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 05/01/2026
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)
F 0690 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and procedure, clinical record review, and staff interviews, it was determined the facility failed to provide adequate urinary catheter care for four of six residents reviewed (Residents 6, 8, 28, and 47) resulting in actual harm for three of six residents who contracted urinary tract infections requiring subsequent hospitalizations (Resident 6, 28 and 47).Findings include: Review of the facility's policy, Catheter Care, Urinary (revised September 2014), revealed documentation of catheter care should be documented in the resident's medical record. This documentation should include the date and time catheter care was given, the name of the staff providing the catheter care, and all assessment data obtained during catheter care. Review of Resident 6's Physician Orders revealed the resident was admitted to the facility on [DATE], with a suprapubic catheter (tube inserted through a small abdominal incision directly into the bladder to drain urine when the urethra is blocked or unusable). Review of Resident 6's clinical progress notes revealed a general note dated October 31, 2025 (12:40 a.m.) indicating Resident c/o (complained of) rib pain and requested to be sent out he said he believes he has an infection.notified supervisor, supervisor came down and assess and said we will continue to monitor in an hour. Further review of Resident 6's progress notes revealed a nursing note dated October 31, 2025, at 12:57 a.m. indicating assessed resident and spoke with him about pain in the ribs and wanting to be sent out to the hospital. His vitals are stable; LPN gave him tramadol for his pain. Explained I could not send him out just because he wanted to go to the hospital, I need a legitimate reason to ask a doctor to send him out, right now there is no reason. I told him give it time for his pain medicine to take effect and would revisit the situation in an hour. Further review of Resident 6's progress notes revealed a general note dated November 1, 2025, at 12:59 p.m. indicating order received from on call to transfer to [local ER] for eval (evaluation) relating to supra pubic cath(catheter) serosanguinous (pink-to-light-red watery fluid) drainage and emesis (vomiting). Review of Resident 6's hospital documentation dated November 1, 2025, revealed patient presented with low suprapubic output, blood tinged leakage and pus around SPT (suprapubic tube), and pus/gross hematuria (blood and urine) within the tubing as well. He had suprapubic abdominal pain and vomiting.urology consulted and exchanged the SPB in ED (emergency department). Resident 6 was admitted to the hospital with a diagnosis of Sepsis (life-threatening medical emergency caused by the body's extreme, dysfunctional response to an infection, leading to potential tissue damage, organ failure, and death) secondary to CAUTI (catheter associated urinary tract infection). Review of Resident 6's physician orders since admission failed to reveal an order for catheter care. Review of Resident 6's task administration record failed to reveal documentation of catheter care being completed since admission of April 2025. The facility failed to provided catheter care to Resident 6's suprapubic catheter increasing his risk for urinary tract infection causing actual harm when Resident 6 was admitted to the hospital on [DATE], due to sepsis secondary to CAUTI. Interview with the Nursing Home Administrator and the Director of Nursing on May 1, 2026, at 11:30 a.m. confirmed there was no order or documented evidence Resident 6 received catheter care per policy for the suprapubic catheter since admission. Review of Resident 28's Census revealed an (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

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 05/01/2026
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F 0690 Level of Harm - Actual harm Residents Affected - Some	admission to the facility on September 28, 2025. Review of Resident 28's admission summary dated [DATE], at 3:34 a.m. stated Resident 28 currently utilizing an indwelling catheter continent of bladder secondary to catheterization (a flexible tube inserted into the bladder to drain urine, typically used for retention, post-surgery, or monitoring output). Further review of Resident 28's clinical record revealed progress note dated October 30, 2025, at 8:15 a.m. indicating, Resident yelling in pain, stated that ?nurses are not flushing' his catheter and that this has caused a lot of pain in his bladder Tylenol given .(RN and LPN) irrigated (pushed sterile water) catheter. Further review of Resident 28's clinical progress notes revealed a nursing note dated October 30, 2025, at 11:00 a.m. revealed, Resident continues with pain after Tylenol was given penis cleaned Foley (catheter)was removed and writer observed pus (yellow fluid) in and around catheter .the physician was notified. Review of Resident 28's physician's orders revealed an order dated October 30, 2025, for urinalysis (non-invasive diagnostic test used to detect urinary tract infections [UTIs]) and to administer ciprofloxacin (antibiotic) 250 mg (milligrams) to be administered two times per day for possible urinary tract infection. Further review of Resident 28's clinical progress notes dated October 30, 2025, at 7:13 p.m. indicated this writer successfully inserted an indwelling catheter. Further review of Resident 28's progress notes revealed a nursing note dated October 31, 2025, at 4:03 p.m. indicating, (physician) made aware of positive (has a UTI) UA (urinalysis) results. Further review of Resident 28's progress notes revealed nursing note dated November 13, 2025, at 4:44 a.m., indicating, Resident 28 heard curing (crying) in pain coming from residents' room Resident 28 had labored breathing and Foley catheter had sediment almost totally occluding (blocking) it and Foley insertion site had yellow pus around it .order from doctor given to send to emergency room for evaluation and treatment related to pain at bladder/insertion site. Further review of Resident 28's progress notes revealed nursing note dated November 13, 2025 at 3:16 p.m. ICU (Intensive Care Unit) nurse has indicated he is being admitted for sepsis (life-threatening medical emergency caused by the body's extreme, dysfunctional response to an infection, leading to tissue damage, organ failure, and potential death). Review of Resident 28's progress notes revealed nursing note dated November 17, 2025, at 3:34 p.m. indicating Resident 28 returned from hospital, new medication orders placed. Review of Resident 28's progress notes revealed nursing note dated December 2, 2025, at 3:33 p.m. indicating Doctor made aware of yellowish discharge around Foley insertion site, urinalysis, culture and sensitivity (test to determine the type of bacteria present and what antibiotics it is suspectable to) and PO (oral) antibiotics ordered. Further review of Resident 28's progress notes revealed nursing note dated December 5, 2025, at 11:53 a.m. indicating, patient was sent out to hospital via ambulance .was assessed this morning related to pain in his penis area .presented with redness around the tip of penis with extreme amount of yellowish drainage .pain was rated 10/10 (extreme) .resident. Further review of Resident 28's progress notes revealed nursing note dated December 23, 2025, at 11:50 a.m. indicating, Resident 28 complained of 10 out of 10 pain at the insertion site scrotum (an external sac of skin between the legs and behind the penis) was red and swollen .provider was notified and gave order to send to ER (Emergency Room). Further review of Resident 28's progress notes revealed a nursing progress note dated December 27 at 11:08 a.m. indicating writer notified MD of readmission. Further review of Resident 28's progress notes revealed nursing progress note dated January 29, 2026, at 6:31 a.m. indicating, Resident 28 had 500 cc (cubic centimeters) of hematuria (blood in urine) in Foley. Further review of Resident 28's progress notes revealed a nursing progress note dated January 29, 2026 (12:55 p.m.) indicating MD gave order for culture and sensitivity. Further review of Resident 28's progress notes revealed a nursing progress note dated February 1, 2026, at 2:42 p.m., stating Resident has Klebsiella (bacteria) in urine culture greater than 100,000, order to give Cipro (antibiotic) 500mg PO twice a day for seven days. Additional review of Resident 28's progress notes revealed nursing progress note dated March 30, 2026 (9:33 p.m.) indicating Resident 28 noted to have cola-colored urine attempted to notify MD. Further review of Resident 28's progress notes revealed a nursing progress note dated March 31, 2026 (3:22 p.m.) indicating spoke with (MD) new order for Cipro (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Some	250mg BID (twice a day) times 7 days. Further review of Resident 28's progress notes revealed a nursing progress note dated April 8, 2026, at 9:48 p.m. indicating, resident complained of pain from his Foley this nurse cleaned the head of the penis and the tubing from catheter as there was crusty drainage on them. Review of Resident 28's physician orders revealed an order dated April 10, 2026, for Bactrim (antibiotic) 800-160mg (milligrams) to be administered twice a day for seven days. Further review of Resident 28's progress notes revealed an alert progress note dated April 11, 2026 at 7:50 a.m., indicating, approximately 2:17 a.m. resident went to hospital due to his genital area being inflamed and swollen, foley was being coming dislodged, tried replacing it and it would not go in .resident sent out to (local hospital) per provider orders. Further review of Resident 28's progress notes revealed a nursing progress note dated April 11, 2026, at 9:41a.m. indicating Resident returned from (local emergency room) status post (after) Foley reinsertion at 8:24 a.m. Review of Resident 28's physician orders since admission on [DATE], failed to reveal an order for catheter care. Review of the Resident 28's task administration record failed to reveal documentation of catheter care being completed since admission. Interview with the Nursing Home Administrator on April 23, 2026, at 12:14 p.m. confirmed the clinical record did not contain documented evidence of catheter care for Resident 28 since admission to the facility. The facility failed to provide catheter care to Resident 28 resulting in multiple urinary tract infections as well as hospitalization for urinary tract infections resulting in actual harm to Resident 28. Review of Resident 47's Physician Orders revealed the resident was admitted to the facility on [DATE]. Further review of Resdient 47's Physician Orders revealed an order dated August 9, 2025 for a foley catheter. Review of Resident 47's progress notes revealed a general note dated November 26, 2025 at 4:53 a.m. indicating, resident with c/o (complaints of) discomfort and pain in abd (abdomen) and penis, requested a PRN (as needed) foley flush with saline (push sterile water into the tube). Upon attempting to flush the resident Foley, a blockage/resistance was found. The supervisor then advised me to follow the residents order & change the Foley catheter completely. After completing a Foley catheter change, the resident is still unable to void (urinate). Bladder scan (noninvasive, painless ultrasound procedure used to measure the volume of urine in the bladder and determine if it is emptying completely) 1211 cc (cubic centimeters) found. ABD hard and distended (visibly swollen, firm, or stretched belly caused by internal pressure). MD aware awaiting instructions. Further review of Resident 47's progress notes revealed general note dated November 26, 2025 (5:15 a.m.) indicating Residents MD/on call physician requested for resident to be sent to hospital. Review of Resident 47's hospital discharge record dated December 1, 2025, revealed the resident was admitted to ICU (intensive care unit) with a diagnosis of septic shock from ESBL (antibiotic resistant infection) Klebsiella (bacteria that causes UTIs) and E.coli (bacteria) bacteremia from complicated UTI/cauti present on admission. Review of Resident 47's physician orders since admission failed to reveal an order for catheter care. Review of Resident 47's task administration record failed to reveal documentation of catheter care completed since admission. The facility failed to provided catheter care to Resident 47's Foley catheter increasing his risk for urinary tract infection causing actual harm when Resident 47 was admitted to the hospital on [DATE], due to septic shock from ESBL (antibiotic resistant infection) Klebsiella (bacteria that causes UTIs) and E.coli (bacteria) bacteremia from complicated UTI/cauti present on admission. Interview with the Nursing Home Administrator and the Director of Nursing on May 1, 2026, at 11:30 a.m. confirmed there was no order or documented evidence Resident 47 received catheter care for the Foley catheter since admission, as facility policy indicates. Review of Resident 8's progress notes revealed admission Summary Notes dated March 4, 2026, at 6:37 p.m. indicating continent of bladder secondary to catheterization. Review of Resident 8's physician orders revealed an order dated March 5, 2026, for a Foley catheter. Review of Resident 8's physician orders since admission failed to reveal an order for catheter care. Review of Resident 8's task administration record failed to reveal documentation of catheter care completed from March 4, 2026, when the resident returned from the hospital until it was discontinued on April 20, 2026. Interview with the Nursing Home Administrator and Director of Nursing on May 1, (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Some	2026, at 11:30 a.m. confirmed there was no order or documented evidence Resident 8 received catheter care as directed by facility policy. 28 Pa. Code 211.12(c)(d)(1)(5) Nursing Services Previously cited 4/19/2024, 5/30/2024, 5/22/2025, 7/16/2025, 8/4/2025, 12/22/2025, 2/4/2026, 3/27/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based upon observation and interview, it was determined that the facility failed to ensure appropriate sanitization monitoring and documentation was completed for daily dishwasher sanitization for one of one dishwasher observed.Findings include:Observation of the facility dishwashing machine located in the kitchen on April 20, 2026, at 10:00 a.m. revealed the dishwashing machine to be running.Interview with Employee E6 on April 20, 2026, at 10:00 a.m. revealed the dishwasher water temperature to be 125 degrees.Review of the dishwasher log on April 20, 2026, at 10:00 a.m. revealed the log to be completed.Observation during a second visit to the kitchen on April 22, 2026, at 10:15 a.m. revealed the dishwasher to be running.Interview with Employee E6 on April 22, 2026, at 10:15 a.m. revealed that no test strips were immediately available to test the sanitization of the water coming out of the dishwasher.Upon locating test strips, the water was tested and revealed to be greater than 100 PPM (parts per million).Review of the dishwasher sanitization log on April 22, 2026, at 10:15 a.m. revealed that the sanitization was tested during the cleaning of breakfast dishes.Interview with Employee E6 on April 22, 2026, at 10:15 a.m. revealed Employee E6 had completed the log for the breakfast dishes.Observation of the dishwasher sanitization log revealed that the entire day was completed on April 22, 2026, at 10:15 a.m.Interview with Food Service Director Employee E7 confirmed that employees are to test the sanitization of the dishwasher during each meal and to complete the log after the completion of the testing of the sanitization of the water.This interview further confirmed that the log was inappropriately completed ahead of the meals on April 22, 2026, and therefore no adequate sanitization was tested during each meal. 28 Pa. Code 211.6(f) Dietary ServicesPreviously cited 5/22/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of clinical records and interview with staff, it was determined that the facility failed to notify the office of the state long term care ombudsman of emergency transfers for four of eight residents reviewed (Residents 2, 5, 8, and 9). Findings include: Review of Resident 2's progress note of January 7, 2026, revealed that the resident was seen by the wound nurse practitioner (NP) and was noted to have a painful, red lump to the incision line. NP recommended to reach out to wound center and or surgeon. An additional note on January 7, 2026, revealed that a representative from the surgical group suggested that the resident be sent to the emergency department. Resident was admitted for left above the knee amputation cellulitis (bacterial infection of the deep skin layers). Review of facility documentation failed to reveal evidence that the State Ombudsman's office was notified of Resident 2's transfer and admission to the hospital. Review of Resident 5's progress note of January 9, 2026, revealed that 911 was activated to take Resident 5 to the hospital for treatment and evaluation of crushing chest pain. An additional note on January 11, 2026, revealed that Resident 5 was admitted to the hospital for congestive heart failure exacerbation. Review of facility documentation failed to reveal evidence that the State Ombudsman's office was notified of Resident 5's transfer and admission to the hospital. Review of Resident 8's progress note of February 16, 2026, revealed that Resident 8 was admitted to the hospital with a diagnosis of osteomyelitis. Review of facility documentation failed to reveal evidence that the State Ombudsman's office was notified of Resident 8's transfer and admission to the hospital. Review of Resident 9's progress note of December 27, 2025, revealed that the resident was experiencing respiratory distress, hypoxia (low oxygen levels), productive cough, and was using abdominal muscles to breath. Resident appeared cyanotic (bluish or purplish discoloration of the skin, lips, or mucous membranes caused by low oxygen saturation in the blood. Resident was transferred to the hospital. Progress note of December 29, 2026, revealed that the resident was admitted to the hospital for respiratory failure with hypoxia. Interview with Employee E5 on April 23, 2026, at 1:00 p.m. confirmed that the above residents were not on the list provided to the State Ombudsman's office. 483.15 Admission, Transfer, and Discharge Previously cited 5/22/25 28 Pa. Code 201.14(a) Responsibility of licensee Previously cited 12/22/25, 8/4/25, 5/22/25

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on clinical record review and staff interview, it was determined that the facility failed to ensure that resident assessments accurately reflected the resident's status for one of 24 residents reviewed (Resident 2).Findings include:Review of Resident 2's quarterly MDS (Minimum Data Set - periodic assessment of resident needs) of March 22, 2026, section N0350 - Insulin, indicated that the resident was receiving insulin on one day in the last seven days Further review of the physician's orders and Medication Administration Record revealed no evidence that the resident received insulin during the assessment lookback period.Interview with licensed staff, E4, on April 23, 2026, at 1:35 p.m. confirmed that the assessment was coded inaccurately.28 Pa. Code 211.5(f) Clinical records

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on review of facility policy, review of clinical records and interview with staff, it was determined that the facility failed to obtain accurate weights and verify weights to maintain acceptable parameters of nutritional status for one of 24 residents reviewed (Resident 31).Findings include:Review of facility policy, Weight Assessment and Intervention revised September 2008, revealed that any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. Review of Resident 31's weights revealed a weight of 131.0 pounds on December 2, 2025, and 111.0 pounds on January 8, 2026 indicating a loss of 20 pounds or 15.3%. Further review of the clinical record revealed that no reweight was obtained. Resident 31's weight was recorded as 113.0 pounds on January 15, 2026, and 125.0 pounds on January 20, 2026, indicating a gain of 14 pounds or 12.6% with no reweight obtained. Next weight of 116.0 pounds was obtained on February 3, 2026, indicating a loss of 9 pounds or 7.2% with no reweight obtained. Interview with Employee E4 on April 23, 2026, at 1:00 p.m. confirmed that Resident 31's weights were not being verified for accuracy. 483.25 Nutrition/Hydration Status MaintenancePreviously cited 5/22/25 28 Pa. Code 211.12(d)(1)(3)(5) Nursing servicesPreviously cited 5/22/25

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based upon review of facility policy and procedure and observation, it was determined that the facility failed to ensure medications were administered following facility infection prevention protocol for one of two residents observed (Resident 1).Findings include:Review of facility policy and procedure titled Administering Medications revealed Staff follows established facility infection control procedures (e.g. handwashing, antiseptic technique, gloves, isolation preventions, etc.) for the administration of medications, as applicable.Observation of medication administration on April 22, 2026, at 9:00 a.m. revealed Licensed Employee E3 cut open medication pill packets and spill the medications onto the top of the medication cart. Licensed Employee E3 picked up the medications off of the top of the medication cart and placed them in a medication cup and administered them to Resident 1.The above information was conveyed to Licensed Employee E4 and the Nursing Home Administrator on April 23, 2026, at 1:00 p.m. 28 Pa. Code 211.12(c)(d)(1)(5) Nursing ServicesPreviously cited 5/22/2025, 7/16/2025, 8/4/225, 12/22/2025, 2/4/2026, 3/27/2026

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observations and interviews with residents and staff, it was determined that the facility failed to post the name, address, and telephone number of the State Survey Agency on two of two units (Station 2 and Station 3).Findings include:Observations on all days of the survey on both units revealed no posting of the contact information for the State Survey Agency. An interview with residents during a group interview on April 21, 2026, at 1:00 p.m. revealed that the residents were not aware of a posting containing the contact information for the State Survey Agency. Interview with the Nursing Home Administrator on April 23, 2026, at 12:50 p.m. confirmed that there was no posting of the State Survey Agency contact information on the nursing units. 28 Pa. Code 201.14(a) Responsibility of licenseePreviously cited 12/22/25, 8/4/25, 5/22/25

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations and interviews with residents and staff, it was determined that the facility failed to post the results of the most recent Department of Health survey in a place readily accessible to residents for two of two units (Stations 2 and 3).Findings include:Observations during all days of the survey revealed a posting that the state survey results were available in the lobby.Interview with residents during a group meeting on April 21, 2026, at 1:00 p.m. revealed that they were not aware of the location of the state survey results. The residents also revealed that they do not have access to the lobby and the elevator to the lobby requires a code.Interview with the Nursing Home Administrator on April 23, 2026, at 12:50 p.m. confirmed that the survey results were only located in the lobby which is not readily accessible to the residents.28 Pa. Code: 201.14(a) Responsibility of licensee.Previously cited 12/22/25, 8/4/25, 5/22/25