STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395518	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Gardens Nursing and Rehab Ctr	999 West Harrisburg Pike Middletown, PA 17057

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 clinical record review and staff interviews, it was determined that the facility failed to provide the highest practical well-being by not following physician orders as well as involve the physician in treatment changes for one of two residents reviewed (Resident 2).Findings include:Review of Resident 2's clinical record revealed diagnoses that included respiratory failure (a condition where the lungs cannot get enough oxygen into the blood) and hypertension (high blood pressure).Review of Resident 2's clinical record revealed the Resident was admitted to the facility on [DATE], with an abdominal fistula (an abnormal opening between the intestines or stomach and another organ or the skin, causing leakage of digestive fluids) which is covered with a colostomy bag (a discreet, odor-proof, disposable pouching system that collects waste from the body).Review of Resident 2's current physician orders revealed an active order for abdominal fistula care, cleanse all abdomen area and fistula site, apply the zinc oxide mixed with A&D ointment (vitamin A & D topical ointment) all over abdomen and around fistula site, then apply pantie liner or exu-dry (multi-layered wound dressing) over top of the fistula, then apply brief on top and secure. Make sure ruff tabs on brief are not touching skin, change as much as needed or when soiled, aides are allowed to check and change once shown how to apply, every shift for fistula care, with a start date of January 14, 2026. Further review of Resident 2's January 2026 TAR (Treatment Administration Record) revealed that the order above was signed off as being completed during the day, evening, and night shift by staff. Review of Resident 2's January 2026 TAR revealed an order for abdominal fistula - change Tuesday, Friday, and as needed (prn) for leaking, cleanse site with wound cleanser and apply skin prep to peri wound, place ostomy device and wafer over fistula site. Please use ostomy belt with device to assist with adherence, wear belt at all times, every day shift, with a start date of January 6, 2026, and a discontinued date of January 9, 2026.Further review of Resident 2's January 2026 TAR revealed an order for abdominal fistula care - cleanse all abdominal area and fistula site, apply the zinc oxide ointment all over abdomen and around fistula site. Then apply pantie liner over top of the fistula. Peel off back of liner then apply brief of top, press down until liner sticks to brief. Then roll Resident and secure brief around back. Make sure ruff tabs on brief are not touching skin. Change as much as needed or when soiled. Aides are allowed to check and change once shown how to apply, every shift for fistula care, with a start date of January 9, 2026, and a discontinued date of January 14, 2026.Review of Resident 2's current care plan failed to include a focus area for their abdominal fistula care or any interventions related to it.Review of Resident 2's clinical record revealed a Health Status Note on January 16, 2026, at 8:58 PM, that indicated fistula care was completed and a colostomy bag was applied.Review of Resident 2's clinical record revealed a Health Status Note on January 17, 2026, at 3:42 AM, that indicated Resident 2's abdominal fistula was covered with a colostomy bag.Review of Resident 2's clinical record revealed an Order-Administration note on January 17, 2026, at 4:10 PM, that Resident 2 had a colostomy (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
	395518	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Gardens Nursing and Rehab Ctr	999 West Harrisburg Pike Middletown, PA 17057

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	appliance at that time.Review of Resident 2's clinical record revealed a Health Status note on January 18, 2026, at 4:17 AM, that the Resident had a colostomy bag attached to fistula, which had been checked hourly to ensure the appliance is intact.Review of Resident 2's clinical record revealed a Health Status note on January 19, 2026, at 4:02 AM, that the Resident's colostomy bag was intact.Review of Resident 2's clinical record revealed a Health Status note on January 19, 2026, at 11:50 PM, that incontinent care was provided and a new colostomy pouch was applied.Review of Resident 2's clinical record revealed a Health Status note on January 20, 2026, at 2:09 AM, that indicated the Resident's abdominal fistula was covered with a colostomy bag.During an interview with the Director of Nursing (DON) on January 20, 2026, at 1:40 PM, she confirmed that nurse aides received verbal and hands on training and education on how to complete the current physicians order for Resident 2's abdominal fistula care and were administering the treatment as ordered to Resident 2. However, the DON was unable to provide where they were documenting when they completed the treatment. DON stated they would have documented the treatment administered under the Resident's bowel and bladder - bowel elimination task , however upon review of the task, the treatment ordered was not an option to document.Further interview with the DON on January 20, 2026, at 2:00 PM, she revealed that she thought Resident 2's colostomy bag appliance had just started up again on January 19, 2026. The DON revealed that she was unsure where it was being documented in the Resident's clinical record when nurse aides are administering abdominal fistula care to Resident 2 as they are not able to document in the TAR and there was not a task in the Resident's record to indicate if fistula care was completed.During an interview with Employee 1 (Wound Nurse) on January 20, 2026, at 2:07 PM, revealed that when Resident 2 was initially admitted to the facility, the Resident was admitted with a colostomy bag to cover their fistula; however, the colostomy bag was never staying on and had liquidy stool coming out of the fistula, so the facility was trying different methods on keeping the Resident's fistula covered. Employee 1 acknowledged there was not currently an order in place for Resident 2 to have a colostomy bag and will put a PRN order in place. Employee 1 revealed that all of the nurses in the facility have discussed Resident 2's situation and determined the best situation is to have the colostomy appliance on so the smell is contained, but that it has not stayed on, so they were doing whatever was working best at the time care was provided to the Resident.Employee 1 revealed that they do not have documentation to prove when staff are applying an ostomy bag to Resident 2 and, as per the current active order, there was nowhere for nurse aides to document when they are administering abdominal fistula care to Resident 2.During an interview with the DON on January 20, 2026, at approximately 2:15 PM, she revealed that she would expect staff to be providing care to Resident 2 as ordered by the physician, and would expect staff to be documenting each time abdominal fistula care is being provided to Resident 2, including when nurse aides are administering the care as ordered.42 CFR 483.25 Quality of care28 Pa. Code 211.12(d)(1)(3)(5)Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395518	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Gardens Nursing and Rehab Ctr	999 West Harrisburg Pike Middletown, PA 17057

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of select facility documentation, and staff interview, it was determined that the facility failed to implement interventions to ensure resident safety during transport, which resulted in actual harm as evidenced by an ankle fracture for one of four residents reviewed (Resident 1).Findings include:Review of Resident 1's clinical record revealed diagnoses that included chronic atrial fibrillation (a long-lasting, irregular heartbeat) and diabetes (when the body doesn't produce enough insulin).Review of Resident 1's care plan revealed a focus area related to the Resident's activities of daily living (ADL) self-care deficit related to impaired cognition, muscle weakness, and decreased mobility. Further review revealed an intervention that the Resident required assistance of one staff for locomotion on the unit in a wheelchair, and for staff to make sure the Resident's feet sit comfortably on footrest, initiated on January 23, 2023.Further review of Resident 1's care plan revealed a focus area related to the Resident being at risk for falling related to balance deficit, history of multiple falls, impaired cognition, and muscle weakness. Further review revealed an intervention that when pushing the Resident in her wheelchair, make sure footrests are in place. Remove footrests when not pushing so that she can self-propel, initiated on March 13, 2024.Review of Resident 1's clinical record revealed a Health Status Note written by Employee 2 (Licensed Practical Nurse) on April 14, 2025, at 2:32 PM, that stated Resident 1 returned to the facility after a leave of absence and was being pushed in the hallway by a transport company in her wheelchair. Resident 1 dropped her right foot and it went under the wheelchair. The Resident was heard calling out. No redness or swelling was noted at the time. Further review of Resident 1's clinical record revealed a Health Status Note written on April 14, 2025, at 9:40 PM, that Resident 1 was complaining of pain in her right ankle and was administered Tylenol for pain. There was swelling and redness noted on the right ankle, and the ankle was wrapped with ace bandage and ice was applied. Further review of the clinical record revealed no evidence that the physician was made aware. On April 15, 2025, at 1:27 AM, there was a Health Status Note that revealed Resident 1 was complaining of pain in her right ankle, with the area slight warmth to tough, slightly swollen and sensitive. The nurse practitioner was made aware and anew order was received for an x-ray of the right ankle.On April 15, 2025, at 7:03 AM, there was a Health Status Note that revealed Resident 1 was continuing to experience pain on the right ankle, and pain medications were administered with little effect.Review of the x-ray report dated April 15, 2025, at 9:15 AM, revealed the presence of a right bimalleolar ankle fracture.On April 15, 2025, at 11:27 AM, the physician was made aware of the xray results and ordered for the Resident to be sent to the orthopedic walk in clinic that day (4/15/2025). The facility received a call from the orthopedic walk in clinic at 3:00 PM that stated Resident 1's fracture will require surgery and she needed sent to the hospital emergency room. Review of Resident 1's physician's progress note on April 24, 2025, at 4:58 PM, revealed that Resident 1 was hospitalized from [DATE] through 24, 2025, due to her ankle fracture and required surgery to fix it.During an interview with the Director of Nursing (DON) on January 20, 2026, at 1:28 PM, she revealed that on April 14, 2025, Resident 1 was leaving the facility for an appointment, and the facility's main transportation was overbooked so they used an outside company to transport the Resident. The transportation company did not notify the facility that they were picking the Resident up and, when she returned, the transportation company was wheeling Resident 1 down the hallway and she dropped her feet and got caught under her wheelchair. The DON confirmed Resident 1 did not have her footrests on her wheelchair before leaving the facility or returning to the facility from her appointment. The DON revealed that the facility (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395518	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Gardens Nursing and Rehab Ctr	999 West Harrisburg Pike Middletown, PA 17057

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	reached out to the transportation company and completed education with them on notifying the facility when they are picking a resident up to ensure all interventions are in place prior to leaving and returning to the facility. The DON confirmed Resident 1 broke her ankle due to not having footrests on her wheelchair.The facility failed to use leg rests on Resident 1's wheelchair to assure Resident safety during transport, resulting in an ankle fracture.28 Pa. Code 201.18(b)(1)(e)(1) Management28 Pa. Code 211.10(c)(d) Resident care policies28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395518	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Gardens Nursing and Rehab Ctr	999 West Harrisburg Pike Middletown, PA 17057

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 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. Based on review of the clinical record, electronic hospital record review, and staff interview, it was determined that the facility failed to ensure pain management was provided in accordance with professional standards of practice for one of four residents reviewed (Resident 1), which resulted in actual harm to the Resident as evidenced by uncontrolled pain and subsequent hospitalization for pain management. Findings include:Review of Resident 1's clinical record revealed diagnoses that included chronic atrial fibrillation (a long-lasting, irregular heartbeat) and diabetes (when the body doesn't produce enough insulin).Review of Resident 1's clinical record revealed a Health Status Note written on March 31, 2025, at 4:18 AM, that the Resident was alert, and able to make her needs known.Review of Resident 1's April 2025 Medication Administration Record (MAR), revealed an order for Acetaminophen Tablet 325 mg, give 650 mg by mouth every 4 hours as needed for pain, max 3,000 mg within a 24-hour period, with a start date of February 18, 2025.Review of Resident 1's clinical record revealed a Health Status Note written by Employee 2 (Licensed Practical Nurse) on April 14, 2025, at 2:32 PM, that stated Resident 1 returned to the facility after a leave of absence and was being pushed in the hallway by a transport company in her wheelchair. Resident 1 dropped her right foot and it went under the wheelchair. The Resident was heard calling out. No redness or swelling was noted at the time. Review of Resident 1's April 2025 MAR revealed on April 14, 2025, at 3:53 PM, she had a pain level of 5 and was administered 650 mg of Acetaminophen.On April 14, 2025, at 7:15 PM, the Resident had a pain level of 5 and was administered 650 mg of Acetaminophen.Further review of Resident 1's clinical record revealed a Health Status Note written on April 14, 2025, at 9:40 PM, that Resident 1 was complaining of pain in her right ankle and was administered pain medication. There was swelling and redness noted on the right ankle, and the ankle was wrapped with ace bandage and ice was applied.There was no evidence that the physician was made aware of Resident 1 having pain.On April 15, 2025, at 1:27 AM, there was a Health Status Note that revealed Resident 1 was complaining of pain in her right ankle, with the area slight warmth to tough, slightly swollen and sensitive, and was ordered an x-ray view of the right ankle.There was no documentation indicating the physician was made aware of the Resident's pain. Further review of Resident 1's April 2025 MAR on April 15, 2025, at 4:16 AM, revealed the Resident had a pain level of 4 and was administered 650 mg of Acetaminophen.On April 15, 2025, at 7:03 AM, there was a Health Status Note that revealed Resident 1 was continuing to experience pain on the right ankle, and pain medications were administered with little effect. There was no evidence that the physician was made aware that Resident 1 experienced pain despite the prn (as needed) medications being ineffective, as well as no call was made for additional pain medications to be administered. Review of the x-ray report completed on April 15, 2025, at 9:15 AM, revealed the presence of a right bimalleolar ankle fracture.Further review of Resident 1's clinical record revealed a Health Status Note on April 15, 2025, at 11:27 AM, that the Resident would be taken at 1:30 PM to a walk-in orthopedic clinic on that day for her fractured ankle.On April 15, 2025, at 2:21 PM, there was a Health Status Note that revealed Resident 1 remained in bed that shift and voiced complaints of discomfort to her right lower extremity during repositioning and received routine pain medication at that time. There was no evidence of the physician being notified regarding Resident's 1 pain.On April 15, 2025, at 2:59 PM, there was a Health Status Note that revealed Resident 1 required surgery for her fractured ankle.Review of Resident 1's clinical record failed to reveal a physician's note or assessment about the Resident's pain.Review of Resident 1's electronic hospital records revealed she arrived at the Emergency Department (ED) on April 15, 2025, at 4:36 PM.Further review of Resident 1's hospital ED electronic records revealed that she was administered 4 mg (milligrams) of intravenous (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395518	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Gardens Nursing and Rehab Ctr	999 West Harrisburg Pike Middletown, PA 17057

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 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	(IV) morphine (a potent opioid analgesic used for acute, severe pain) on April 15, 2025, at 5:15 PM.Additionally, while in the ED the Resident also received 50 mcg (microgram) of IV fentanyl (a potent pain reliever used for rapid, short-acting pain relief) on April 15, 2025, at 7:42 PM.Review of the ED physician History and Physical note on April 15, 2025, revealed Resident 1 presented to the ED complaining of right ankle fracture, and reported that when she was in her wheelchair yesterday (April 14, 2025) she felt that she was falling out of it. The Resident stated that her ankle rolled underneath the wheelchair while it was being pushed forward and said that she had immediate pain to her right ankle.Review of Resident 1's ED physicians musculoskeletal exam completed on April 15, 2025, revealed the Resident was experiencing significant ankle pain. Further review of Resident 1's hospital ED record revealed the Resident required hospitalization for IV pain medications, sufficient pain control not achieved.Electronic mail received from the Director of Nursing on January 27, 2026, at 10:33 AM, revealed that she felt they were attentive to Resident 1's situation regarding managing their pain at the time of the incident. The facility failed to ensure pain management was provided in accordance with professional standards of practice for Resident 1, which resulted in actual harm to the Resident as evidenced by continued pain and subsequent hospitalization for pain management. 28 Pa. Code 211.12(d)(1) Nursing services.28 Pa. Code 211.12(d)(3) Nursing services.28 Pa. Code 211.12(d)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395518	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courtyard Gardens Nursing and Rehab Ctr	999 West Harrisburg Pike Middletown, PA 17057

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care for one of one resident reviewed (Resident 2).Findings include:Review of Resident 2's clinical record revealed diagnoses that included respiratory failure (a condition where the lungs cannot get enough oxygen into the blood) and hypertension (high blood pressure).Review of Resident 2's clinical record revealed the Resident was admitted to the facility on [DATE], with an abdominal fistula, which is covered with a colostomy bag.Review of Resident 2's current physician orders revealed an active order for abdominal fistula care, cleanse all abdomen area and fistula site, apply the zinc oxide mixed with A&D ointment (vitamin A & D topical ointment) all over abdomen and around fistula site, then apply pantie liner or exu-dry (multi-layered wound dressing) over top of the fistula, then apply brief on top and secure. Make sure ruff tabs on brief are not touching skin, change as much as needed or when soiled, aides are allowed to check and change once shown how to apply, every shift for fistula care, with a start date of January 14, 2026.Interview conducted with the Director of Nursing (DON) on January 20, 2026, at 1:40 PM, revealed that Employee 1 (Wound Nurse) conducted verbal training with nurse aides on how to administer Resident 2's order for abdominal fistula care above as it was not something they are used to doing and were initially fearful on completing the order to Resident 2. The DON revealed that nurse aides do things outside of their scope and practice sometimes, and nurse aides have told the DON they were uncomfortable completing the care to Resident 2. DON revealed that if a nurse aide told them they were not comfortable performing abdominal fistula care to Resident 2, they would have a nurse go in with them and would never force any one to administer the care if they did not feel comfortable. Interview conducted with Employee 1 on January 20, 2026, at 2:07 PM, revealed that she went over education verbally with nurse aides as well as provided hands on training on how to administer the order for Resident 2's abdominal fistula care above, but did not have any documentation of the training or education provided and did not have any signed documentation by the nurse aides who received the training.The facility failed to provide a list of nurse aides who completed training and any documentation indicating education and training was completed on how to administer Resident 2's abdominal fistula care order above.483.35 Nursing Services483.35(d) Proficiency of nurse aides