

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395469	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2025
NAME OF PROVIDER OR SUPPLIER Emerald Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 320 South Market Street Elizabethtown, PA 17022	

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observations as well as resident and staff interviews, it was determined that the facility failed to maintain a safe, comfortable, and home-like interior one of two nursing units (2nd floor). Findings include: The grievance log documented on May 4, 2025, environmental concerns pertaining to lack of cleanliness in the building and overflowing trash. Observation in Resident 8's room on July 14, 2025, at 2:25 PM: the trash can at the sink was overflowing; one package of wipes under Resident 8's bed and brown food crumbs on the floor around the bed; a white powdery film on the night stand (able to be wiped away with a paper towel); the baseboard to the right of the door had a dried brown substance; behind the door were 2 enabler bars, a dusty blue foam square cushion and a headboard from Resident 8's bed; and the windowsill contained a white film and dried watermarks around the plants. Resident 8 stated that her room has not been cleaned by housekeeping since July 10th, and nursing staff have not emptied the trash can at the sink. Observation with the Nursing Home Administrator on July 14, 2025, at 3:00 PM the environmental concerns remained as stated above, and the Nursing Home Administrator confirmed the room needed to be cleaned. At that time Resident 15, Resident 8's roommate, confirmed that housekeeping has not cleaned their room since July 10th. Observation in Resident 16's room on July 14th, 2025, at 2:57 PM. On the floor in front of her closet was a soiled pair of pants and a bag containing a soiled brief, crumbs of food on the floor near her bed, and seven dried red stain/marks on the privacy curtain; and in the bathroom the toilet contained a brown substance around the entire inside of the bowl and urine and wipes were inside the toilet, three light brown pieces of unknown substance were on the floor to the left side of the toilet. Resident 16 stated that her room is not cleaned daily. Observation and interview with the Nursing Home Administrator on July 14, 2025, at 3:21 PM the environmental concerns remained as stated above, and the Nursing Home Administrator confirmed the room needed to be cleaned. Observation in Resident 13's room on July 14, 2025, at 2:51PM food crumbs were on the floor around his bed and on the bilateral floor mats. The mats also contained a white film. Observation and interview with the Nursing Home Administrator on July 14, 2025, at 3:24 PM the environmental concerns remained as stated above, and the Nursing Home Administrator confirmed the room needed to be cleaned. Observation in Resident 14's room on July 14, 2025, at 2:51PM under the bed were torn tissues, three empty clear plastic cups, one black hanger, and a pink bin. On the floor in the bathroom was a used tissue, a urinal, tan crumbs, the baseboard contained a brown film, and the floor tiles were lifted to the left of the toilet; there was a strong urine odor. Observation and interview with the Nursing Home Administrator on July 14, 2025, at 3:24 PM the environmental concerns remained as stated above, and the Nursing Home Administrator confirmed the room needed to be cleaned. Observation on July 14, 2025, at 2:55 PM the floor inside and outside the chapel and down Sunshine Way contained black wheelchair marks, dried brownish grey patches, and light brown food crumbs. Observation and interview with the Nursing Home Administrator at 3:20 PM the floor remained as stated above, and the Nursing Home Administrator stated that she would find out if housekeeping had cleaned the area that day (it was later noted that the area was not cleaned and there was a call off in housekeeping). Observation on July 15, 2025, at 9:00AM in the chapel on the second floor the air conditioning wall unit to the left had 5 dried dark brown smudge marks on the control panel. Of the three units in that room none of them were operational (the ambient temperature in the room was comfortable). The middle window had a dead vine growing up through the window into the building from the outside of the building. Interview with the Nursing Home Administrator on July 15, 2025, at 10:00 AM it was revealed that a work order would be submitted. 28 Pa. Code 201.18 (b)(1)(3)(e)(2.1) Management</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards for two of 6 resident clinical records reviewed (Residents 2 and 6). Clinical record review of Resident 2 documented diagnoses that included: metabolic encephalopathy (a brain disorder caused by a chemical imbalance in the blood stemming from an underlying illness or organ dysfunction), diabetes mellitus (the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine), obesity, frequent falls, chronic obstructive pulmonary disease (a group of lung disease that block airflow and make it difficult to breathe), atrial fibrillation (irregular, often rapid heart rate that causes poor blood flow), dysphagia (difficulty swallowing), congestive heart failure (the heart can't pump enough blood to meet the body's need), and shortness of breath. Review of Resident 2's Medication Administration Record (MAR- documentation of administration of physician orders) pertaining to NovoLog Flex Pen Subcutaneous (under the skin) Solution Insulin aspart (a rapid acting insulin) Inject as per sliding scale: if 151 - 200 = 3 units; 201 - 250 = 5 units; 251 - 300 = 8 units; 301 - 350 = 10 units; 351 - 400 = 12unit and if &gt;400 give 15 units and notify MD, with meals related to diabetes mellitus, start date May 6, 2025. Vitals and MAR documented blood sugar was above 400 ml/dl on the following dates: 431 ml/dl on May 25th at 6:20 PM; and 446 ml/dl on May 30th at 5:15 PM. Further clinical record review documented 14 units of aspart insulin was administered on May 25th at 6:20 PM and the supervisor was made aware. There was no documentation aspart insulin was administered on May 30th or that the physician was notified. Progress notes failed to document that the physician was notified on the 25th or 30th. Interview with the Director of Nursing on July 15, 2025, at 3:15 PM revealed that physician orders should be followed. Review of Resident 6's clinical record documented diagnoses that included muscle weakness, abnormalities of gait, and right knee pain. Interview with Resident 6 on July 15, 2025, at 8:30 AM it was revealed she sustained a fall several weeks ago and sustained a brush burn on her left forearm near her elbow. She stated at the time of the fall the facility placed a bandaged over the area but never cleaned it. No one looked at the area for three days, so she requested to have the area cleaned and rebandaged. Observed a white bandaged date marked July 13, on 3-11 shift. Progress note dated July 3, 2025, at 1:43PM documented Resident 6 was participating in an outside activity when she fell to the ground and sustained a skin tear on the left lower arm. No documentation that the physician was notified, or treatment orders were obtained. Further review of Resident 6's clinical record failed to include physician orders for a treatment to Resident 6's left arm. During an interview with the Director of Nursing on July 15, 2025, at 3:15 PM it was revealed that the resident should have a standard order for the aforementioned dressing and treatment. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.12(d)(1) Nursing services</p>		

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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. (continued on next page)

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on clinical record review, observations, and staff interviews it was determined that the facility failed to maintain adequate personal hygiene and grooming of residents' dependent on staff for assistance with incontinence care for two of 15 resident s reviewed (Residents 12, and 16).Review of resident council meeting minutes documented:June 19, 2025, call bells are taking over an hour to be answered, staff turning off call bells without helping the resident or stating they'll be back and never return, Nursing Assistants sitting at the nursing desk on their phone on 2nd and 3rd shift, ear buds in during care. The expectation was for call bells to be answered in 10-20 minutes.May 15, 2025, call bells are not being answered or are being turned off without resident's needs being met (mainly 3rd shift), and ear buds are worn during care. Discussed calling down to the receptionist if call bells are being ignored and to Nursing Home Administrator over the weekend and calling the Director of Nursing or the Nursing Home Administrator in real time to report Nursing Assistants.April 17, 2025, residents are waiting hours in soiled clothing and bedding before call bells are answered, 3rd shift not doing their job causing 1st and 2nd shift to fall behind. Interviews with multiple Residents on July 15, 2025, between 2:00 and 3:00 PM it was revealed extended call bell wait times for incontinence care. Resident 4 stated there were times she has waited over 20 minutes for the call bell and eventually she has taken herself to the restroom, however she has difficulty backing her wheelchair out of the restroom. Resident 8 stated she has waited two hours for her call bell to be answered. It was also revealed that she is a heavy sleeper and if they don't wake her on night shift she remains in a soiled brief for hours. She prefers to get out of bed into her wheelchair for an hour or two each day however she is hesitant to do so because she is left in her chair well into the next shift. Resident 15 revealed staff turn off call bell and don't respond to the resident needs. Observations on July 15, 2025, at 2:50 PM at the second-floor nursing station there were two Nurses and three Nursing Assistants; two of the Nursing Assistants were utilizing their personal cell phones. The two Nurses and the other Nursing Assistant were utilizing facility computers. Review of Resident 12's clinical record documented diagnoses that included urge incontinence, and dementia (a condition characterized by progressive loss of intellectual functioning, impairment of memory and abstract thinking). Further review of the clinical record documented a care plan intervention for a toileting program: bladder retraining; toilet upon rising, before bed, after each meal, & as needed based on resident's needs, initiated April 8, 2025. Observation of Resident 12's room on July 14th at 2:19 PM the call bell was on, and both residents were sleeping. The call bell was off at 2:57 PM and interview with Resident 12 revealed the staff must have come and turned the call bell off and it was revealed that she needed to use the restroom. The call bell was turned back on at 3:00 PM and staff provided assistance at 3:22 PM. Review of Resident 16's clinical record documented diagnoses that included displaced fracture right lower leg, anxiety, abnormalities of gait, history of falling. Further review of the clinical record documented a care plan focus area for urinary incontinence related to impaired mobility, initiated June 24, 2025; interventions included provide assistance with toileting or provide incontinent care as needed, initiated June 24, 2025. Observation of Resident 16's room on July 14th, 2025, at 2:42PM the call bell was on and resident 16 was sitting in her wheelchair with her back to the door. The call bell was off at 2:57 PM. Interview with Resident 16 at 2:57 PM revealed that staff came in and turned the call bell off and didn't assist her with incontinence care. The Resident stated her brief was soiled and required assistance to lay down in bed. It was also revealed that if she soils her brief over night she has to wait until morning for her brief to be changed, and she prefers to be woken up for her brief to be changed. The night prior, she was left in a soiled brief for three hours. Observation with the Nursing Home Administrator on July 14, 2025, at 3:20 PM at the second-floor nursing station there were two Nurses and three Nursing Assistants; two of the Nursing Assistants were utilizing their personal cell phones. The two Nurses and the other Nursing Assistant were utilizing facility computers. During an interview with the Nursing Home Administrator on July 14, 2025, at 3:30 PM it was revealed the expectation is for call bells to be answered within 10 to 20 minutes and incontinence care should be provided timely. 28 Pa code 211.12.(d)(1)(5) Nursing services</p>		