STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Milford Rehabilitation and Healthcare Center	264 Route 6 & 209 Milford, PA 18337

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement an individualized, person-centered care plan to address dementia-related behaviors and cognitive decline for one of 17 residents reviewed (Resident 36).Findings include:A review of Resident 36's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), cerebral infarction (a stroke), and communication deficit disorder.A review of Resident 36's Quarterly Minimum Data Set Assessment (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated April 11, 2026, revealed the resident was severely cognitively impaired.A review of the resident's current care plan, initially dated March 24, 2026, revealed the resident had the potential to be physically aggressive related to dementia and poor impulse control. The care plan indicated the resident would not harm himself or others. Interventions included modifying the resident's environment, maintaining constant visual observation when out of his room, and monitoring and documenting observed behaviors and attempted interventions in a behavior log.Review of nursing documentation and facility investigative documentation revealed Resident 36 demonstrated repeated dementia-related behaviors from December 2025 through May 2026, including verbal aggression, physical aggression toward staff and residents, sexually inappropriate behaviors, unsafe attempts to stand and ambulate, wandering into restricted areas and other residents' rooms, pulling the fire alarm, attempting to access medication carts, and behaviors that did not consistently respond to staff redirection.Nursing documentation dated December 14, 2025, at 2:26 PM revealed Resident 36 had several behavioral outbursts during the shift. The resident shouted profanities, made verbal threats toward others, exhibited inappropriate behaviors toward female residents, became aggressive when redirected, entered other residents' rooms, and spit on the floor. Nursing documentation dated December 30, 2025, at 4:16 PM revealed Resident 36 exhibited increased behaviors, agitation, and combative behavior. Resident 36 transferred himself by wheelchair into the central bathroom and used his wheelchair and a linen/brief cart to block the door in an attempt to prevent staff from entering the room. When nursing staff attempted to redirect the resident, he struck staff. A nurse's note dated December 31, 2025, at 6:20 PM revealed that during medication pass, the nurse observed Resident 36 in the dining room. The resident stood from his wheelchair and fell to the floor. No injuries were noted.Investigative documentation provided by the facility dated January 3, 2026, at 5:40 PM revealed Resident 36 was found on the floor in the television room. The resident stated he was attempting to stand and walk. The chair alarm was not sounding at the time of the fall. The resident had been placed in a regular chair prior to the fall. The report indicated Resident 36 frequently attempted to self-ambulate despite education and was noncompliant with safety measures.Investigative documentation dated January 9, 2026, at 2:30 PM revealed Resident 36 and Resident 50 were seated in the second-floor television lounge after lunch. Employee 7, housekeeping staff, observed Resident 36 approach Resident 50 and placed his hand on (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

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 50's exposed right breast. Employee 7 separated the residents and notified nursing staff. Resident 50 was admitted to the facility on [DATE], with diagnoses including dementia. Resident 50's Quarterly Minimum Data Set Assessment, dated November 17, 2025, revealed Resident 50 was severely cognitively impaired. Nursing documentation dated January 10, 2026, at 4:43 PM revealed Resident 36 was under close supervision related to the January 9, 2026, incident. Documentation revealed the resident became increasingly agitated with staff redirection and exhibited behaviors including cursing, punching and kicking staff, moving furniture, slapping counters, and licking walls. A nursing note dated January 10, 2026, at 8:27 PM revealed Resident 36 exhibited ongoing and escalating behaviors including wandering into restricted areas, verbal aggression, attempting to access medication carts, smearing food, and pulling the fire alarm. Staff redirection was largely ineffective. Documentation indicated staff would continue close supervision and monitor the resident's response to interventions. A physician's order dated January 11, 2026, revealed Seroquel (an antipsychotic medication) 25 milligrams by mouth twice daily was ordered in response to increased behaviors. The resident had previously received Seroquel 25 milligrams by mouth daily for cognitive communication deficit disorder. The dose was increased due to ongoing behaviors including striking staff, verbal threats toward others, and kicking furniture. Close supervision continued in addition to the medication increase. Nursing documentation dated January 16, 2026, at 11:15 AM revealed Resident 36 exhibited increased agitation and aggressive behaviors that did not respond to redirection. The resident cursed at and struck staff members. Nursing documentation dated January 16, 2026, at 6:34 PM revealed Resident 36 exhibited aggression and agitation toward staff providing care. Resident 36 struck a staff member while care was being provided to another resident in close proximity. A nurse's note dated January 20, 2026, at 8:34 PM revealed Resident 36 removed his brief in the hallway and exposed his genitals. The resident also pulled the cover off the fire alarm and continued attempting to bang on and pull the alarm cover. The resident became verbally aggressive when redirected by staff. Nursing documentation dated January 22, 2026, at 6:20 PM revealed Resident 36 became physically violent and exhibited sexual behaviors toward staff during the shift. Documentation revealed the resident used vulgar language toward staff and became violent when redirected. The resident attempted to stand from his wheelchair and fought with staff during redirection. The physician was notified and ordered Seroquel 25 milligrams by mouth twice daily. Documentation further revealed Resident 36 punched a nurse aide on the thigh while she was seated completing documentation. The resident wheeled into other residents' rooms and cursed at staff when redirected. Nursing documentation dated January 27, 2026, at 10:18 AM revealed Resident 36 exhibited aggressive and sexually inappropriate behaviors toward staff. The resident touched and grabbed female staff members' genital areas during care. Staff redirection resulted in increased agitation. Nursing documentation dated January 28, 2026, at 7:06 PM revealed Resident 36 exhibited inappropriate behaviors including touching and grabbing staff during care and attempting to stand without assistance. Redirection was ineffective. Nursing documentation dated January 29, 2026, at 10:34 AM revealed Resident 36 was seated in his wheelchair near the nurses' station and propelled himself toward a nurse, kicking her leg. At 11:35 AM, the resident propelled his wheelchair toward staff, kicking, hitting, and grabbing them while making verbal threats and profane statements. Additional nursing documentation revealed that at 12:47 PM, Resident 36 was seated in the dining room and stood, attempting to walk while holding onto a table. When staff attempted to assist the resident back into his wheelchair, Resident 36 threw a chair toward another resident. The chair struck the resident's leg rest and did not strike the resident. Resident 36 then made threatening and inappropriate statements. The physician was contacted and increased the resident's Seroquel to 50 milligrams by mouth twice daily in response to the resident's behaviors. Nursing documentation dated February 2, 2026, at 6:32 PM revealed Resident 36 grabbed the buttocks of a contracted nursing staff member. Nursing documentation dated February 12, 2026, at 9:52 AM revealed staff attempted to refasten the resident's brief after he had undone it. The resident became agitated, shouted (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	profanities, attempted to punch staff with both fists, and struck a staff member. The resident was situated near the nurses' station and continued leaning over his wheelchair attempting to strike others. Facility investigative documentation dated February 14, 2026, at 6:15 PM revealed Resident 36 struck another ambulatory resident twice in the abdomen while seated in his wheelchair. The residents were separated and the physician was notified. Continued negative behaviors, including striking staff, were documented. Nursing documentation dated February 21, 2026, at 7:30 AM revealed staff redirected Resident 36 away from a cleaning cart. The resident grabbed the cart, struck staff, yelled profanities repeatedly, and grabbed other residents' wheelchairs while exhibiting escalating behaviors. Facility investigative documentation and nursing documentation dated February 23, 2026, at 7:50 PM revealed Resident 36 attempted to enter the central shower room. A nurse attempted to redirect the resident backward. The resident resisted and fell to the floor, sustaining two small skin tears to the left forearm. Nursing documentation dated February 24, 2026, at 2:37 PM revealed Resident 36 exhibited aggressive behaviors during care and attempted to strike staff. Staff redirection was ineffective. Facility investigative documentation dated March 23, 2026, at 6:35 PM revealed Resident 36 was observed arguing with another male resident. The residents were in close proximity and made brief physical contact. Staff immediately separated the residents. The physician was notified. Resident 36 was maintained in line-of-sight supervision and later placed in bed for the evening. Facility investigative documentation dated March 25, 2026, at 7:14 AM revealed Resident 36 was found on the dining room floor at 6:25 AM with a small skin tear. The physician was notified and the resident was returned to bed. Nursing documentation dated April 28, 2026, at 7:30 PM revealed Resident 36 struck a nurse in the hip during care. Nursing documentation dated May 12, 2026, at 1:47 PM revealed Resident 36 grabbed the telephone from the nurses' station and attempted to punch a nurse in the face when she attempted to retrieve the phone. The resident made threatening and profane statements toward staff. Nursing documentation dated May 14, 2026, at 6:52 AM revealed Resident 36 grabbed a nurse inappropriately as she walked past him and made sexually inappropriate statements. The facility failed to develop and implement an individualized, person-centered plan to address, modify, and manage Resident 36's dementia-related behaviors. The resident's care plan identified physical aggression related to dementia and poor impulse control; however, the care plan did not include individualized interventions based on assessment of the resident's preferences, social and past life history, customary routines, interests, triggers, or effective approaches to manage, modify, or decrease the resident's dementia-related behavioral symptoms. During an interview on May 14, 2026, at 10:00 AM, the Nursing Home Administrator confirmed the facility was unable to provide evidence of the development and implementation of an individualized, person-centered plan to address Resident 36's dementia care. 28 Pa. Code 211.12(d)(3)(5) Nursing Services

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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 select facility policy, clinical record review, observations, and staff interview, it was determined the facility failed to implement infection prevention practices and adhere to the facility policy for identifying, treating and preventing the transmission of scabies for two of 17 residents reviewed (Resident 16 and Resident 72) and for implementing enhanced barrier precautions for one of 17 residents reviewed (Resident 16). Findings include:According to the Centers for Disease Control and Prevention (CDC) guidance titled Public Health Strategies for Scabies Outbreaks in Institutional Settings (updated December 18, 2025), residents with confirmed or suspected scabies (a skin condition caused by microscopic mites that burrow into the skin and lay eggs, resulting in intense itching, often worse at night, and a pimple-like rash) should be placed on contact precautions, including the use of gowns and gloves and avoidance of direct skin-to-skin contact. The guidance further stated that roommates or close contacts with prolonged skin exposure should be identified, offered prophylactic treatment, and monitored but do not require room isolation. A review of the facility policy titled Scabies Identification, Treatment, and Environmental Cleaning, adopted on February 9, 2026, indicated the facility would treat residents infected with scabies and prevent transmission to other residents and staff. The policy required residents with scabies to remain on contact precautions (use of gowns and gloves) for 24 hours after treatment. It further required staff who may have been exposed to report any rash development to the infection preventionist. The policy also required that roommates of infected residents be carefully assessed and treated if symptoms were present or monitored daily if asymptomatic until resolution. Clinical record review revealed Resident 72 was admitted to the facility on [DATE], with diagnoses that included congestive heart failure (a condition in which the heart is unable to pump blood effectively to meet the body's needs) and rash and other nonspecific skin eruption (a generalized or localized rash without a definitive diagnosis). A review of Resident 72's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 1, 2026, revealed that Resident 72 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a range of 12-15 means normal thinking and memory, reflecting little to no cognitive impairment). Observation and interview with Resident 72 on May 12, 2026, at 11:30 AM revealed the resident continued to report intense itching, worse at night, resulting in interrupted sleep. Contact precautions signage was posted outside the room, and gowns and gloves were available at the entrance. Review of hospital discharge documentation dated April 24, 2026, revealed Resident 72 had chronic pruritic dermatitis (long-term itchy skin inflammation) and had been treated with topical medications including triamcinolone (a corticosteroid used to reduce inflammation) and nystatin (an antifungal medication). The hospital record also recommended outpatient dermatology follow-up. admission documentation dated April 24, 2026, identified a rash on the resident's upper shoulders at time of admission. Nursing documentation dated April 27, 2026, revealed progression of the rash to the arms, legs, and torso, with the resident reporting worsening symptoms over approximately four months. A physician note dated April 28, 2026, described a maculopapular erythematous rash with excoriations (red, raised and flat rash with scratch marks from itching) on both upper extremities. A review of clinical records revealed on May 5, 2026, the resident left the facility for an outside medical appointment without additional infection control precautions. A specialty wound care evaluation dated May 7, 2026, documented scabbing rash involving the back, sacrum, chest, abdomen, and bilateral arms. Dermoscopy (a magnified skin examination using a handheld device with light) confirmed a diagnosis of scabies. Treatment with permethrin 5 percent cream (a topical scabicidal medication used to kill mites causing scabies) was ordered. Nursing documentation dated May 8, 2026, confirmed application of permethrin cream. The (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's personal clothing was discarded at his request, linens were changed and placed in a red biohazard bag (used for potentially infectious materials), and clean garments were provided. A physician order dated May 10, 2026, initiated contact isolation precautions requiring all care to be provided in the resident's room due to scabies, with reassessment after treatment initiated on May 8, 2026. Infection control documentation titled Infections for April 2026 did not include Resident 72's rash identified on admission. A separate infection control tool titled Revised McGeer Criteria (standardized infection surveillance guidelines used to determine whether a resident meets criteria for a suspected healthcare-associated infection) for Infection Control Surveillance Checklist was incomplete, undated, and did not include completed scabies surveillance criteria. This information was reviewed with the Nursing Home Administrator (NHA) on May 12, 2026, at 1:00 PM. The resident continued to exhibit symptoms consistent with scabies, and timely implementation of appropriate precautions and infection control measures was not evident. During an interview on May 14, 2026, at 11:40 AM, the NHA acknowledged that the facility did not timely identify scabies, did not consistently implement CDC-recommended precautions, and did not ensure appropriate treatment and infection prevention measures were followed for Resident 72. Clinical record review revealed Resident 16 was admitted on [DATE], with a diagnosis of acute respiratory failure with hypoxia (a condition in which the lungs cannot adequately oxygenate the blood, resulting in low oxygen levels). The admission MDS dated [DATE], indicated Resident 16 was cognitively intact with a BIMS score of 14, reflecting no significant cognitive impairment. During an interview on May 12, 2026, at 11:45 AM, Resident 16 reported being in quarantine due to the roommate's skin condition and denied any symptoms of rash or itching. Nursing documentation confirmed a full skin assessment on May 8, 2026, showed no evidence of scabies, and the resident received permethrin treatment on May 9, 2026. According to CDC guidance, roommates of residents diagnosed with scabies should be identified as close contacts, evaluated, offered prophylactic treatment as indicated, and monitored; however, room isolation is not required. An interview with the infection control nurse and Nursing Home Administrator on May 13, 2026, at 2:10 PM confirmed uncertainty regarding the duration and necessity of isolating Resident 16, and inability to justify the extended precautions applied. Review of Resident 16's clinical record revealed a physician order dated April 17, 2026, for Enhanced Barrier Precautions (EBP) due to the presence of an indwelling catheter. A review of the facility policy titled Enhanced Barrier Precautions (EBP), adopted February 9, 2026, indicated gowns and gloves are required during high-contact care activities for residents with indwelling medical devices, including urinary catheters (a flexible tube inserted into the bladder to drain urine into a collection bag). Observation on May 12, 2026, at 11:45 AM revealed Resident 16 was transferred by two nursing assistants without the use of required gowns and gloves. On May 12, 2026, at 1:45 PM, the Nursing Home Administrator and infection control nurse were notified of the observation and acknowledged that Enhanced Barrier Precautions were not implemented during the care of Resident 16. 28 Pa Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of select facility policy, clinical records, and staff interview it was determined the facility failed to develop a comprehensive care plan to meet the individualized needs of two residents of 17 residents reviewed (Resident 13 and Resident 16)Findings include:A review of the facility's policy titled Care Plans, Comprehensive Personˆ Centered, adopted February 9, 2026, showed that a comprehensive, personˆcentered care plan must be developed and implemented for each resident. The policy stated that the care plan describes the services necessary to help the residents attain or maintain their highest practicable physical, mental, and psychosocial wellˆbeing and must reflect currently recognized standards of practice for identified problems and conditions. The policy also specified that resident assessments are ongoing and that care plans must be revised as new information becomes available or as the resident's condition changes.Clinical record review revealed Resident 13 was admitted to the facility on [DATE], with diagnoses which included fracture to the neck of the left femur (a break in the leg bone just below the ball of the hip joint).A review of Resident 13's admission Minimum Data Set Assessment (MDS a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated February 26, 2026, revealed that Resident 13 was cognitively impaired with a BIMS score of 5 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a range of 0-7 indicates severe cognitive decline indicating Resident 13 has significant challenges with memory, orientation, or both).A review of the resident's clinical record revealed a document dated May 7, 2026, entitled, Specialty Physician Wound Evaluation & Management Summary. The documentation indicated the presence of a Stage 3 pressure wound (deep sore that is through all layers of the skin and reached the layer of fat underneath) on the right heel. An observation on May 14, 2026 at 10:00 AM of the resident room included the availability of gowns and gloves for Enhanced Barrier Precautions (an infection control strategy recommended by the CDC for nursing homes and skilled nursing facilities. They mandate the use of gowns and gloves during high-contact resident care to prevent the spread of multidrug-resistant organisms). The observation also included a sign communicating the presence of enhanced barrier precautions and the need for gowns and gloves during high risk activities such as dressing, bathing, transferring, and wound care.A review of the resident's current plan of care revealed the care plan failed to identify the resident's Enhanced Barrier Precaution status and lacked appropriate interventions to address the resident's needs.A clinical record review reveals Resident 16 was admitted to the facility on [DATE], with a diagnosis of acute respiratory failure with hypoxia (sudden inability of the lungs to supply adequate oxygen to the bloodstream, leading to abnormally low oxygen levels). A review of Resident 16's (admission) MDS dated [DATE], revealed that Resident 16 was cognitively intact with a BIMS score of 14 (a range of 12-15 means normal thinking and memory, reflecting little to no cognitive impairment). A clinical record review revealed a physician order dated April 17, 2026, for Enhanced Barrier Precautions due to the presence of an indwelling catheter (soft, flexible tube designed to stay in place inside the bladder and continually drain urine into a bag).A review of the resident's current plan of care revealed the care plan failed to identify the resident's Enhanced Barrier Precaution status and lacked appropriate interventions to address the resident's needs.An interview was conducted with the Nursing Home Administrator on May 14, 2026, at 10:15 AM to acknowledge the concerns identified with resident care plans.28 Pa. Code 211.10 (c)(d) Resident care policies.28 Pa Code 211.12(d)(3) Nursing services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of select facility policy, clinical records, and staff interview, it was determined the facility failed to review and revise a comprehensive plan of care in response to a fall for one resident out of 17 residents reviewed (Resident 11).Findings include:A review of the facility's policy titled Care Plans, Comprehensive Person Centered, adopted February 9, 2026, the policy indicated that the care plan describes the services necessary to help the residents attain or maintain their highest practicable physical, mental, and psychosocial well being and must reflect currently recognized standards of practice for identified problems and conditions. The policy also specified that resident assessments are ongoing and that care plans must be revised as new information becomes available or as the residents' condition changes. A clinical review revealed Resident 11 was admitted to the facility on [DATE], with a diagnosis of primary generalized osteoarthritis (wear and tear in several joints throughout the body). A review of Resident 11's quarterly) Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 20, 2026, revealed the resident was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a range of 12-15 means normal thinking and memory, reflecting little to no cognitive impairment). A review of facility investigative documentation dated May 6, 2026, at 2:30 PM revealed Resident 11 fell from the bed in her room. The documentation description indicated the resident reported she was reaching for an item when the fall occurred. Further review of the documentation indicated the immediate action taken to prevent additional falls included placing a sign instructing the resident to call for assistance. A review of facility investigative documentation dated May 10, 2026, at 2:40 PM revealed Resident 11 experienced another fall in her room and was found seated on the floor. The resident reported she fell while attempting to transfer into bed. Additional review of the documentation indicated that immediate fall prevention measures included the use of a chair clip alarm (small clip that is attached to a person's clothing or belt and connects to an alarm device alert staff of unassisted transfers).A review of the resident's Care Plan Report, revealed a care plan for the resident being at risk for falls due to impaired cognition, impaired coordination, and medication side effects. The care plan was initiated on November 25, 2025, and included the goal of reducing the fall risk. Review of the resident's plan of care revealed the facility failed to review and revise the resident's fall-risk care plan to include the interventions implemented following the falls that occurred on May 6, 2026, and May 10, 2026. An interview was conducted with the Nursing Home Administrator on May 14, 2026, at 10:15 AM to acknowledge the concerns identified with resident care plans.28 Pa. Code 211.10 (c)(d) Resident care policies.28 Pa Code 211.12(d)(3) 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, and staff interviews, it was determined the facility failed to provide nursing services in accordance with professional standards of quality by failing to ensure prompt clinical evaluation and timely treatment of an injury for one of 17 sampled residents (Resident 13).Findings include:A clinical record review revealed Resident 13 was admitted to the facility on [DATE], with a diagnosis of fracture of the unspecified part of the neck of the left femur (a break in the neck of the left femur located just below the ball of the hip joint).A review of Resident 13's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to assist in planning resident care), dated February 26, 2026, revealed Resident 13 was cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 5. (The BIMS is a screening tool within the Cognitive Patterns section of the MDS used to assess attention, orientation, and the ability to register and recall information. A score of 0-7 indicates severe cognitive impairment and reflects significant difficulty with memory, orientation, or both).A review of the clinical record revealed a nursing progress note dated April 15, 2026, at 2:43 PM, documented as a late entry for an incident that occurred on April 14, 2026. The documentation indicated that while seated in the dining room for lunch, Resident 13 independently self-propelled in her wheelchair to obtain coffee from a cart located at the front of the dining room. A kitchen staff member assisted by pouring the coffee into the cup the resident was holding. As Resident 13 returned to her table while holding the cup, the coffee spilled onto her clothing and upper legs. Nursing documentation indicated that the resident's wet garments were removed and an assessment was completed, which noted mild redness on both thighs and a flattened blister measuring 2 centimeters (cm) (length) and 2 cm (width) on the midˆleft thigh. A cool compress was applied, and the resident was evaluated by the nurse practitioner who was present in the facility. The provider recommended continued cool compresses and application of Silvadene (a cream that keeps harmful germs out and helps the burn heal safely).A review of an incident note completed by the Director of Nursing (DON), dated April 14, 2026, at 12:10 PM, documented as a late entry note on April 15, 2026, at 2:43 PM revealed Resident 13 was seated in the main dining room for lunch when she self-propelled to the coffee cart. The note indicated Resident 13 attempted to pour herself a cup of coffee from the carafe when a dietary aide offered assistance. The dietary aide then poured the coffee into the cup while the resident held it. The note further documented that while attempting to return to her table, Resident 13 spilled the hot coffee onto herself. The resident's wet garments were immediately removed and the resident was assessed for injury. The resident was noted to have mild redness to both thighs and a flattened blister measuring 2 cm by 2 cm to the mid-thigh area. Cool compresses were applied, and the nurse practitioner evaluated the resident while on site. The note documented the nurse practitioner recommended continued cool compresses and application of Silvadene cream. The note indicated the DON, physician, and Nursing Home Administrator (NHA) were notified of the incident.The facility failed to document in the clinical record on April 14, 2026, at the time the incident occurred. In addition, there was no evidence that a physician's order for treatment related to the resident's burn injury was obtained on the date of the incident.A review of the physician's orders revealed an order dated April 17, 2026, for Silvadene 1% external cream to be applied topically to both thighs every day shift for five days for treatment of a hot-liquid burn.A review of the electronic Medication Administration Record (eMAR) revealed the Silvadene cream was not initiated until April 18, 2026, four days after the burn injury occurred, and continued through April 22, 2026.A review of the facility document entitled Medication Error, Wrong Time indicated the resident was burned on April 14, 2026, and referenced application of Silvadene from stock medication on April 14 and April 15, 2026. The document also referenced the ordered written on April 17, 2026, and documented administration of Silvadene from April 18 through April 22, 2026.A review of the eMAR revealed no documented evidence that Silvadene was administered on (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	April 14, 2026, through April 17, 2026.A review of the clinical record revealed the facility did not complete additional clinical assessments or obtain a skin evaluation by a wound care specialist following the burn injury. There was no documentation indicating that a comprehensive assessment of the burn, including evaluation by a wound care specialist, was conducted after the incident. This failure, in addition to inconsistencies and delay in treatment, failed to provide appropriate care and monitoring of the resident's injury.28 Pa. Code 211.12(d)(3)(5) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policies, clinical records, facility-provided investigations, and staff interviews, it was determined the facility failed to provide adequate supervision and implement effective fall prevention interventions to prevent recurrent falls for one of 17 residents reviewed (Resident 4).Findings include:A review of the facility policy titled Falls and Fall Risk, Managing, adopted by the facility on February 9, 2026, indicated based on previous evaluations and current data, staff were to identify interventions related to the resident's specific risks and causes to attempt to prevent falls and minimize complications related to falls. The policy further indicated that staff, with input from the attending physician, were to implement a resident-centered fall prevention plan to reduce specific fall risk factors for each resident identified as at risk for falls or with a history of falls. If falls recurred despite initial interventions, staff were to implement additional or different interventions or document why the current interventions remained appropriate. If underlying causes could not readily be identified or corrected, staff were to trial various interventions until falls were reduced, prevented, or determined unavoidable.A clinical record review revealed Resident 4 was admitted to the facility on [DATE], with diagnoses that included post-traumatic stress disorder (PTSD, a serious mental health condition that can develop after an individual experiences or witnesses a traumatic event) and Alzheimer's disease (the most common cause of dementia and a progressive brain disease caused by changes in the brain, including buildup of proteins, resulting in memory loss, cognitive decline, and impaired functioning).A review of the resident's annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process used to assess residents and develop individualized care plans) dated February 14, 2026, revealed Resident 4 was unable to complete the Brief Interview for Mental Status due to being rarely or never understood because of cognitive impairment. Section GG (functional abilities and goals) revealed the resident required partial/moderate assistance (helper does less than half the effort and assists with lifting, holding, or supporting trunk or limbs) and supervision or touching assistance with walking 10 feet and walking 50 feet (the helper provides verbal cueing, steadying, contact guard assistance, or intermittent physical assistance during ambulation).A review of Resident 4's care plan, initiated on April 25, 2024, identified the resident was at risk for falls related to sensory deficits and use of antipsychotic medication (a class of psychotropic medications primarily used to manage psychosis, including symptoms such as hallucinations, delusions, paranoia, or disordered thinking). Resident goals included minimizing risk for falls and fall-related injuries. Planned interventions included assistance with transfers and ambulation, reinforcement to request assistance, and standby assistance/contact guard with use of a wheeled walker when unsteady.A review of the resident's physician's order entered by the facility's Director of Nursing (DON) on April 10, 2026, at 5:18 PM, directed staff to maintain close observation of the resident during ambulation.A review of facility investigative documentation dated April 29, 2026, at 2:30 AM, revealed Resident 4 was observed tripping over a tray table near the nursing station. The resident sustained a skin tear measuring approximately 1 centimeter (cm) by 1 cm. Documentation indicated the resident did not hit his head, vital signs were stable, range of motion was within normal limits, and the resident denied pain or discomfort. Resident 4 was unable to describe the incident.A review of a post-fall nursing note dated April 29, 2026, at 2:44 PM, revealed interventions included monitoring gait (a person's walking pattern) during ambulation and ensuring pathways remained clear.A review of the resident's Morse Fall Scale Assessment (a standardized tool used to evaluate a resident's risk for falling based on factors such as prior falls, mobility, use of assistive devices, gait and mental status), dated April 30, 2026, at 2:03 PM, identified Resident 4 as a high fall risk due to poor recall, impaired judgment, impaired safety awareness, decreased muscular coordination, one to two falls within the past three months, and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	multiple predisposing conditions including dementia and wandering behaviors.A review of facility investigative documentation completed by Employee 2 Registered Nurse (RN), dated May 3, 2026, at 12:05 AM, revealed staff responded to a noise in Resident 4's room and observed the resident on the floor bleeding from the forehead area. The resident was unable to describe the incident. The physician was notified and an order was obtained to transfer to the resident to the emergency room for further evaluation and treatment.A review of documentation provided by the facility indicated on May 3, 2026, at 6:08 PM, the resident had a fall in the facility and was transferred out to the hospital. The facility indicated planned interventions post fall to prevent recurrence included an evaluation by physical therapy (PT) and occupational therapy (OT) upon the resident's return from the hospital. It was indicated Resident 4 returned to the facility on May 4, 2026, at 3:00 PM, with two staples (metal clips used to close wounds or lacerations) to the forehead area.The facility failed to implement the planned interventions as documented in the report. The clinical record revealed no documented evidence PT or OT completed a timely evaluation following the resident's return from the hospital.A review of a PT evaluation and plan of treatment dated May 6, 2026, revealed Resident 4 demonstrated decline in functional ambulation, mobility, dynamic balance, gait mechanics, and posture deficits, contributing to decreased gait safety and two falls within a two-week period. Documentation described a shuffled gait pattern and increasingly rounded kyphotic posture (an excessive forward curvature of the upper spine), which compromised mobility and overall conditioning.Further review revealed the resident's care plan was not revised to reflect the resident's decline in mobility or to include additional interventions to address increased fall risk and impaired ambulation.A nursing progress note dated May 9, 2026, at 1:50 PM, documented Resident 4 appeared weak, hunched over, and unable to maintain gait while ambulating. The resident was returned to bed to rest. Vital signs were stable and the resident was afebrile (without fever).Clinical record review revealed documentation dated May 10, 2026, at 9:50 PM, indicating the resident became weak while ambulating and was lowered to the floor by staff, sustaining a skin tear to the right hand.A review of facility investigative documentation completed by Employee 3, Licensed Practical Nurse (LPN), dated May 10, 2026, at 9:50 PM, revealed staff reported Resident 4 became too weak to continue ambulating and no wheelchair or additional staff assistance was immediately available. Resident 4 sustained a skin tear measuring 3 cm by 2 cm to the top of the right hand. Vital signs were within normal limits. The resident required assistance from two staff members to transfer from the floor into a wheelchair and was returned to bed. The physician was notified and PT/OT evaluation for ambulatory status was ordered.A review of the resident's fall care plan revised by the DON on May 11, 2026, revealed interventions included staff assistance with ambulation when visible and wheelchair follow when possible.A review of facility investigative documentation completed by the Assistant Director of Nursing (ADON) dated May 12, 2026, at 11:15 AM, revealed Resident 4 was observed by Employee 3, Speech Therapist (SLP), attempting to rise from a chair in the second-floor television lounge and subsequently fell, striking the right side of the head on the floor. Documentation indicated the resident was prescribed Eliquis (a prescription anticoagulant, also referred to as a blood thinner, used to prevent and treat blood clots and reduce the risk of stroke). Resident 4 sustained abrasions to the knees and right shoulder, along with a skin tear to the right knee measuring 1.5 cm by 1.5 cm. The physician was notified and ordered transfer to the ER (emergency room) for evaluation and treatment, including a computed tomography (CT) scan (a diagnostic imaging test used to identify injuries and medical conditions) of the head due to the fall with head strike.A witness statement completed by Employee 3 dated May 12, 2026, indicated the employee observed Resident 4 rise from a chair and fall, striking the right forehead area with audible impact.A review of the emergency department Discharge summary dated [DATE], at 3:23 PM, revealed diagnoses that included closed head injury (a type of traumatic brain injury in which damage occurs to the brain without penetration or fracture of the skull), abrasion of the right shoulder area, and right shoulder contusion (a bruise resulting from blunt force trauma).The facility failed to ensure adequate supervision and implement effective fall prevention interventions for Resident 4, a (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident identified as high risk for falls due to impaired cognition, poor safety awareness, and declining mobility. The facility further failed to timely revise and update the resident's care plan to reflect recurrent falls, declining ambulation status, and increased need for supervision and safety interventions. These failures resulted in repeated falls with injuries, including a closed head injury requiring emergency room evaluation and treatment.During an interview conducted on May 14, 2026, at 12:40 PM, the facility's Nursing Home Administrator (NHA) reviewed and confirmed the above findings related to the facility's failure to ensure Resident 4's safety through increased supervision and effective fall prevention interventions.28 Pa. Code S211.10(c) Resident care policies28 Pa. Code S201.18(b)(1) Management28 Pa. Code S211.12(d)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on select facility policy, clinical record review, and staff and resident interviews, it was determined the facility failed to monitor and manage hydration status in accordance with a physician ordered fluid restriction to ensure proper fluid balance for one of 17 residents reviewed (Resident 72).Findings include: A review of the facility policy titled Restricting Fluids, adopted on February 9, 2026, indicated that the facility is required to provide an appropriate amount of fluids to support an optimal level of health. The policy states that when a resident is placed on a fluid restriction (a specific daily limit on how much liquid a person can consume, including all drinks and high fluid foods such as soups, ice cream, gelatin, and ice), free water (available water at the bedside) is not to be provided unless specifically included in the resident's total daily fluid allowance. The policy required documentation of the resident's fluid intake and adherence to the prescribed allowance to determine whether the resident met the designated fluid limit. A review of the facility policy titled Measuring and Recording Intake of Food and Fluids, adopted on February 9, 2026, showed that the purpose of the procedure is to obtain an accurate record of the food and fluids consumed by the resident. The policy stated the amount of food and fluid taken during meals and between meals will be recorded in the electronic medical record (digital version of a patient's medical chart), and that all fluids will be documented in milliliters (mL). The policy requires that if a resident on a fluid restriction exceeds the prescribed allowance, the provider, registered dietitian, and resident representative will be notified. A clinical record review revealed resident 72 was admitted to the facility on [DATE] with a diagnosis of congestive heart failure (a condition where the heart is unable to pump blood effectively enough to meet the body's needs) and rash and other nonspecific skin eruption (generalized or localized rash with no definitive diagnosis). A review of Resident 72's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 1, 2026, revealed that Resident 72 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a range of 12-15 means normal thinking and memory, reflecting little to no cognitive impairment). Clinical record review revealed a physician's order dated April 24, 2026, for a 1500 mL daily fluid restriction, including 840 mL with meals, 220 mL on day shift, 220 mL on evening shift, and 220 mL during nursing care and medication administration. A nutritional risk care plan initiated on April 25, 2026, identified the resident required a fluid restriction related to fluid overload (a condition in which the body retains excess fluid, potentially causing swelling, respiratory symptoms, and worsening cardiac function). The care plan goal indicated Resident 72 would avoid significant weight changes associated with fluid retention and consume 75 percent or more of meals. Interventions included monitoring for signs and symptoms of excess fluid intake, including anxiety, behavioral changes, increased respiratory rate, shortness of breath, fatigue, cough, and congestion. During an interview conducted with Resident 72 on May 12, 2026, at 10:30 AM, the resident stated he was unaware of the physician ordered fluid restriction. Observation of the bedside area revealed a white Styrofoam cup containing water and a clear plastic bottle of orange soda accessible to the resident. Resident 72 stated he experienced thirst and consumed available liquids. A review of the nutrition evaluation completed by the clinical nutritionist on April 24, 2026, acknowledged the resident's 1500 mL fluid restriction; however, the clinical record failed to reveal evidence the resident's adherence to the prescribed fluid restriction was monitored or documented in accordance with facility policy. During an interview conducted on May 13, 2026, at 1:30 PM, the Assistant Director of Nursing (ADON) confirmed there was no documentation in the electronic medical record reflecting Resident 72's daily fluid intake from admission on [DATE], through the time of survey. The ADON acknowledged the facility failed to monitor and document the resident's fluid intake, hydration status, availability of fluids at bedside, (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and adherence to the prescribed fluid restriction in accordance with facility policy. The facility failed to ensure monitoring and documentation of fluid intake for Resident 72, a resident with a physician ordered fluid restriction related to congestive heart failure. The facility further failed to ensure staff implemented and monitored compliance with the ordered fluid restriction and failed to ensure the resident was aware of the prescribed fluid limitation. 28 Pa Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c) (d)(3)(5) Nursing services.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 clinical record review and staff interview, it was determined the attending physician failed to act upon pharmacist identified irregularities in the medication regimen for one resident out of five residents reviewed for unnecessary medications (Resident 3).Findings include:A review of the clinical record revealed Resident 3 was admitted to the facility on [DATE], with diagnoses that included anxiety disorder (a mental health condition characterized by excessive and persistent fear or worry that interferes with daily functioning and is difficult to control). A review of a consultant pharmacist report dated December 7, 2025, revealed Resident 3 was prescribed the following psychoactive medications:Lexapro 10 milligrams (mg) one tablet daily, an antidepressant classified as a selective serotonin reuptake inhibitor (SSRI) used to treat depression and anxiety disorders.Klonopin 0.5 mg one tablet daily, a benzodiazepine medication used to relieve symptoms of anxiety. The consultant pharmacist documented that Resident 3 required periodic review of psychoactive medications and consideration of a gradual dose reduction (GDR, the stepwise tapering of a medication dose to determine whether symptoms or conditions can be managed with a lower dose or whether the medication may be discontinued, in accordance with CMS requirements regarding unnecessary medications) if clinically appropriate. Review of Resident 3's clinical record failed to reveal documentation indicating the attending physician reviewed, acknowledged, or responded to the consultant pharmacist's recommendation. The clinical record additionally failed to reveal evidence that a gradual dose reduction was attempted or documentation supporting a clinical contraindication for why a gradual dose reduction could not be implemented. The facility failed to ensure the attending physician reviewed and addressed the consultant pharmacist's recommendation regarding psychoactive medication use and consideration of gradual dose reduction for Resident 3. As a result, the facility failed to ensure ongoing monitoring and evaluation of psychoactive medications to determine continued clinical necessity and compliance with requirements related to unnecessary medications. During an interview conducted on May 14, 2026, at 1:00 PM, the Nursing Home Administrator (NHA) confirmed the facility was unable to provide documentation showing the attending physician reviewed or acted upon the consultant pharmacist's recommendation. 28 Pa. Code 211.9 (k) Pharmacy services.28 Pa. Code 211.12 (c) Nursing services.28 Pa. Code 211.2 (d)(3) Medical Director.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on a review of select facility policies, observations, and staff interviews, it was determined the facility failed to implement and adhere to established procedures to ensure appropriate storage and compliance with use-by dates for multi-dose medications in one of two medication rooms (first-floor medication room)Findings include:A review of the facility policy titled Medication Labeling and Storage, adopted on February 9, 2026, indicated that medications and biologicals (treatments derived from living organisms or their products) are required to be stored in locked compartments under appropriate temperature, humidity, and light controls. The policy further stated that expired medications and/or biologicals are to be managed by contacting the dispensing pharmacy for return or destruction instructions. Additionally, the policy required that multi-dose vials be dated upon opening and discarded within 28 days unless otherwise specified. An observation of the first-floor medication room on May 13, 2026, at 10:24 AM, in the presence of Employee 1, Registered Nurse (RN), revealed the following expired or improperly stored medications available for resident use:One bottle of Geri-Lanta (an over-the-counter liquid antacid and antiflatulent medication) with an expiration date of August 2025.One opened multi-dose vial of Tuberculin Purified Protein Derivative (a diagnostic solution used for tuberculosis skin testing) with no date indicating when the vial was opened.Two bottles of All-Relief Naproxen Sodium (an over-the-counter nonsteroidal anti-inflammatory drug used for pain and fever reduction) with an expiration date of December 2025. During an interview conducted on May 13, 2026, at 10:30 AM, Employee 1 RN confirmed the identified medications were expired and that the Tuberculin vial was undated while stored in the medication room and available for resident use. During an interview on May 13, 2026, at 1:44 PM, the Nursing Home Administrator reviewed and acknowledged the findings, confirming the facility failed to adhere to established medication storage requirements, including proper dating, monitoring, and removal of expired medications and biologicals from use. 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services.