

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 03/27/2026
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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Based on observation and staff interview, it was determined that the facility failed to ensure residents were provided with a clean and homelike environment for one of three bathrooms observed (Resident 2's bathroom). Findings: An observation was conducted in Resident 2's bathroom on March 27, 2026, at 12:10 p.m., in the presence of licensed nurse Employee E3. The observations revealed the following: dried brown substances in front of the toilet bowl; brown substances in the toilet bowl; two used towels in the sink; one used drawsheet, a used gown, and a wet washcloth with brown stains on the bathroom floor; and a garbage can overflowed with used incontinent briefs. An interview with Employee E3 was conducted on March 27, 2026, at 12:15 p.m. Employee E3 confirmed that the resident's bathroom smelled of urine. The above findings were conveyed to the Nursing Home Administrator on March 27, 2026, at 3:00 p.m. The facility failed to ensure Resident 2's bathroom was maintained clean. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management</p>

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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident?s preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, and staff interviews, it was determined that the facility failed to ensure physician's orders were followed for one three of five residents reviewed resulting in actual harm to one, resident Resident1. (Resident 1, 2, and 3).Findings include:</p> <p>Review of Resident 1's quarterly Minimum Data Set (MDS) assessment (mandated assessment of a resident's abilities and care needs) dated November 27, 2025, revealed the resident was cognitively intact; dependent on staff for daily care needs, and had a diagnosis of Chronic diastolic (congestive) Heart Failure (CHF-progressive condition where the heart cannot pump blood effectively, causing blood to back up and fluid to accumulate in the lungs and body).</p> <p>Review of Resident 1's physician's orders revealed an order dated November 22, 2025, for Torsemide (medication used to treat high blood pressure and fluid retention caused by congestive heart failure) 120 mg (milligrams) by mouth twice a day for CHF (congestive heart failure).</p> <p>Further review of Resident 1's physician's orders, revealed an order dated January 23, 2026, to obtain weight one time a day every Monday, Wednesday, and Friday for congestive heart failure. Weigh every Mon, Wed, Fri. Notify provider weight gain > (greater than) 2 pounds overnight or 5 pounds in one week. Notify daughter of any weight refusals.</p> <p>Review of Resident 1's nursing progress note dated February 6, 2026, (12:07 p.m.) revealed: NP (nurse practitioner) notified of patient abdominal discomfort order to give Zofran 4mg 1 tab (tablet) PO (by mouth) Q (every) 6 hours prn (as needed) nausea. Resident informed of order but requested to go to hospital for evaluation and treatment NP notified gave order to go to hospital for evaluation and treatment. 911 called at 12 noon, EMS (emergency management services) arrived at 1212 pm with stretcher to take resident to hospital for treatment.</p> <p>Review of Resident 1's nursing progress note dated February 6, 2026, (2:11 p.m.) revealed, Resident c/o (complains of) pain and discomfort in the stomach. Resident c/o that (he/she) felt nausea and 'needed to go to the hospital.' RN (Registered Nurse) supervisor immediately notified of the situation. Resident's vital signs stable BP (blood pressure): 106/64, O2 (oxygen level): 96%, HR (heart rate):70, R (respirations):18, T (temperature): 97.6. Resident transported to hospital, POA (Power of Attorney) notified by RN supervisor. Resident's afternoon insulin held before going to hospital.</p> <p>Review of Resident 1's hospital provider notes, dated February 6, 2026, revealed Resident 1 had a previous admission in November of 2025 for similar presentation. Required Lasix drip and discharged on increased torsemide dose of 120 mg twice daily.</p> <p>Review of Resident 1's hospital discharge records dated February 18, 2026, revealed Resident 1 was ordered to continue oral torsemide 120 mg twice a day.</p> <p>Review of Resident 1's February 2026 MAR (Medication Administration Record) revealed an order dated February 19, 2026, for Torsemide Oral Tablet 20 mg; give 20 mg by mouth two times a day for CHF.</p> <p>Review of Resident 1's Cardiology follow up appointment consult report dated February 26, 2026 reveal a hand written note from the Nurse Practitioner indicating: needs BMP (Basic Metabolic Panel (continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>is a test measuring key substances in the blood that assess metabolism, fluid balance, and kidney function) weekly, should be on 120 mg of torsemide but since (he/she) has only been getting 20 twice a day (BID). increase to 60 mg BID. Please weigh them daily.</p> <p>Review Resident 1's March TAR (Treatment Administration Record) revealed the following documented weights: February 27, 2026: 191 pounds and March 2, 2026: 187 pounds. Further review of the TAR revealed no other weights recorded from February 26, 2026, through March 4, 2026.</p> <p>Review of Resident 1's dietary progress note, dated March 4, 2026, at 12:53 p.m., revealed a weight warning, current weight reflects a 7.8% weight change x 90 days. Provider is aware and increased torsemide per progress notes.will make nursing aware of weight changes and add Juven BID (twice daily) to promote nutrition and healing.</p> <p>Further review of Resident 1's nursing progress notes dated March 5, 2026, at 1:39 p.m. revealed Resident 1 refused to attend an appointment outside the facility for an IV diuresis (procedure to treat severe edema or swelling caused by excess fluid accumulation). The provider was notified and an order was received for STAT (as soon as possible) BMP and MAG (test to measure magnesium levels in the blood).</p> <p>Further review of Resident 1's nursing progress notes dated March 6, 2026, at 11:21 a.m. revealed: per DON (director of nursing) resp. (respiratory) assessment completed. Lungs sta [sic] bilaterally pulse ox (test to determine how much oxygen in the blood) 97% pulse 70 no respiratory distress pulse 20 edema noted plus 2 (moderate swelling where pressure leaves a dimple in the skin that rebounds within 15 seconds).</p> <p>Review of Resident 1's nursing progress notes dated March 6, 2026 at 11:21 a.m. revealed the facility received the following abnormal blood test results from the BMP: Glucose 318 (normal range = 65-140), BUN 43 (normal range = 8-23), CR 0.55, (normal range = 0.60 &ndash; 1.10) CAL 8.1 (normal range = 8.6 &ndash; 10.3), MAG 1.7 (normal range = 1.8 &ndash; 2.7). Further review of Resident 1's progress note revealed the provider was notified and ordered nursing to encourage fluids due to dehydration and to increase torsemide to 80 mg twice a day with blood pressures every shift for three days. This order was entered on March 7, 2026, and review of Resident 1's March 2026 MAR revealed the resident received the ordered doses on March 7, 2026, and March 8, 2026 and Resident 1 attended an outside appointment for IV diuresis on March 9, 2026 but did not receive the third dose of torsemide due to being out of the facility at the appointment.</p> <p>Review of Resident 1's cardiac provider visit records dated March 9, 2026, revealed Resident 1 was to increase torsemide to 80 mg twice a day, obtain a BMP and Magnesium blood test, and weigh every morning before breakfast. Call your doctor or nurse practitioner for weight gain greater than 2 pounds overnight or 5 pounds in one week and/or worsening shortness of breath, and/or worsening swelling in the legs or belly.</p> <p>Review of Resident 1's weights revealed on March 11, 2026, a weight of 194.4 pounds, on March 13, 2026, a weight of 193 pounds, and March 16, 2026, a weight of 194.4 pounds.</p> <p>Review of Resident 1's progress notes revealed a dietary note dated March 16, 2026, (6:31 a.m.) for an additional weight warning of a 5% gain. Weekly weight taken M/W/F related to CHF.fluid retention likely the cause of these shifts. Will continue to monitor and make nursing aware and follow up as nutritionally indicated.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of Resident 1's progress notes revealed a nursing entry dated March 17, 2026 (10:26 p.m.) Staff reported weeping edema (severe form of swelling where fluid seeps through the skin) from b/l (bilateral) LEs (lower extremities). Resident denies pain or discomfort, noted in Dr.'s communication book.</p> <p>Further review of Resident 1's nursing progress notes dated March 18, 2026, at 11:17 a.m. revealed: Resident reassessed after previous shift reported fluid overload symptoms. Report received that the resident's bilateral lower extremities are weeping, and that the resident has had a 5 point increase in weight gain. Head to toe assessment done: .3 + pitting edema (moderate to severe swelling where pressure leaves a dimple that remains for up to 60 seconds after pressure is released) noted on bilateral lower extremities. Upper extremities have multiple discoloration, with an open area around the right forearm. Vital signs are unremarkable: 98%, and 97.0 degrees Fahrenheit. The provider was notified - see new orders.</p> <p>Further review of nursing progress notes dated March 18, 2026, (12:08 p.m.) revealed Provider was contacted by another staff member and orders were for BLE (bilateral lower extremity) US (ultrasound) and blood work (not specified) in the am (morning).</p> <p>Further review of nursing progress notes dated March 18, 2026, (2:37 p.m.) revealed: Spoke with resident's POA (power of attorney), regarding US that is ordered. POA is OK with resident not having US done. POA also stated that resident's cardiology's office was called by family and updated.</p> <p>Further review of nursing progress notes dated March 18, 2026, 3:03 p.m. revealed: Spoke with family, who spoke with the heart group. The provider would like to see resident tomorrow, POA made appt (appointment) for 1345 (1:45 p.m.) tomorrow.</p> <p>Further review of Resident 1's nursing progress dated March 19, 2026, 2:52 p.m. revealed: Received cardiology office that resident is being sent to ED (Emergency Department) secondary to fluid volume overload.</p> <p>Review of hospital admission records dated March 20, 2026, revealed Resident 1 was admitted to the hospital for monitoring and treatment with a diagnosis of acute on chronic CHF.</p> <p>These findings were shared with the Nursing Home Administrator and Director of Nursing at approximately 4:00 p.m. on March 24, 2026.</p> <p>The facility failed to implement medication orders and failed to monitor resident's weight as ordered resulting in increased symptoms of Resident 1's CHF including edema and weight gain resulting in actual harm when Resident 1 was admitted to the hospital on [DATE], for treatment.</p> <p>Review of Resident 2's physician order dated March 17, 2026, revealed an order for Oxycodone HCL 5 mg (An opioid pain-relief medicine used to relieve moderate to severe pain). Give one tablet by mouth every eight hours for three days. The start date was March 17, 2026, at 2:00 p.m.</p> <p>Review of Resident 2's March 2026 Medication Administration Record (MAR) revealed the medication was not administered to the resident on the following dates and times: March 19, 2026, at 6:00 a.m., March 19, 2026, at 2:00 p.m., and March 20, 2026, at 6:00 a.m.</p> <p>Review of Resident 2's nursing progress notes dated March 19, 2026, at 2:00 p.m., revealed: (continued on next page)</p>		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	<p>medication held due to resident being hard to arouse, pulse ox (Spo2-blood oxygen saturation-normal range 95%-100%) 86% pulse 68, resp (respirations)18, b/p (blood pressure) 104/64, supervisor aware.</p> <p>Further review of Resident 2's clinical record revealed no documentation indicating a reason Resident 2's ordered Oxycodone was not administered on March 19, 2026, at 6:00 a.m., and March 20, 2026, at 6:00 a.m.</p> <p>Review of Resident 2's clinical record revealed no documented evidence the physician was notified of Resident 2's change in condition (low SpO2 and difficulty to arouse/awaken) on March 19, 2026, at 2:00 p.m., and not notified of the Oxycodone not being administered on the dates mentioned above.</p> <p>Interview with the Director of Nursing (DON), conducted on March 27, 2026, at 3:00 p.m. revealed Resident 2 missed the Oxycodone ordered three times, and the physician was not notified of the resident's change in condition or the missed medications.</p> <p>Review of Resident 2's wound consult dated March 18, 2026, revealed the following: left lower leg cellulitis (deep infection of the skin caused by bacteria), present on admission, measuring 15 x 17 x .10 cm., full thickness with 70% eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like), and serosanguinous (type of wound drainage that is a combination of blood and serum) drainage. The treatment order was to cleanse the left lower leg with soap and water, pat dry, apply Betadine (antiseptic solution used to treat minor cuts, scrapes, and burns by killing bacteria) twice daily, then leave wound open to air. Right lower leg cellulitis is present on admission, measuring 15 x 38 x 0.1 cm (centimeter), full thickness, with 90% eschar, moderate serosanguinous. The treatment order was to cleanse the right lower leg with Acetic Acid 1% (A colorless, organic liquid with a pungent, vinegar-like smell), apply Xeroform (sterile, non-adherent, petrolatum-based mesh dressing impregnated with 3% bismuth tribromo phenate used to cover wounds and promote healing), bordered dressing every other day, and as needed.</p> <p>Review of Resident 2's physician orders revealed there was no order for wound care to the right leg of Acetic Acid and Xeroform. Further review of the physician orders revealed an order for Betadine for the left leg wound dated March 18, 2026.</p> <p>Review of Resident 2's March 2026 Treatment Administration Record (TAR) revealed the ordered wound treatment of Betadine to the left leg was not transcribed on the March TAR.</p> <p>Review of Resident 2's physician order dated March 20, 2026, revealed an order to cleanse the bilateral lower extremity open areas with normal saline solution, apply Hydrogel (water based wound care treatment) to the open wounds with swab, cover with bordered foam (absorbent foam dressing with adhesive border), and wrap with kerlix (gauze) and Tubi grips (compression bandage) every other day and as needed.</p> <p>Review of Resident 2's March 2026 TAR revealed the above ordered Hydrogel treatment was not completed as ordered for the resident's bilateral legs from March 20, 2026, until March 26, 2026 when there was a new order for wound care that was completed as ordered. The order of March 20, 2026 was not transcribed into the resident's TAR.</p> <p>Review of Resident 2's nursing progress notes dated March 20, 2026, and March 23, 2026, revealed Resident 2 was taking off the leg dressing. Neither progress note indicated what treatment/dressing was administered as a replacement to the resident's legs or what the dressing was that Resident 2 (continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>was removing.</p> <p>During an interview with the Director of Nursing on March 27, 2026, at 3:00 p.m. revealed the DON could not provide an explanation why Resident 2's wound order was not followed as ordered or what treatments were placed when Resident 2 removed the dressing on March 20, 2026 and March 23, 2026.</p> <p>Interview with the corporate nurse Employee E4 conducted on March 27, 2026, at 4:00 p.m., revealed the facility's EMR (electronic medical record) system had some changes with transcribing the order into the resident's TAR, which caused issue.</p> <p>Review of Resident 3's history and physical dated December 19, 2025, revealed the resident had a lower left leg wound with hematomas (bruise), which required surgical intervention of incision and drainage. The resident was also diagnosed with Cellulitis and Lymphedema (chronic condition that causes swelling in the body's tissue).</p> <p>Review of Resident 3's wound physician consult dated December 24, 2025, revealed the resident had an unstageable wound (obscured full-thickness skin and tissue loss) to the left calf that measures 4.3 x 4.8 x 0.2 cm with 11 o'clock 1.1 cm. tunneling (deep wound that develops narrow, channel-like pathways beneath the skin surface), with moderate serosanguinous drainage. The treatment order was to cleanse the wound with normal saline, apply Wound Vac (NPTW-Negative Pressure Wound Therapy- therapeutic technique using a vacuum dressing system to promote healing in acute or chronic wounds) at 125 mmHg (millimeters of mercury) continuous three times per week and as needed.</p> <p>Review of Resident 3's nursing progress notes dated December 30, 2026, 2:36 p.m., revealed resident came back from a wound center appointment with an order to discontinue the wound vac.</p> <p>Review of Resident 3's physician order dated January 2, 2026, revealed a new wound treatment order to cleanse left lower leg with soap and water, apply Prisma (sterile wound dressing composed of collagen, oxidized regenerated cellulose and silver) and Calcium alginate (biodegradable wound treatment derived from brown seaweed) every Tuesday and Friday then apply Profore (multi-layer compression bandage)from toes to knees.</p> <p>Review of Resident 3's weekly skin assessment dated [DATE], and January 7, 2026, revealed: Skin intact- No. However, further review of the same skin assessments failed to reveal an assessment was completed on resident 3's left calf wound.</p> <p>Review of Resident 3's clinical record failed to reveal documentation of a weekly skin assessment on the resident's left calf wound was done on January 14 and January 21, 2026.</p> <p>Interview with the Director of Nursing on March 27, 2026, confirmed Resident 3's left calf wound was not assessed from December 31, 2025, until January 21, 2026.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		