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). A review a facility policy entitled Food Receiving and Storage last reviewed by the facility on April 23, 2025, indicated that opened food items would include a use by date and all dry foods and goods should be stored in a manner that maintains the integrity of the packaging until ready to be used and all bulk food item should be removed from their original packaging, placed in bins, and labeled with a use by date. The initial tour of the dietary department conducted on June 28, 2025, at 10:41 AM, revealed the following unsanitary practices with the potential to introduce contaminants into food and increase the potential for food-borne illness: Inside of the cook's reach-in cooler, observed open bottles of chocolate syrup and caramel syrup that did not have an open date noted. In the dry storage room, eight cranberry bowls of pre-portioned cold cereals were not dated. Two crates containing gallon jugs of water were placed in direct contact with the floor. An open package of brown gravy mix was observed without an open date, along with a brown cardboard box containing an opened, unsealed bulk bag of thickener powder with an uncovered ladle resting on top. Further inspection of the dry storage area revealed a dirty hand broom and dusters were stored among food items and pots on the second shelf of a wire rack. In the janitor's closet, two yellow mop buckets containing dirty water and mops were stored with brooms placed across the tops of the buckets. A ceiling fan located in the dish room was noted to be corroded with accumulated dust and debris. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Additionally, during the same tour, Employee 1 (dietary staff) was observed using the 3-compartment sink to soak, clean, and sanitize sheet pans and cooking equipment but was unable to locate the litmus strips needed to test sanitizer strength and did not demonstrate knowledge of the proper sanitizing procedure. When tested, during observation by the surveyor, the sanitizer concentration measured 0 ppm (parts per million), whereas proper concentration must be greater than 150 ppm, indicating that no sanitizer was present in the sanitizing sink compartment. Employee 2 (Human Resources Director and former Dietary Manager) then emptied the 3-compartment sink, restarted the cleaning process, and tested the sanitizer concentration, which measured greater than 150 ppm. The facility subsequently developed and implemented a plan to educate dietary staff on correct sanitation procedures for using the 3-compartment sink. On June 30, 2025, at 12:15 PM, during an observation of lunch tray line service, Employee 3 (server) was seen dipping his gloved hands into a red bucket next to a cutting board on a preparation table. When instructed by the food service manager to change gloves, Employee 3 reported it was only sanitizer and immediately handled a pile of Styrofoam containers before applying new gloves. During an interview with the Nursing Home Administrator (NHA) on July 1, 2025, at 10:45 AM, the above observations were confirmed. The NHA acknowledged the dietary department must be maintained in a sanitary manner to prevent potential food contamination and foodborne illness. The above findings were reviewed with the Nursing Home Administrator on July 1, 2025. 28 Pa. Code 201.18 (e) (2.1) Management 28 Pa. Code 211.6 (f) Dietary Services