

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395480	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2025
NAME OF PROVIDER OR SUPPLIER Mahoning Operating LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 397 Hemlock Drive Lehighton, PA 18235	
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and select facility policy and staff interviews, it was determined that the facility failed to ensure residents are informed and provided written information regarding the right to formulate advance directives and failed to determine whether residents had advance directives upon admission for four out of 27 residents sampled (Residents 15, 26, 54, and 111). Findings include: A review of the facility's policy titled Advance Directives, last reviewed [DATE], indicated that it is the policy of the facility to encourage residents to make their own decisions for all aspects of their care. The Facility shall provide residents and/or resident representatives with information related to the right to complete an Advance Directive for Health Care (Living Will) and assignment of a Health Care Agent or identification of a Health Care Representative to serve as medical treatment decision-makers should they become incapable of making their own medical treatment decisions. The facility will provide written information regarding the resident's right to make healthcare decisions and information concerning the right to complete an Advance Directive for Healthcare and to appoint a Healthcare POA Agent or Healthcare Representative. Resident's Advance Directives, Healthcare Agents, and/or Healthcare Representatives documents shall be requested from the resident and/or the family at time of admission and intermittently. If the resident does not have an advance directive or wishes to change their directive, nursing will complete a healthcare directive form (a facility form that reflects life-sustaining treatments desired by the resident). The process of obtaining documents shall be a joint effort on the part of nursing, social services, admission personnel, and physician services. A review of Pennsylvania Statutes, Title 20, Chapter 54, Health Care, indicated that an advance health care directive is defined as a health care power of attorney, a living will, or a written combination of a health care power of attorney and a living will. A review of Resident 15's admission Minimum Data Set (MDS, a federally mandated standardized assessment process completed periodically to plan resident care) dated [DATE], revealed that the resident was cognitively intact with a BIMS (brief interview mental screening tool used to screen and identify cognitive impairment) score of 13 (13 to 15 indicates cognitively intact). A review of Resident 15's quarterly MDS dated [DATE], revealed that the residents had a BIMS score of 9 (a score of 8 to 12 indicates moderate cognitive impairment). Further review of Resident 15's clinical record revealed a Health Care Declaration form (facility form) which indicated the resident's chosen special treatment concerns included cardiac resuscitation (CPR), mechanical respiration (breathing machine), tube feedings or other artificial nutrition, artificial or invasive forms of hydration, blood or blood products, surgery or invasive tests, renal dialysis, and antibiotics and was signed on [DATE] (30 days after admission), by the resident's representative. A clinical record review revealed Resident 26 was admitted to the facility on [DATE], with diagnoses that include acute respiratory failure (a condition where the lungs fail to adequately oxygenate the blood or remove carbon dioxide, leading to insufficient oxygen to meet the body's needs). A review of an admission Minimum Data Set assessment dated [DATE], revealed that Resident 26 was moderately cognitively impaired with a BIMS score of 12 (a score of 8 to 12 indicates cognition is moderately impaired). A clinical record review revealed Resident 111 was (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admitted to the facility on [DATE], with diagnoses that included chronic kidney disease (gradual loss of kidney function).A review of a quarterly MDS assessment dated [DATE], revealed that Resident 111 was moderately cognitively impaired with a BIMS score of 10 (a score of 8 to 12 indicates cognition is moderately impaired).A clinical record review revealed Resident 54 was admitted to the facility on [DATE], with diagnoses that include acute kidney failure (a condition in which the kidneys suddenly are not able to function to meet the body's needs) and dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities).A review of a quarterly MDS assessment dated [DATE], revealed that Resident 54 was cognitively intact with a BIMS score of 13 (a score of 13 to 15 indicates cognition is intact).A review of the clinical records for Residents 15, 26, 54, and 111 revealed no documented evidence that written information regarding the right to formulate advance directives was provided upon admission. Additionally, there was no documented evidence that the facility determined whether these residents had existing advance directives, health care powers of attorney, or health care representatives at the time of admission.During an interview on [DATE], at 10:35 AM, the Director of Social Services confirmed there was no documented evidence that Residents 15, 26, 54, and 111 were provided with written information regarding the right to formulate an advance directive for health care or to appoint a health care power of attorney agent or health care representative. The Director of Social Services further confirmed there was no documented evidence indicating whether these residents did or did not have advance directives upon admission.During an interview on [DATE], at 12:10 PM, the above findings were reviewed with the Nursing Home Administrator (NHA). The facility failed to ensure that Residents 15, 26, 54, and 111 were provided with written information concerning the right to formulate advance directives and failed to document whether advance directives were in place upon admission.28 Pa. Code 201.14 (a) Responsibility of licensee.28 Pa. Code 201.18 (b)(2) Management.28 Pa. Code 201.29 (a) Resident rights.28 Pa. Code 221.10 (c) Resident car policies		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, select facility policy, and resident and staff interviews, it was determined the facility failed to consistently provide restorative nursing services as planned to maintain mobility to the extent possible for one resident out of 27 residents sampled (Resident 57). Findings include: A review of the facility policy titled Restorative Nursing, last reviewed by the facility on September 1, 2025, revealed it is the facility's policy to provide maintenance and restorative services designed to maintain or improve a resident's ability to the highest practicable level. Further review of the policy revealed that the restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible and that residents may receive restorative nursing services upon admission, when restorative needs arise during the course of a longer-term stay, in conjunction with specialized rehabilitation therapy, or upon discharge from therapy. Restorative nursing refers to nursing-implemented programs that are planned, monitored, and carried out by nursing staff to maintain or improve a resident's functional status, mobility, strength, endurance, or ability to perform activities of daily living after formal therapy services have ended, in accordance with the resident's assessed needs, care plan, and professional recommendations. A review of the clinical record revealed Resident 57 was admitted to the facility on [DATE], with diagnoses that included hemiplegia and hemiparesis affecting the left side (conditions involving paralysis or significant weakness and loss of muscle function on one side of the body) and rheumatoid arthritis (a chronic inflammatory disorder that primarily affects joints and can impact mobility and function). A review of a quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 22, 2025, revealed that Resident 57 was cognitively intact with a BIMS score of 13 (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 score of 13-15 indicates cognition is intact). A review of care plan dated September 25, 2025, indicated Resident 57 required restorative programs to address muscle weakness, with goals that included ambulating safely and consistently using a rollator walker. A review of a physical therapy Discharge summary dated [DATE], revealed that Resident 57 was discharged from physical therapy services with recommendations for nursing to implement a restorative ambulation program. The discharge recommendations specified that the resident was to ambulate using a platform rollator walker with the assistance of two caregivers and a wheelchair follow for safety. A review of Resident 57's task report, an electronic record used to outline and track planned resident-centered nursing tasks, indicated that the resident was to ambulate in a straight path for 30 to 50 feet with the assistance of two caregivers using a platform rollator walker, with additional assistance required to place and remove the resident's left upper extremity on and off the platform of the walker. During an interview on December 9, 2025, at 11:05 AM, Resident 57 stated that she had exercised regularly while receiving physical therapy; however, after therapy services ended, no staff had provided restorative ambulation services. The resident stated that no one had walked with her since physical therapy was discontinued. A review of Resident 57's Documentation Survey Report v2, which reflects care tasks completed for the resident, for November 2025 and December 2025, revealed inconsistent, incomplete, and conflicting documentation of restorative ambulation services, including multiple entries of not applicable, blank documentation, limited distances ambulated that did not align with the restorative plan, and documentation of ambulation on dates the resident later denied occurred. Specifically, documentation revealed the following: On November 27, 2025, documentation indicated that during the day shift the resident was documented as unavailable. Documentation for the evening shift and night shift reflected NA (not applicable). On November 28, 2025, documentation for the day shift was left (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	blank. During the evening shift, documentation indicated that 15 minutes were spent providing ambulation, and the resident ambulated a distance of 10 feet. No documentation was recorded for the night shift. On November 29, 2025, documentation indicated NA for the day shift. For the evening shift, documentation reflected that the resident refused ambulation. Documentation for the night shift reflected NA. On November 30, 2025, documentation reflected NA for the day shift. During the evening shift, documentation indicated that 15 minutes were spent with ambulation and that the resident ambulated 30 feet. Documentation for the night shift was left blank. On December 1, 2025, documentation reflected NA for the day shift, evening shift, and night shift. On December 2, 2025, documentation reflected NA for the day shift and evening shift. Documentation for the night shift indicated that 15 minutes were spent providing ambulation and that the resident ambulated 50 feet. On December 3, 2025, documentation reflected NA for the day shift. During the evening shift, documentation indicated that 15 minutes were spent with ambulation and that the resident ambulated 50 feet. Documentation for the night shift reflected NA. On December 4, 2025, documentation reflected NA for the day shift, evening shift, and night shift. On December 5, 2025, documentation reflected NA for the day shift, evening shift, and night shift. On December 6, 2025, documentation reflected NA for the day shift, evening shift, and night shift. On December 7, 2025, documentation for the day shift indicated that zero minutes were spent ambulating and that the resident ambulated zero feet. Documentation for the evening shift and night shift reflected NA. On December 8, 2025, documentation for the day shift indicated that 15 minutes were spent ambulating; however, the distance ambulated was documented as NA. Documentation for the evening shift reflected that the resident refused ambulation. Documentation for the night shift reflected NA. On December 9, 2025, documentation reflected NA for the day shift, evening shift, and night shift. On December 10, 2025, documentation reflected NA for the day shift, evening shift, and night shift. On December 11, 2025, documentation reflected NA for the day shift and evening shift. Documentation for the night shift indicated that 15 minutes were spent ambulating and that the resident ambulated 50 feet. During an interview on December 12, 2025, at 9:00 AM, Resident 57 stated that she did not ambulate the night prior, despite documentation indicating that she ambulated for 15 minutes and 50 feet. The resident further stated that she had not ambulated since physical therapy services ended and denied refusing ambulation services. During an interview on December 12, 2025, at 11:00 AM, the Assistant Director of Nursing confirmed that it is the facility's responsibility to ensure restorative nursing services are implemented and provided as planned following discharge from therapy services to maintain or improve resident function. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa Code 211.12(d)(5) Nursing services.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, observation, and staff interviews, it was determined the facility failed to ensure oxygen therapy was administered per physician's orders for three residents out of 27 sampled (Residents 1, 26, and 38). Findings include: A review of the facility's policy titled Oxygen Administration, last reviewed September 1, 2025, revealed it is the facility policy that oxygen is administered to residents who need it is consistent with professional standards of practice, the comprehensive person-centered care plans, and the residents' goals and preferences. The policy indicates oxygen is administered under orders of a physician, except in the case of an emergency. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to, (1) the type of oxygen delivery system, (2) monitoring of blood oxygen saturation levels (SPO2, the percentage of red blood cells that are carrying oxygen, indicating how well oxygen is being delivered to the body's tissues; normal levels are typically 95 to 100%) and vital signs, and (3) monitoring of complications associated with the use of oxygen. Further review of the policy revealed that staff should perform hand hygiene and put on gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include changing and dating oxygen tubing and masks/cannulas every two weeks and as needed. A clinical record review revealed Resident 1 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). Further review of the clinical record revealed a physician's order dated April 3, 2025, for respiratory care directing staff to administer oxygen at 2.0 liters per minute (L/min) by way of nasal cannula/mask (a device, a flexible tube with two prongs that fit into the nostrils, used to deliver supplemental oxygen) initiated on April 3, 2025. A review of the resident's care plan indicated that oxygen therapy related to ineffective gas exchange was initiated on July 15, 2024. Interventions included maintaining oxygen delivery via nasal cannula or mask at 2.0 L/min with humidification. On December 9, 2025, at 12:39 PM, an observation revealed Resident 1 was seated in the dining room in his wheelchair and connected to a portable oxygen tank via nasal cannula. The oxygen tank was observed to be empty. Employee 3, Licensed Practical Nurse (LPN), confirmed the oxygen tank was empty and stated the resident had physician's orders for continuous oxygen. Employee 3 further stated that oxygen tank levels should have been checked prior to the resident leaving his room for the dining room. On December 9, 2025, at 12:47 PM, Employee 3 LPN replaced Resident 1's oxygen tank and measured the resident's oxygen saturation (SpO²), defined as the percentage of oxygen in the blood, which measured 96%. A clinical record review revealed Resident 26 was admitted to the facility on [DATE], with diagnoses that include acute respiratory failure (a condition where the lungs fail to adequately oxygenate the blood or remove carbon dioxide, leading to insufficient oxygen to meet the body's needs). Further review revealed a physician's order dated October 22, 2025, directing staff to administer oxygen at 3.0 L/min continuously via nasal cannula. A review of the care plan indicated that Resident 26 had an altered respiratory status related to acute respiratory failure, initiated on October 1, 2025. Interventions included administering medications as ordered, monitoring for signs and symptoms of respiratory distress, and reporting changes to the physician as indicated. On December 9, 2025, at 10:05 AM, an observation revealed Resident 26 sitting in her room with her oxygen turned off. Employee 2, LPN, stated that the resident had physician's orders for continuous oxygen therapy and that the oxygen should always be in use. Employee 2 further stated that staff had not informed her that the resident had returned to her room and required her oxygen to be reapplied or adjusted. On December 9, 2025, at 10:13 AM, Employee 2 measured Resident 26's oxygen saturation (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(SpO²), which was 92%. During an interview on December 9, 2025, at 1:00 PM, the above findings were reviewed with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). The NHA confirmed that it is the facility's responsibility to ensure that oxygen therapy is administered and maintained in accordance with physician orders. A clinical record review revealed Resident 38 was admitted to the facility on [DATE], with diagnoses that included acute and chronic respiratory failure and asthma (a chronic lung disease causing inflammation and narrowing of the airways). Further review of the clinical record revealed a physician's order dated October 29, 2025, for oxygen administration at 2.0 L/min via nasal cannula and for oxygen tubing, including nasal cannula or mask, to be changed every two weeks on Monday night and as needed. On December 9, 2025, at 11:10 AM, an observation revealed an oxygen concentrator in Resident 38's room. The oxygen tubing attached to the concentrator was dated November 20, 2025, as confirmed by Employee 5, LPN. An interview conducted on December 9, 2025, at 2:15 PM, with the Assistant Director of Nursing confirmed that the oxygen tubing for Resident 38 had not been changed in accordance with the physician's order and facility policy 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.		

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. Based on review of clinical records, the Resident Assessment Instrument Manual, and staff interview, it was determined that the facility failed to ensure that quarterly Minimum Data Set assessments (MDS, a federally mandated standardized assessment process completed periodically to plan resident care) were completed within the required time frame for two of 27 residents reviewed (Residents 48 and 105). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required MDS assessments, dated October 2024, indicated that the assessment reference date (ARD, the last day of the assessment's look-back period) of a quarterly MDS assessment must be no more than 92 days after the ARD of the most recent assessment of any type, and the assessment was to have a completion date (Section Z0500B) that was no later than the ARD plus 14 calendar days. Review of a quarterly MDS assessment for Resident 48 revealed an ARD of November 8, 2025. The MDS was signed as completed by the RNAC (Registered Nurse Assessment Coordinator, who is responsible for the completion of MDS assessments) on December 3, 2025 (25 days after the ARD date). Review of a quarterly MDS assessment for Resident 105 revealed an ARD of November 10, 2025. The MDS was signed as completed by the RNAC on December 10, 2025 (30 days after the ARD date). Interview with the RNAC on December 11, 2025, at 10:45 AM confirmed that the above quarterly MDS assessments were not signed as completed in the required time frames. 28 Pa. Code 211.5(f) (ix) Medical records.		

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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 clinical record review, select facility policy, and resident representative and staff interviews, it was determined the facility failed to ensure a comprehensive care plan was developed and revised with the participation of the resident and the resident's representative for one resident out of 27 residents sampled (Resident 89). Findings include: A review of the facility's Resident Care Plan policy last reviewed September 1, 2025, indicated that the facility will develop a comprehensive care plan, for each resident, that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan will be developed by the facility's interdisciplinary team in conjunction with the resident and, or the resident's responsible party, surrogate, or family, as designated by the resident. Review of the facility Care Conference policy last reviewed September 1, 2025, indicated it is the policy of the facility to conduct care conferences to promote resident-centered care through interdisciplinary communication, resident and/or resident representative involvement, and ongoing evaluation of the resident's needs, goals, and preferences. Care conferences provide an opportunity for the interdisciplinary team to review and coordinate care, discuss changes in condition, evaluate outcomes, and involve the resident and/or resident representative in care planning and decision-making. Residents and/or resident representatives will be invited to participate in care conferences. Reasonable efforts will be made to accommodate availability and preferences. If the resident or representative declines or is unable to attend, this will be documented. A clinical record review revealed Resident 89 was admitted to the facility on [DATE], with diagnoses which included heart failure (condition in which the heart muscle cannot pump enough blood to meet the body's need for blood and oxygen) and diabetes (a disorder in which there are high levels of sugar in the blood). A review of a quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 14, 2024, revealed that Resident 89 was moderately cognitively impaired with a BIMS score of 9 (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 score of 8-12 indicates moderately impaired cognition). A review of Resident 89's clinical record revealed no documented evidence Resident 89 and resident representative were invited to participate or participated in the development of the resident's person-centered care plan. During an interview on December 9, 2025, at 12:00 PM, Resident 89's resident representative indicated that she has not been invited to participate in the development and revision of the resident's person-centered care plan. Resident 89's resident representative indicated that she had not been invited to any care plan meetings at the facility. During an interview on December 11, 2025, at 10:00 AM the Social Services Director (SSD) indicated that care planning conferences are completed for newly admitted residents and at least quarterly for each resident following admission to the facility. The SSD could not provide evidence that Resident 89's resident representative was being provided the opportunity to participate in the development and revision of the resident's comprehensive resident-centered care plan. The SSD confirmed it is the facility's responsibility to ensure comprehensive care plans are developed and revised with the participation of the resident and the resident's representative. The SSD was unable to provide documented evidence that Resident 89 and Resident 89's resident representative were being provided with an opportunity to participate in the development and revision of comprehensive resident-centered care plans. During an interview on December 12, 2025, at approximately 9:30 AM, the Nursing Home Administrator (NHA) confirmed that it is the facility's responsibility to ensure that residents and resident representatives are provided an opportunity to participate in development and revisions of their comprehensive care plans. The NHA confirmed the interdisciplinary team meets (continued on next page)		

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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, select facility policy, and staff and resident interviews, it was determined the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices to maintain skin integrity for one resident out of 27 sampled (Resident 54). Findings include: A review of the facility policy titled Alteration in Skin Integrity Identification and Treatment, last reviewed by the facility on September 1, 2025, revealed it is the facility policy that the physician or practitioner will be notified of all new alterations in skin integrity. A clinical record review revealed Resident 54 was admitted to the facility on [DATE], with diagnoses that include acute kidney failure (a condition in which the kidneys suddenly are not able to function to meet the body's needs) and dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A review of a quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated September 9, 2025, revealed that Resident 54 was cognitively intact with a BIMS score of 13 (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 score of 13 to 15 indicates cognition is intact). A care plan indicating Resident 54 had the potential for skin impairment and was prone to bruising with slight pressure was initiated on August 17, 2022. Interventions developed to assist Resident 54 to be free from potential skin injury included assessing skin integrity, noting color, texture, temperature, redness, scaling, breaking, or ulcerations, and reporting to the charge nurse. A physician's order for weekly skin checks with directions to document no new areas of skin impairment, new areas of skin impairment, or existing areas of skin impairment every Thursday day shift was initiated on July 31, 2025. During an interview and observation on December 9, 2025, at 10:31 AM, Resident 54 explained that her arms have been irritated for weeks. Her left arm presented with erythema (redness) and inflammation along her forearm, 8 abrasions with dried blood measuring under 0.5 inches, and bright red blood from a scratches measured 0.25 inches. Resident 54 indicated that her arms were very itchy, and she thinks she may be allergic to the facility detergent. She explained she has reported the issue to nursing staff, but they only give her a moisturizer that does not help. A review of Resident 54's Medication Administration Record (MAR) dated December 2025 revealed skin checks were performed as ordered by the physician on December 4, 2025, and December 11, 2025. There was no documentation indicating if the resident had no new skin impairment, new skin impairment, or existing areas of skin impairment on either date. Further review of Resident 54's clinical record revealed no documentation of an ongoing issue with upper extremity skin irritation or inflammation or ongoing assessment monitoring her upper extremity irritation, inflammation, or injuries. During an interview on December 12, 2025, at 11:00 AM, Employee 4, a Licensed Practical Nurse (LPN), confirmed there was no documentation in Resident 54's medical record indicating findings of Resident 54's weekly skin checks on December 4, 2025, or December 11, 2025, consistent with the facility policy to identify when there are no new areas of skin impairment and new or existing areas of skin impairment. Employee 4, LPN, confirmed Resident 54's medical record should contain information describing Resident 54's skin integrity status. During an interview on December 12, 2025, at 11:20 AM, the above findings were reviewed with the Nursing Home Administrator (NHA). The NHA was unable to provide documented evidence that the facility was monitoring Resident 54's skin consistent with facility policy. The facility failed to ensure Resident 54 received care and treatment to maintain skin integrity. 28 Pa. Code 211.5(f)(ii) Medical records. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.		

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NAME OF PROVIDER OR SUPPLIER Mahoning Operating LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 397 Hemlock Drive Leighton, PA 18235	
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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and staff interview, it was determined that the facility failed to ensure that one of 27 residents sampled (Resident 2) received a psychotropic medication only when medically necessary and supported by adequate clinical justification, documentation of behavioral symptoms and attempts of nonpharmacological interventions were prior to administration. Findings include: A review of the facility policy titled Psychoactive Medication, last reviewed by the facility on September 1, 2025, revealed it is the facility's policy that psychoactive medications will be utilized for the purpose of adding quality of life for those residents who require psychoactive medications. Initiation of drug therapy will be done after non-pharmacological interventions have been attempted and documented as ineffective. A review of the resident's clinical record revealed Resident 2 was admitted to the facility on [DATE], with diagnoses that included unspecified dementia with other behavioral disturbance (a disease that is characterized by a decline in cognitive abilities that affects a person's ability to perform everyday activities) and major depressive disorder (a mental disorder that is characterized by persistent feeling of sadness, hopelessness, and loss of interest or pleasure in activities that were once found enjoyable). A review of a quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 5, 2025, revealed that Resident 2 was severely cognitively impaired with a BIMS score of 3 (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 score of 0 to 7 indicates severe cognitive impairment). A review of Resident 2's physician orders revealed the following: July 28, 2025: Ativan (a medication used primarily for anxiety and panic disorders) 0.5 mg one tablet by mouth every 12 hours as needed (PRN) for anxiety or agitation for 3 months. A review of the electronic medication administration record (eMAR) revealed Resident 2 received PRN (as needed) Ativan 0.5 mg on eight occasions between October 5 and October 26, 2025. The administrations occurred on: October 5, 2025, at 12:48 PM; October 9, 2025, at 7:51 PM; October 13, 2025, at 9:31 PM; October 15, 2025, at 9:12 PM; October 17, 2025, at 12:58 AM; October 20, 2025, at 7:16 PM; and October 23, 2025, at 4:57 AM and 7:46 PM. For each of the eight administrations, the clinical record lacked documentation identifying specific behavioral symptoms, distress, or clinical indicators that would support the need for PRN administration of Ativan. Additionally, for each administration, the clinical record lacked documentation indicating that nonpharmacological interventions were attempted prior to medication use. Nonpharmacological interventions are individualized approaches that do not involve medication, such as redirection, reassurance, therapeutic communication, structured activities, or environmental modification. The absence of documented behavioral symptoms, medical necessity, and attempted nonpharmacological interventions indicated that the administration of Ativan was not supported by adequate clinical justification, resulting in the use of an unnecessary psychotropic medication for Resident 2. An interview with the Director of Nursing was conducted on December 11, 2025, at 1:28 PM regarding the facility's failure to provide documentation supporting medical necessity for the PRN use of Ativan and evidence that nonpharmacological interventions were attempted prior to administration. 28 Pa. Code 211.5(i)(ii)(viii)(xi) Clinical records. 28 Pa. Code 211.9(b)(2) Pharmacy services. 28 Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(2)(5) Nursing Services.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and resident and staff interviews, it was determined that the facility failed to ensure medications were properly stored and administered in accordance with physician orders and accepted standards of nursing practice, resulting in a medication error that caused pain and discomfort for one of one resident out of 27 residents sampled (Resident 82). Findings include: A review of the facility policy titled Medication Administration, last reviewed by the facility on September 1, 2025, revealed it is the facility policy to administer medications to all residents in a timely fashion and within prescribed parameters. Resident medications will be stored in appropriate areas of the medication room, carts, or medication room refrigerator. The nurse will verify the resident has taken or received all medications before the nurse leaves the bedside. Medications are never to be left at the bedside, on a resident's meal table, etc. A clinical record review revealed that Resident 82 was admitted to the facility on [DATE], with diagnoses that included chronic kidney disease (gradual loss of kidney function). A review of a quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 5, 2025, revealed that Resident 82 is moderately cognitively impaired with a BIMS score of 10 (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 score of 08 to 12 indicates moderate cognitive impairment). A review of physician orders revealed: An order dated December 8, 2025, to apply zinc oxide paste to the groin, abdominal folds, bilateral buttocks, posterior thighs, and right anterior thigh every shift and as needed until resolved. An order dated September 17, 2025, to apply muscle rub external cream (Menthol-Methyl Salicylate 10%/15%) to the right knee topically two times daily for pain. Menthol-Methyl Salicylate is a topical analgesic intended for application to intact skin and may cause irritation or burning if applied to wounds or compromised skin. A review of a progress note dated December 10, 2025, at 9:16 AM, revealed Resident 82 had a chronic open wound under the right abdominal fold. The wound was described as stable and measured 1.0 cm by 0.7 cm by 0.2 cm with exposed subcutaneous tissue (below the top layer of the skin) and a moderate amount of serosanguineous exudate (a mixture of clear fluid and blood). During an interview on December 11, 2025, at 10:20 AM, Resident 82 explained that she was upset because yesterday (December 10, 2025) she needed an ice pack after a male nurse aide, Employee 7, put muscle rub cream on her wound. She indicated that the cream immediately started to burn, and she told the nurse aide. Resident 82 explained that the nurse aide cleaned off the muscle rub cream with water and then gave her an ice pack for the discomfort. She indicated that she lay in bed for an hour before the pain subsided. Resident 82 indicated that it was an awful experience, and the nurse knows about what happened. A review of the clinical record revealed no documented evidence that: Muscle rub external cream was administered to the resident. The resident's pain or discomfort was assessed or monitored. Nursing interventions were implemented following the event. The physician was notified of the medication error or the resident's response. During an interview on December 11, 2025, at 10:26 AM, Employee 6, Licensed Practical Nurse (LPN), indicated that she heard something about Resident 82 experiencing pain after a muscle rub cream was applied. She provided the name of the nurse aide that was assigned to provide care to Resident 82 on December 10, 2025. Employee 6, LPN, explained that the muscle rub external cream Menthol-Methyl Salicylate (10% Menthol and 15% Methyl Salicylate) should not be left at the resident's bedside. She indicated it is the nurse's responsibility to apply the medication. An interview statement dated December 11, 2025, revealed the Director of Nursing (DON) identified that Employee 7, Agency Nurse Aide, applied a cream to Resident 82 from a cup. The DON stated the resident reported the cream caused burning. The DON indicated the nurse aide washed the cream off and provided ice to relieve the discomfort. The DON stated the nurse aide was educated that topical medications are to (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be applied from their original containers and only those identified on the resident's Kardex (a quick-reference tool used by nursing staff to summarize essential resident care information). During a phone interview on December 12, 2025, at 11:50 AM, Employee 7, Agency Nurse Aide, stated he accidentally applied muscle rub external cream to Resident 82's abdominal folds and peri-area, believing it was zinc oxide paste. He stated the medication had been left at the resident's bedside. He reported that the resident immediately experienced a burning sensation, after which he washed the cream off and provided a cold, wet washcloth. He stated he reported the incident to a nurse but was unable to identify the nurse by name. During an interview on December 12, 2025, at 12:10 PM, the above findings were reviewed with the Nursing Home Administrator (NHA). The facility failed to ensure medications were securely stored and administered only by licensed nursing staff in accordance with physician orders, resulting in a medication error that caused Resident 82 pain and discomfort. 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 211.5 (ii) Medical records. 28 Pa. Code 211.10 (c) (d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.		

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of select facility policy, clinical records, and staff interviews, it was determined the facility failed to timely notify the physician of abnormal lab results for one resident out of 27 sampled (Resident 119). Findings included: A review of the facility policy entitled Laboratory Testing and Notification, last reviewed on September 1, 2025, indicated that physicians will be notified of abnormal laboratory results in a timely fashion. Further review revealed that all laboratory testing results will be reviewed by a nurse as they are received by the facility, and the nurse who receives the laboratory result will be responsible for notifying the resident's physician of abnormal or critical results, with documentation of same in the resident's medical record. A review of the clinical record revealed that Resident 119 was admitted to the facility on [DATE], and had diagnoses that included diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces) and hypertension (blood pressure that is higher than normal). A review of an admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 22, 2025, revealed that Resident 119 had moderately impaired cognition with a BIMS score of 9 (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 score of 8-12 indicates cognition is moderately impaired). A review of a physician's order for Resident 119 dated November 30, 2025, revealed a laboratory order for urinalysis (UA) and C & S (culture and sensitivity, a urine culture is a method to grow and identify bacteria that may be in the urine. The sensitivity test helps select the best medicine to treat the infection).). A review of the final urine culture (C&S) results dated December 4, 2025, identified abnormal findings of greater than 100,000 colonies per milliliter of Escherichia coli (E. coli, a bacterium). A review of nursing progress notes for Resident 119 revealed that the abnormal C&S results from December 4, 2025, were not communicated to the physician by staff until December 7, 2025, at 1:45 PM, three days after the result was available. During an interview on December 11, 2025, at 10:00 AM, the Assistant Director of Nursing confirmed that laboratory results are sent to the nursing department, and it is the responsibility of nursing staff to notify the physician of any abnormal results in a timely fashion, and confirmed that the urine culture results were not relayed to the physician in a timely manner for Resident 119. 28 Pa. Code 211.12 (d)(3)(5) Nursing services. 28 Pa Code 211.10 (a)(c) Resident care policies.		