STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395493	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Julia Ribaudo Extended Care Center	1404 Golf Park Drive Lake Ariel, PA 18436

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 on observation and staff interview, it was determined that the facility failed to maintain sanitary food storage, dishwashing, and ice machine sanitation practices in the food and nutrition services department. These failures had the potential to contaminate food and ice served to residents and increased the risk of foodborne illness.Findings include: Food safety and inspection standards for safe food handling indicate that everything that encounters food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). During the initial tour of the food and nutrition services department on June 14, 2026, at 9:15 AM, in the presence of Employee 3, Cook/Dietary Aide observation revealed the following food storage concerns with the potential to increase the potential for food-borne illnesses: Cardboard food containers stored on metal shelving were wet and covered with freezer burn. A large accumulation of ice was observed on the ceiling, shelving beneath the exhaust fans, storage shelves, food containers, the floor, and the door threshold. At the time of the observation, the freezer temperature measured 9 degrees Fahrenheit. Commercial freezers are generally maintained at 0 degrees Fahrenheit or below to keep food frozen, preserve food quality, and minimize conditions that could contribute to food deterioration. Excessive ice accumulation and elevated freezer temperatures may indicate that the freezer is not functioning effectively and may compromise the safe storage of food. During the observation, the Certified Dietary Manager was unable to state whether the freezer had been consistently maintained at acceptable temperatures to ensure safe food storage or prevent the excessive ice accumulation observed throughout the freezer. Observation on June 14, 2026, at 9:15 AM revealed Employee 3, dietary aide, loaded soiled dishes into the dishwasher while wearing gloves that had contacted dirty dishware. After the wash cycle was completed, Employee 3 removed clean dishes from the dishwasher using the same gloves without removing the gloves or performing hand hygiene. The use of the same gloves for both dirty and clean dishware created the potential for cross-contamination by transferring microorganisms from soiled surfaces to cleaned and sanitized items. A second observation on June 15, 2026, at 9:30 AM revealed Employee 4, dietary aide, loaded soiled dishes into the dishwasher while wearing gloves and subsequently removed clean dishes from the dishwasher using the same gloves without changing gloves or performing hand hygiene. This practice also created the potential for cross-contamination between dirty and clean dishware. Observation of the ice machine located in the AB dining room/activity room on June 14, 2026, at 10:00 AM revealed a heavy accumulation of lint on the external filter. The exterior chrome surfaces contained dried liquid residue. The floor beneath and behind the machine contained paper debris, plastic debris, liquid stains, and dirt. The plastic drainpipe connected to the machine contained a large accumulation of brown sticky residue. The floor drain located two inches below the drainpipe contained a similar brown sticky substance. Additional plastic piping located at the rear of the machine near the floor contained numerous black spots throughout (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the length of the pipe. (Ice is considered food and must be protected from contamination during production, storage, and dispensing. Unsanitary conditions on and around ice machines and drainage systems may contribute to contamination of ice intended for resident consumption) Observation of the ice machine located in the CD dining room/activity room on June 14, 2026, at 10:30 AM revealed paper debris, plastic debris, liquid stains, and dirt on the floor beneath and behind the machine. The plastic drainpipe connected to the machine was then connected directly into the drainpipe. The drainpipe contained brown sticky residue, visible dirt, and staining. The surrounding floor area also contained brown residue, dirt, and liquid staining. Interview with the Nursing Home Administrator on June 15, 2026, at 12:00 PM confirmed the facility was expected to maintain safe food storage practices and sanitary conditions for equipment used in the preparation and service of food and ice. Cross refer F908 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Coe 211.6 (f) Dietary.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility infection control records, clinical records, facility policy, and staff interview, it was determined that the facility failed to implement and maintain an antibiotic stewardship program and conduct and document antibiotic stewardship monitoring for eight of 8 months reviewed (November 2025 through June 2026) and failed to follow its antibiotic stewardship process for 1 of 20 residents reviewed (Resident 97).Findings include: A review of the facility policy titled Antimicrobial Stewardship Program, last updated June 5, 2026, revealed the program focuses on improving antimicrobial use by avoiding inappropriate or unnecessary antimicrobials. The policy stated antimicrobial use would be reviewed through monitoring and tracking of antimicrobial prescribing, use, and resistance to promote optimal antimicrobial use within the facility. The policy required the use of an antimicrobial tracking form or system to track and trend infections by site and organism. The policy also required monthly review of antimicrobial utilization reports from the pharmacy, including the type of drug prescribed, number of days of treatment, and number of new antimicrobial starts. The policy further required monthly antimicrobial use surveillance, including monitoring, tracking, and trending for patterns, trends, and clusters, and required clinical and diagnostic testing for specific infections.In addition, the policy required antimicrobial use protocols to address prescribing practices, documentation of the indication, dose, and duration of antimicrobial therapy, review of laboratory reports to determine whether antimicrobial therapy was indicated or required adjustment, completion of an infection assessment prior to prescribing, and monitoring of antimicrobial use through antimicrobial utilization reports, antimicrobial resistance reports, and current McGeer Criteria. McGeer Criteria are standardized surveillance definitions used in long-term care facilities to identify infections based on specific clinical signs, symptoms, and laboratory findings. The policy further stated that antibiotics would be prescribed and administered under the guidance of the facility's antibiotic stewardship program, which was established to monitor antibiotic use among residents. A review of the facility's infection control surveillance records from November 2025 through June 2026 revealed no documentation that antibiotic stewardship monitoring, tracking, trending, or utilization review activities had been completed during any of the eight months reviewed. A review of Resident 97's clinical record revealed the resident was admitted on [DATE], with diagnoses that included epilepsy (a neurological disorder characterized by recurrent seizures) and parkinsonism (a group of neurological disorders that cause symptoms such as tremors and slowed movement). A review of a physician's order dated April 27, 2026, revealed Macrobid 100 mg (an antibiotic used to treat urinary tract infections) was ordered twice daily for five days for a urinary tract infection (UTI, an infection involving the urinary system). A review of the April 2026 Medication Administration Record revealed Resident 97 received four doses of Macrobid. A review of Resident 97's clinical record revealed no documentation that a McGeer Criteria assessment had been completed prior to initiation of the antibiotic. Further review failed to identify documentation supporting the clinical signs or symptoms used to determine whether the resident met the facility's criteria for antibiotic treatment. A review of a urinalysis with culture report dated April 27, 2026, at 3:40 PM revealed minimal bacterial growth consisting of mixed normal urogenital flora (bacteria commonly found on the skin and surrounding areas that do not necessarily indicate infection). Documentation revealed the laboratory results were reviewed by the provider on April 30, 2026. Following review of the culture results, which did not identify evidence of a urinary tract infection, the antibiotic was discontinued. During an interview on June 15, 2026, at 11:00 AM, the Infection Preventionist stated Resident 97 met McGeer Criteria for antibiotic treatment. However, the facility was unable to provide documentation identifying the clinical findings that met the criteria or a completed McGeer Criteria assessment supporting initiation of the antibiotic. During an interview on June 16, 2026, at 1:00 PM, the Director of Nursing confirmed the facility had not completed antibiotic stewardship monitoring as required and acknowledged the (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	facility's antibiotic stewardship process had not been followed. Cross refer F757 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation and staff interview, it was determined the facility failed to ensure that essential equipment was in safe operating condition in the facility's food and nutrition area. Findings include: A review of a policy for Freezers and Refrigerators, lase reviewed June 5, 2026, revealed the facility will ensure safe refrigerator and freezer maintenance and sanitation. The food and nutrition services director will inspect refrigerators and freezers monthly for gasket, fan condition, the presence of rust, excess condensation and any other damage or maintenance issues. Necessary repairs will be initiated immediately. A tour of the facility's main kitchen area on June 14, 2026, at approximately 9:30 AM revealed the walk in freezer with a large ice buildup on the ceiling, double exhaust fans, walls and floor. The pipe located under the exhaust fans (to remove the condensation/water from inside the unit to the outside of the building was missing, leaving an exposed hole in the freezer to the outside of the building. The freezer was located on an outside wall of the kitchen. The metal shelving unit located under the exhaust fans had two large plastic containers with individual ice cream cups encased in ice. These plastic containers were frozen to the metal shelves. There were multiple metal shelving units on either side of the freezer with wet cardboard boxes containing food. The cardboard boxes fell apart when moved. Several boxes of food, including two cakes, were noted to be freezer burned with ice on the food. A review of the freezer temperature logs at the time of the tour revealed the temperature inside the freezer was 9 degrees Fahrenheit. A review of a service order from the freezer repair company dated June 3, 2026 revealed that a technician was in the building on that date and inspected the freezer unit in the kitchen. He noted on the invoice that the walk in freezer needed a drain pipe, it was coming off the fan inside the unit. The technician left the building stating he needed to get parts to repair the unit. The service order noted that the technician was again in the building June 5, 2026, to make additional repairs to additional machines in the kitchen. The freezer was not repaired at that time. The repair company was contacted by the facility staff on June 14, 2026, after the survey team identified the issue with the walk in freezer. During an interview on June 15, 2026, at 10:00 AM, the Certified Dietary Manager (CDM) stated the pipe under the exhaust fans in the freezer had broken off two weeks ago. He stated the repair company was contacted and came out to the facility at that time but didn't have the needed part to fix the issue. As of the time of the start of the survey, June 14, 2026 the walk in freezer remained broken. An interview with the Nursing Home Administrator (NHA) on June 15, 2026, at 10:00 AM confirmed the facility failed to ensure that essential equipment was in safe operating condition. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(e)(2.1) Management.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and interview, it was determined the facility failed to maintain a clean, comfortable and homelike environment for residents on five of 5 resident units. (Units A,B,C,D and E)Findings include: An environmental tour conducted on June 14, 2026, at 9:30 AM revealed that the floor on all resident hallways (A,B,C,D and E) had a thick, yellow sticky substance around the perimeter to include in front of resident rooms and ancillary rooms. The high back upholstered chairs in the A,B activity/dining room had food and dried liquid stains on them. The floor was dirty with dirt and liquid stains. The floor under the ice machine had a black sticky substance on it as well as a large amount of dirt, paper and dried liquid stains. The C/D activity/dining room floor was dirty with dried food debris, dirt and dried liquid stains. The floor behind the ice machine was dirty with paper and plastic debris, dried liquid stains and visible dirt. The high back upholstered chairs had food and dried liquid stains on them. There was a large, uncovered bin with bagged dirty linen as well as a large, uncovered bin with bagged garbage on the patio outside the laundry area. During a Resident council meeting held June 15, 2026, at 10:00AM, revealed six out of 6 residents (Resident 33, 39, 48, 69, 75, and 95) complained of the shower rooms. Three out of 7 residents reported that the D Hall shower room has a mold like substance around the edges of the showers. Resident 75 and Resident 39 revealed the shower room was frequently full of wheelchairs, garbage cans, and other stored items, that limit the amount of room the residents have to take their showers. Six out of 6 residents revealed that staff do not clean the showers prior to showering residents, six out of 6 residents stated that when going to the shower there are dirty clothes, towels, and even dirty briefs, from the previous resident still present in the shower when they utilize it. Observation of the Hallway D shower room on June 15, 2026, at 11:40 AM revealed a presence of black mold along 3 out of 4 bottom edges of the shower walls. The fuzzy black mold was consistent along the bottom where the floor meets the wall, the mold was unable to be wiped clean with a paper towel. Observations of the A Hall shower room revealed 6 wheelchairs present in the shower room with a small walking path to the shower area. The small walking path was large enough to fit one wheelchair in the area. The shower room also revealed 3 garbage cans present, one filled with soiled linens. Observations of the B hall bathtub room revealed a bathtub full of equipment, including bed bolsters, two wheelchairs, and multiple garbage cans with lids present. The area revealed no walking path. The bathtub unable to be used. Interview with the Director of Nursing on June 16, 2026, at 1:00 PM reviewed the above findings of the facility's failure to ensure the facility was homelike, clean, and properly maintained. 28 Pa Code 201.18(e)(2.1) Management.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility policies, observations, and staff interviews, it was determined that the facility failed to implement procedures to maintain accurate records of controlled substances and ensure accountability for controlled drug administration for one resident (Resident 35), and failed to notify the physician when a prescribed medication could not be administered as ordered for one resident (Resident 98) out of 20 residents reviewed.Findings include: A review of the facility policy titled Routine Reconciliation of Controlled Substances, last reviewed by the facility on June 5, 2026, revealed that the facility will maintain separate controlled substance records for all Schedule II medications and other medications with a potential for abuse or diversion through the use of a Controlled Substance Declining Inventory Record. The policy further revealed that incoming nurses (the nurses beginning a shift and accepting responsibility for resident care and medication accountability) and outgoing nurses (the nurses ending a shift and transferring responsibility for resident care and medication accountability to the next shift) are responsible for jointly counting all Schedule II controlled substances and other medications at risk for abuse or diversion at each shift change and documenting that the count was verified as accurate. A review of the clinical record revealed Resident 35 was admitted to the facility on [DATE], with diagnoses that included dementia (a progressive decline in memory, thinking, and reasoning abilities that interferes with daily functioning) and chronic obstructive pulmonary disease (COPD, a chronic lung disease that restricts airflow and makes breathing difficult). A review of physician orders revealed an order dated February 9, 2026, for hydrocodone-acetaminophen 5/325 milligrams, a narcotic pain medication. A narcotic is a controlled substance. A controlled substance is a medication regulated by federal law because it has the potential for misuse, abuse, diversion, dependence, or addiction and therefore requires strict inventory controls and accurate recordkeeping. The order directed staff to administer the medication every six hours as needed for a pain scale of 4 through 10. A pain scale is a standardized tool used to measure the intensity of pain, typically on a scale from 0 to 10, with higher numbers indicating more severe pain. A review of facility records revealed the facility utilized a Controlled Substance Record to track the receipt, administration, and remaining inventory of controlled medications, including hydrocodone. A review of the Medication Administration Record (MAR) revealed the MAR documents the medication administered, date and time of administration, staff administering the medication, pain assessment, and reason for administration. A comparison of Resident 35's Controlled Substance Record and February 2026 MAR revealed discrepancies between the number of doses removed from controlled substance inventory and the number of doses documented as administered. The Controlled Substance Record indicated hydrocodone was removed from inventory on eight occasions. However, only four administrations were documented on the MAR. The MAR lacked documentation that the medication was administered on the following occasions despite the medication being removed from the controlled substance inventory:February 2, 2026, at 10:30 AM;February 7, 2026, at 12:33 PM;February 11, 2026, at 1:00 PM; andFebruary 12, 2026, at 9:30 PM. Observation of the A Hall medication cart on June 14, 2026, at 9:53 AM revealed the facility failed to consistently complete controlled substance shift count documentation used to verify the accuracy of controlled substance inventories at the change of shift. Specifically, the controlled substance count records lacked required signatures indicating that incoming and outgoing nurses verified the accuracy of the controlled substance count on the following dates:March 12, 2026, the outgoing evening shift nurse failed to sign that the controlled substance count was verified as accurate.March 16, 2026, the incoming day shift nurse failed to sign that the controlled substance count was verified as accurate.March 17, 2026, the outgoing evening shift nurse failed to sign that the controlled substance count was verified as accurate.March 18, 2026, the incoming day shift nurse failed to sign that the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	controlled substance count was verified as accurate.March 18, 2026, the outgoing evening shift nurse failed to sign that the controlled substance count was verified as accurate.March 22, 2026, the incoming night shift nurse failed to sign that the controlled substance count was verified as accurate.March 23, 2026, the incoming nurse and outgoing nurse assigned to the day shift failed to sign that the controlled substance count was verified as accurate.March 25, 2026, the outgoing evening shift nurse failed to sign that the controlled substance count was verified as accurate.April 1, 2026, the outgoing evening shift nurse failed to sign that the controlled substance count was verified as accurate.April 2, 2026, the incoming day shift nurse failed to sign that the controlled substance count was verified as accurate.April 3, 2026, the outgoing night shift nurse failed to sign that the controlled substance count was verified as accurate.April 7, 2026, the outgoing night shift nurse failed to sign that the controlled substance count was verified as accurate.April 9, 2026, the outgoing night shift nurse failed to sign that the controlled substance count was verified as accurate.April 12, 2026, the incoming nurse and outgoing nurse assigned to the evening shift failed to sign that the controlled substance count was verified as accurate.April 13, 2026, the outgoing night shift nurse failed to sign that the controlled substance count was verified as accurate.April 13, 2026, the incoming day shift nurse failed to sign that the controlled substance count was verified as accurate.April 30, 2026, the incoming night shift nurse failed to sign that the controlled substance count was verified as accurate.May 5, 2026, the incoming evening shift nurse failed to sign that the controlled substance count was verified as accurate.May 7, 2026, the incoming day shift nurse failed to sign that the controlled substance count was verified as accurate.May 9, 2026, the outgoing evening shift nurse failed to sign that the controlled substance count was verified as accurate.May 14, 2026, the outgoing night shift nurse failed to sign that the controlled substance count was verified as accurate.May 31, 2026, the incoming evening shift nurse failed to sign that the controlled substance count was verified as accurate.June 6, 2026, the incoming night shift nurse failed to sign that the controlled substance count was verified as accurate.The observation conducted on June 14, 2026, at 9:53 AM revealed the incoming day shift nurse signed the controlled substance count record indicating the count was verified for both the incoming day shift and the outgoing 11:00 PM shift. The documentation reflected verification of the outgoing shift count before the end of that shift and prior to the actual shift change, creating inaccurate controlled substance accountability documentation. An interview conducted on June 16, 2026, at 1:00 PM with the Director of Nursing and Nursing Home Administrator reviewed the above findings related to the facility's failure to implement effective procedures to reconcile, monitor, and account for controlled substances administered to Resident 35. A review of the clinical record revealed Resident 98 was admitted to the facility on [DATE], with diagnoses that included osteoarthritis (a degenerative joint disease caused by the breakdown of cartilage and changes in the underlying bone) and rheumatoid arthritis (an autoimmune disease in which the body's immune system attacks the joints, causing inflammation, pain, and joint damage). A review of Resident 98's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 20, 2026, revealed that Resident 98 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 0-7, indicates severe cognitive impairment indicating significant difficulty with basic memory tasks, recognizing the date, or recalling recent information). A review of the facility policy, Medication Shortages/ Unavailable Medications, last reviewed June 5, 2026, indicates that upon discovery there is an inadequate supply of medication, the facility should immediately notify the pharmacy. If the medication is unavailable through the emergency medication supply, and an emergency delivery of the medication is not possible, the facility nurse should contact the attending physician to obtain new orders or directions for alternate administration. A review of the Resident 98's physician's orders includes an order for Prolia (denosumab, a medication that helps strengthen bones by slowing down the process that breaks them (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	down), dated October 22, 2025. The order directed administration on the 22nd day of every sixth month. A review of nursing progress notes dated April 22, 2026, at 12:47 PM revealed the medication was unavailable and the pharmacy had been contacted. The note indicated the medication would be delivered with the next pharmacy delivery scheduled for April 25, 2026. This resulted in a three-day delay in administration of the medication ordered. The clinical record failed to reveal documentation that the attending physician was notified of the delay in medication administration or consulted regarding alternate treatment instructions as required by facility policy. During an interview on June 16, 2026, at 10:57 AM, the Nursing Home Administrator and Director of Nursing confirmed the pharmacy did not have the medication available, including within the emergency medication supply, and that the medication had to be ordered, resulting in a three-day delay in availability. The Nursing Home Administrator and Director of Nursing further confirmed it is the facility's responsibility to implement procedures that promote timely medication administration and physician notification when medications cannot be administered as ordered. 28 Pa Code 211.9(a)(1)(k) Pharmacy services. 28 Pa Code 211.10 Resident care policies. 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on a review of scheduled facility mealtimes, facility policy, resident interviews, and staff interview, it was determined that the facility failed to consistently offer nourishing evening snacks when the scheduled time between dinner and breakfast exceeded 14 hours for residents residing on four nursing units. This deficient practice affected six of six residents who participated in a resident council interview (Residents 48, 95, 39, 33, 75, and 69).Findings include: A review of the facility policy titled Meal Times and Frequency Policy, last reviewed by the facility on June 5, 2026, revealed it is the facility policy that there will be no more than 14 hours between a substantial evening meal (dinner) and breakfast the following day; except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal (dinner) and breakfast the following day if a resident group agrees to this meal span. A review of the facility's scheduled meal service times revealed that the time between dinner and breakfast exceeded 14 hours on all nursing units reviewed. Residents residing in North Nursing Unit Area 1 were scheduled to receive dinner at 4:40 PM and breakfast at 7:10 AM the following day, resulting in a meal interval of 14 hours and 30 minutes. Residents residing in North Nursing Unit Area 2 were scheduled to receive dinner at 5:00 PM and breakfast at 7:20 AM the following day, resulting in a meal interval of 14 hours and 20 minutes. Residents residing in South Nursing Unit Area 1 were scheduled to receive dinner at 4:50 PM and breakfast at 7:15 AM the following day, resulting in a meal interval of 14 hours and 25 minutes. Residents residing in South Nursing Unit Area 2 were scheduled to receive dinner at 5:15 PM and breakfast at 7:30 AM the following day, resulting in a meal interval of 14 hours and 15 minutes. During a resident council interview on June 15, 2026, at 10:00 AM, six of six residents interviewed (Residents 48, 95, 39, 33, 75, and 69) stated that evening snacks were not consistently offered. During an interview on June 15, 2026, at 2:00 PM, the Nursing Home Administrator (NHA) stated that it was the facility's practice to offer residents nourishing evening snacks. However, the NHA was unable to provide documentation or other evidence demonstrating that evening snacks were consistently offered to residents. 28 Pa. Code 211.12 (d)(3)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395493	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Julia Ribaudo Extended Care Center	1404 Golf Park Drive Lake Ariel, PA 18436

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, medication administration records, and staff interview, it was determined the facility failed to document the use of non-pharmacological interventions prior to the administration of an as needed psychotropic medication and failed to obtain and document a clinical rationale to support continuation of the psychotropic medication beyond the federally permitted 14-day period for one of 20 residents reviewed (Resident 98).Findings include: Federal requirements for the use of psychotropic medications expect that psychotropic medications are used only when necessary to treat a specific, documented condition. A PRN (as needed) psychotropic medication order is limited to 14 days unless the prescribing practitioner documents the clinical rationale for extending the order and specifies the duration of the extension. Non-pharmacological interventions are approaches that do not involve medications, such as reassurance, redirection, environmental modifications, distraction techniques, or comfort measures. When clinically appropriate, these interventions should be attempted and documented prior to administering a PRN psychotropic medication. A review of the facility's policy titled Psychoactive Medication Policy reviewed June 5, 2026, indicated that all residents receiving psychoactive medications will have their behaviors, effectiveness of interventions (pharmacological and non-pharmacological) and potential for a gradual dose reduction of psychoactive medication monitored and documented. The policy further revealed that individualized non-pharmacological approaches are provided as part of a supportive physical and psychological environment and are directed toward preventing, relieving, or accommodating a resident's distressed behavior. Clinical record review revealed Resident 98 was admitted on [DATE], with diagnoses including asthma (a chronic condition that causes inflammation and narrowing of the airways) and chronic obstructive pulmonary disease (COPD, a progressive lung disease that limits airflow and makes breathing difficult). A review of Resident 98's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 20, 2026, revealed that Resident 98 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 0-7 indicates severe cognitive impairment including significant difficulty with basic memory tasks, recognizing the date, or recalling recent information). Review of physician orders revealed an order dated September 29, 2025, for Lorazepam 0.25 milligrams (a psychotropic medication classified as an anti-anxiety medication used to reduce symptoms of anxiety or agitation) every six hours PRN for anxiety. Review of the Medication Administration Record (MAR) revealed 0.25mg was administered on the following dates and times: September 29, 2026, at 11:03 PMOctober 1, 2025, at 6:38 PMOctober 2, 2025, at 9:39 PMOctober 5, 2025, at 5:28 PMOctober 9, 2025, at 1:35 AMNovember 1, 2025, at 5:53 PMNovember 6, 2025, at 00:45 AM Review of the clinical record failed to identify documentation that non-pharmacological interventions were attempted or ineffective prior to administration of the PRN psychotropic medication on any of the seven occasions. As a result, the facility could not demonstrate that less restrictive interventions were considered before the medication was administered. A review of the clinical record failed to identify documentation from the prescribing practitioner providing a clinical rationale to support continuation of the PRN Lorazepam order beyond 14 days, nor did the record identify a documented duration for the extension of the order as required by federal regulations. During an interview on June 15, 2026, at 12:30 PM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) confirmed the clinical record did not contain documentation of non-pharmacologic interventions prior to the administration of the psychotropic medication on the seven identified occasions and lacked documented clinical justification supporting (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	continuation of the PRN psychotropic medication beyond 14 days. 28 Pa. Code 211.2(3) Medical director. 28 Pa. Code 211.5(ii)(xi) Clinical records. 28 Pa. Code 211.8(e) Use of restraints. 28 Pa. Code 211.9(1) Pharmacy services. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (d)(1)(2)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 interviews, it was determined the facility failed to provide nursing services consistent with professional standards of quality by failing to ensure licensed nurses administered medications in accordance with physician-ordered parameters for one of 20 residents reviewed (Resident 38).Findings include: A review of the facility policy titled Administering Medications last reviewed on June 5, 2026, revealed that medications are administered as prescribed in a safe, timely manner. Medications are administered in accordance with prescriber orders, and information is verified prior to administering medication including vital signs (measurements of basic body functions such as blood pressure, pulse, temperature, and breathing), are verified prior to administering medications when specific parameters are ordered. A review of the clinical record revealed Resident 38 was admitted to the facility on [DATE], with diagnoses to include hypotension (low blood pressure). A review of Resident 38's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 29, 2026, revealed that Resident 38 was moderately cognitively impaired with a BIMS score of 11 (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 through 12 indicates moderate cognitive impairment). A review of the physician's order dated January 26, 2026, directed staff to administer Midodrine HCl (medication used to treat low blood pressure) 5 milligrams (mg) orally three times a day. The physician's order specified to hold (not give) the medication if the systolic blood pressure (top number in a blood pressure reading, representing pressure when the heart contracts) was greater than 120 millimeters of mercury (mm/Hg). A review of the May 2026 and June 2026 Medication Administration Records (MARs), the legal documents used to record medication administration, revealed nursing staff administered Midodrine HCl on 15 occasions despite documented systolic blood pressure readings exceeding the physician-ordered hold parameter of 120 mm/Hg. These administrations included: May 15, 2026, at 12:00 PM, systolic blood pressure 150/80 mm/Hg;May 16, 2026, at 6:00 PM, systolic blood pressure 134/68 mm/Hg;May 17, 2026, at 12:00 PM, systolic blood pressure 144/76 mm/Hg;May 18, 2026, at 12:00 PM, systolic blood pressure 150/82 mm/Hg;May 21, 2026, at 12:00 PM, systolic blood pressure 142/68 mm/Hg;May 23, 2026, at 12:00 PM, systolic blood pressure 158/82 mm/Hg;May 24, 2026, at 12:00 PM, systolic blood pressure 146/76 mm/Hg;May 25, 2026, at 12:00 PM, systolic blood pressure 142/90 mm/Hg;May 27, 2026, at 12:00 PM, systolic blood pressure 126/80 mm/Hg;June 7, 2026, at 12:00 PM, systolic blood pressure 130/82 mm/Hg;June 10, 2026, at 12:00 PM, systolic blood pressure 130/82 mm/Hg;June 11, 2026, at 12:00 PM, systolic blood pressure 136/90 mm/Hg;June 12, 2026, at 6:00 AM, systolic blood pressure 126/68 mm/Hg;June 12, 2026, at 12:00 PM, systolic blood pressure 130/82 mm/Hg; andJune 13, 2026, at 6:00 AM, systolic blood pressure 137/80 mm/Hg. These records revealed nursing staff administered Midodrine HCl despite documented blood pressure readings that exceeded the physician's ordered parameter requiring the medication to be withheld. An interview with the Nursing Home Administrator and Director of Nursing on June 15, 2026, at 1:30 PM reviewed the above findings related to the facility's failure to ensure nursing staff administered blood pressure medications according to physician ordered parameters. 28 Pa. Code 211.9 (a)(1)(d) Pharmacy services. 28 Pa Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observations, clinical record review, and resident and staff interviews, it was determined the facility failed to ensure residents with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility for one of 20 residents reviewed (Resident 84). Findings Include: Review of the clinical record revealed Resident 84 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the left dominant side. Hemiplegia is paralysis of one side of the body. Hemiparesis is weakness on one side of the body. A cerebral infarction is a stroke caused by an interruption of blood flow to an area of the brain. A review of a quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 28, 2026, revealed that Resident 84 was severely cognitively impaired with a BIMS score of 7 (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 0-7 indicates cognition is severely impaired). Review of Resident 84's Occupational Therapy (OT) evaluation dated May 12, 2026, revealed that OT observed a contracture (the permanent shortening or tightening of muscles, tendons, ligaments, or joints that restricts normal movement and range of motion) to the residents left hand during an assessment and believed a palm guard to the resident's left hand would prevent further contracture. Review of current physician orders revealed an order dated May 12, 2026, directing staff to apply a left palm guard in the morning and remove it in the evening. Review of the resident's current care plan revealed an intervention initiated May 12, 2026, directing staff to apply a left palm splint to prevent worsening contracture, remove the device in the evening, and perform skin checks each shift beneath the device. Observation of Resident 84 in the dining room on June 15, 2026, at 11:30 AM revealed the resident's left hand was positioned beneath her shirt. Upon request from the surveyor, Resident 84 removed her left hand from beneath her shirt. Observation revealed the physician-ordered left palm guard/splint was not in place. Resident 84 was able to partially open her left hand; however, observation revealed contracture of the left hand. Review of the resident's Point of Care History, which documents care and services provided to the resident, for May 2026 and June 2026, revealed repeated documentation indicating the splint intervention was not performed. Specifically, documentation revealed the following: On May 13, 2026, documentation indicated for the evening shift reflected not performed.On May 14, 2026, documentation indicated for the evening shift reflected not performed.On May 15, 2026, documentation indicated for the day shift reflected not performed.On May 18, 2026, documentation indicated for the day, and evening shift reflected not performed.On May 19, 2026, documentation indicated for the day, and evening shift reflected not performed.On May 20, 2026, documentation indicated for the day, and evening shift reflected not performed.On May 21, 2026, documentation indicated for the day, and evening shift reflected not performed.On May 24, 2026, documentation indicated for the day shift reflected not performed.On May 29, 2026, documentation indicated for the evening shift reflected not performed.On May 31, 2026, documentation indicated for the evening shift reflected not performed.On June 3, 2026, documentation indicated for the day, and evening shift reflected not performed.On June 6, 2026, documentation indicated for the day shift unanswered and evening shift reflected not performed.On June 8, 2026, documentation indicated for the day, and evening shift reflected not performed.On June 10, 2026, documentation indicated for the day, and evening shift reflected not performed.On June 12, 2026, documentation indicated for the evening shift reflected not performed.On June 14, 2026, documentation indicated for the day shift reflected not performed.On June 15, 2026, documentation indicated for the day shift reflected not performed. Review of the Point of Care History revealed incomplete and conflicting documentation regarding splint application, including blank entries and (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	multiple entries indicating the intervention was not performed. On June 15, 2026, the same date the surveyor observed the resident without the splint in place, Point of Care documentation indicated the splint intervention was not performed during the day shift. During an interview on June 15, 2026, at 1:30 PM the Director of Nursing was unable to provide documented evidence demonstrating the physician-ordered palm guard intervention was consistently implemented as ordered. 28 Pa. Code: 211.5(f)(i)(ii) Medical records. 28 Pa Code 211.12 (c)(d)(5) Nursing services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, review of facility policy, and staff interview, it was determined that the facility failed to ensure oxygen was administered in accordance with physician orders for one of 20 residents reviewed (Resident 98).Findings include: A review of the facility policy titled Oxygen Administration, last reviewed by the facility on June 5, 2026, revealed it is the facility's policy to administer oxygen by the route and at the rate ordered by the provider. Clinical record review revealed Resident 98 was admitted to the facility on [DATE], with diagnoses that included asthma (a chronic condition in which the airways become inflamed and narrowed, making breathing difficult) and chronic obstructive pulmonary disease (COPD, a progressive lung disease that limits airflow and makes breathing difficult). A review of Resident 98's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 20, 2026, revealed that Resident 98 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 0-7 indicates severe cognitive impairment indicating significant difficulty with basic memory tasks, recognizing the date, or recalling recent information). Clinical record review revealed a physician order dated April 18, 2024, directing oxygen administration at two liters per minute (L/min) via nasal cannula (a device consisting of small prongs placed in the nostrils to deliver supplemental oxygen). Observation on June 14, 2026, at 9:43AM revealed Resident 98 was asleep in bed with oxygen in use through a nasal cannula. The oxygen tubing connected the nasal cannula to an oxygen concentrator (a machine that filters room air and delivers concentrated oxygen). Observation of the concentrator revealed the oxygen flow rate was set at 4.5 L/min. During an interview on June 14, 2026, at 11:16 a.m., Employee 1, Licensed Practical Nurse (LPN), confirmed Resident 98's physician order directed oxygen administration at 2 L/min. Employee 1 observed the oxygen concentrator setting and adjusted the flow rate from 4.5 L/min to 2 L/min. The above information was reviewed during an interview on June 15, 2026, at 12:30 PM, with the facility Director of Nursing and Nursing Home Administrator (NHA). 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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, laboratory reports, facility policy, and staff interviews, it was determined the facility failed to ensure a resident was free from unnecessary medication by administering an antibiotic without documented clinical evidence supporting an active infection for one of 20 residents reviewed (Resident 97).Findings Include:A review of Resident 97's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included epilepsy (a chronic neurological disorder characterized by recurring seizures) and parkinsonism (a group of neurological disorders that cause movement problems such as tremors, stiffness, and slowed movement). A review of the facility policy titled Antimicrobial Stewardship Program Policy, last reviewed by the facility on June 6, 2026, revealed antibiotics should be prescribed only when clinical evidence supports the presence of an active infection. The policy further revealed appropriate indications for antibiotic use include meeting established clinical criteria for an active infection. The policy indicated that prescribers should provide complete antibiotic orders, including the medication name, dose, duration of treatment, and indication for use. The facility utilized McGeer's Criteria Checklist to determine whether residents met evidence-based criteria for the initiation of antibiotic therapy. McGeer's Criteria is a standardized surveillance tool used in long-term care facilities to identify signs and symptoms consistent with infection and to support appropriate antibiotic use. A review of a physician's order dated April 27, 2026, revealed an order for Macrobid 100 milligrams (an antibiotic medication) to be administered twice daily for five days for a urinary tract infection (UTI, an infection involving the urinary system). A review of Resident 97's clinical record failed to identify documentation of signs or symptoms supporting a urinary tract infection prior to the initiation of antibiotic therapy. Specifically, the clinical record failed to identify documented fever (an elevated body temperature that may indicate infection), dysuria (pain or burning during urination), urinary urgency (a sudden need to urinate), urinary frequency (urinating more often than usual), suprapubic pain (pain in the lower abdomen over the bladder), flank pain (pain in the side or back near the kidneys), rigors (episodes of shaking chills), acute mental status changes, or other documented clinical findings supporting the presence of an active urinary tract infection. A review of Resident 97's clinical record failed to identify a completed McGeer's Criteria Checklist or other documentation demonstrating the resident met the facility's established criteria for antibiotic treatment prior to the initiation of therapy. A review of Resident 97's April 2026 Medication Administration Record revealed the resident received four doses of Macrobid. A review of a urinalysis with culture report (a report used to check if a resident has an active infection, the culture report is a two-part test used to detect, identify, and determine the treatment for urinary tract infections.) dated April 27, 2026, at 3:40PM, revealed minimal bacterial growth consisting of mixed normal urogenital skin microbiota, which are bacteria commonly found on the skin and genital area and are generally not indicative of a urinary tract infection. Further review revealed the provider reviewed the urine culture results on April 30, 2026. The culture findings did not support the presence of a urinary tract infection, and the provider subsequently discontinued the antibiotic. During an interview on June 15, 2026, at 11:00 AM, the Infection Preventionist stated Resident 97 met McGeer's Criteria for antibiotic use. However, the facility was unable to provide documentation of signs or symptoms supporting an active urinary tract infection or documentation demonstrating the resident met McGeer's Criteria prior to the initiation of antibiotic therapy. The facility failed to ensure Resident 97 was free from unnecessary antibiotic use by initiating and administering an antibiotic without documented clinical evidence of an active infection and without documentation supporting that the resident met the facility's established criteria for antibiotic treatment prior to initiation of therapy. As a result, Resident 97 received four doses of an antibiotic before the urine culture results were reviewed and the medication was discontinued. During an interview on June 16, 2026, at 1:00 PM, the above findings were review with (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Director of Nursing. 28 Pa. Code 211.2(d)(3)(5) Medical Director. 28 Pa. Code 211.12(d)(3)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of select facility policy, and staff interviews, it was determined the facility failed to adhere to acceptable storage and labeling practices for multi-dose medications for two of two medication carts observed (A Hall and B Hall medication carts).Findings include: Review of the facility policy titled Storage and Expiration Dating of Medications and Biologicals last reviewed by the facility [DATE], indicated that multi-use medication vials or bottles that have been opened or accessed (e.g. seal broken) are to be labeled with the date they were opened to ensure proper tracking for expiration purposes. An observation of the medication cart located on A hall unit on [DATE], at 8:56 AM, in the presence of Employee 2 RN (Registered Nurse) of the medication stored in the medication cart, revealed one (1) multi-dose insulin pen of Insulin glargine (a long acting insulin medication used to lower blood sugar) and one (1) multi-dose pen of Insulin Aspart (a fast short acting insulin medication used to lower blood sugar), and one (1) Insulin Lispro (a fast acting insulin medication used to lower blood sugar) that had been opened and available for resident use, but not dated when initially opened. Review of manufacturer safety information revealed the multi-dose pens of Insulin are to be discarded 28 days after opening and available for resident use. An interview with Employee 2 RN on [DATE], at 8:59 AM, confirmed all three (3) multi dose insulin pens, one (1) Insulin Aspart, one (1) Insulin Glargine and one (1) Insulin Lispro were opened, available for use, currently being used for administration, and not dated when initially opened. An observation of the medication cart located on B hall unit on [DATE], at 9: 53 AM, in the presence of Employee 1 LPN (Licensed Practical Nurse) revealed one (1) multi-dose insulin pen of SoloStar insulin (prefilled insulin pen containing a long-acting insulin that works steadily over 24 hours without big peaks or drops in effect) with an expiration date of [DATE] and one (1) vial of Insulin Lispro that had been opened and available for use, but not dated when initially opened. An interview with Employee 1 (LPN) on [DATE], at 9:55 AM, confirmed the one multi dose insulin pen of Solostar insulin was expired, and one (1) Insulin vial Lispro was not dated when initially opened. Both medications were being stored in the medication cart, and currently being used for administration. Interview with Director of Nursing and the Nursing Home Administrator on [DATE], at 01:00PM, reviewed the above findings of the facility's failure to ensure staff date each insulin when opened, to ensure the medication was not used passed the expiration date. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services