STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395533	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Ridge Senior Living at Windy Hill	100 Dogwood Drive Philipsburg, PA 16866

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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 store food items in a safe and sanitary manner and maintain equipment in a sanitary condition, in the main kitchen of the facility and store a prepared juice in a safe and sanitary manner during medication pass on one of three nursing units observed (first floor Cherry Blossom Lane). Findings include: Initial tour of the facility's main kitchen with Employee 10, dietary staff, on June 8, 2026, at 9:43 AM revealed the following: A tray holding various clean items and cups had a brown colored sticky substance and stains on the tray. A stack of green cups was observed laying in the substance. Coffee filters were stored in a plastic, clear container. The bottom of the container had an accumulation of coffee-ground appearing debris in the bottom of it. The exterior of the container was sticky to the touch near the base. There was a large bag of lettuce in a walk-in cooler that was open to the ambient air. There was extensive staining (appeared to be food splashes) to the ceiling and adjacent light fixture above the steam table area. Interview with kitchen staff revealed the dishwasher was a low-temperature sanitizing dishwasher. An observation of the dishwasher during the initial tour of the kitchen revealed a manufacturer's notice on the machine that indicated the wash temperature 120 degrees Fahrenheit minimum and the rinse temperature 120 degrees Fahrenheit minimum. Initial observation with Employee 10 of the dishwasher revealed that the temperature of the dishwasher observed at the exterior temperature gauge did not reach the minimum temperature of 120 degrees. A follow-up observation with Employee 11, director of dietary, of the dishwasher on June 8, 2026, at 1:45 PM, revealed that the dishwasher external temperature gauge starts at 120 degrees Fahrenheit and falls to 118 degrees Fahrenheit during the wash and rinse cycles. Employee 11 proceeded to measure the internal temperature of the machine during operation and the water in a front basin area utilizing a regular food/meat thermometer which indicated 122 degrees Fahrenheit. These concerns were concurrently reviewed with the Nursing Home Administrator. Review of the facility documentation titled, Dish machine Temperature/Sanitizer Log, dated for June 2026 and May 2026 revealed (in part) that temperatures are to be logged daily at each meal, wash temperature is between 120-140, and report any problems to production manager or director. The log noted that staff documented the following wash temperatures below the noted minimum temperature: June 1: Breakfast, lunch, and dinner wash temperatures at 100.June 2: Breakfast, lunch, and dinner wash temperatures at 100.June 3: Breakfast wash temperature at 115.June 4: Breakfast and lunch wash temperature at 109.June 6: Breakfast wash temperature at 115, dinner temperature at 100.June 7: Breakfast wash temperature at 106, lunch temperature at 110, and dinner temperature at, 100. May 8: Lunch wash temperature at 110.May 9: Lunch wash temperature at 110.May 10: Breakfast wash temperature at 110.May 15: Lunch wash temperature at 115.May 16: Breakfast wash temperature at 110.May 18: Dinner wash temperature at 100.May 19: Dinner wash temperature at 100.May 20: Dinner wash temperature at 100.May 21: Breakfast and lunch wash temperature at 115.May 23: Breakfast wash temperature at 115.May 24: Breakfast wash temperature at 110.May 25: Breakfast wash temperature at 112.May 29: Breakfast wash temperature at 110, lunch wash temperature at 110.May 30: Dinner wash temperature at 100.May 31: Dinner wash temperature at 100. There was no documentation to indicate that the (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	temperatures were reported to the production manager or director as instructed on the document. Review of the policy titled, Food Temperature Logs, noted (in part) that food temperatures of cold and hot items will be recorded on all menu items for meal service. The document noted that food temperatures must be recorded on all hot and cold foods by point of service on the Temperature and Meal Evaluation sheet. Review of the facility documentation titled, Food Temperature Log, for May 2026, revealed the following missing temperatures: May 7, 2026: missing food temperatures for breakfast and lunch. May 12, 2026: missing food temperatures for dinner. May 21, 2026: missing food temperatures for breakfast and lunch. A follow-up interview with Employee 11 on June 10, 2026, at 12:24 PM revealed that the facility could provide no further documentation on the missing temperatures. The above information was reviewed with the Nursing Home Administrator and Director of Nursing on June 10, 2026, at 2:00 PM. Observation during the medication pass on the first floor North Cherry Blossom Lane nursing unit on June 11, 2026, at 9:00 AM revealed a medication cart being utilized by Employee 9, licensed practical nurse. Employee 9 was observed mixing Miralax (a laxative medication) with orange juice from a plastic, clear juice pitcher. A label affixed to the side of the juice pitcher noted orange juice with the dates of 6/6/26 and 6/9/26. Employee 9 reported that the kitchen prepares the orange juice and based on the dates on the side of the container, the juice should be discarded. Employee 9 then proceeded to discard the prepared Miralax and prepare a new one with water. The above information related to the orange juice was discussed in a meeting with the Nursing Home Administrator on June 11, 2026, at 10:20 AM. 483.60(i) Food prepare, distribute, and serve -sanitary/safetyPreviously cited 7/10/25 28 Pa. Code 201.14(a) Responsibility of licensee

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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. Based on review of clinical records, and staff interview, it was determined that the facility failed to provide documentation that residents or resident representatives were given the opportunity to formulate an advance directive (a written instruction such as a living will or durable power of attorney for health care for when the individual is incapacitated) for six of 12 residents reviewed (Residents 7, 9, 10, 26, 38, and 46). Findings: Clinical record review for Resident 9 revealed an active physician's order dated March 13, 2026, indicating they were a full code (patient wishes to receive all possible life-saving interventions if their heart stops or they stop breathing). There was no evidence Resident 9 or the resident's responsible party were offered or assisted if needed in formulating an advance directive. Additional information regarding advanced directives for Resident 9 was requested during an interview with the Nursing Home Administrator and the Director of Nursing on June 9, 2026, at 2:15 PM, and again on June 10, 2026, at 2:15 PM, but no further information was provided. Clinical record review for Resident 26 revealed an active physician's order dated January 4, 2026, indicating they were a DNR (do not resuscitate, patient does not wish to receive any life-saving interventions if their heart stops or they stop breathing). There was no evidence Resident 26 or the resident's responsible party were offered or assisted if needed in formulating and advance directive. Additional information related to advanced directives for Resident 26 was requested during an interview with the Nursing Home Administrator and the Director of Nursing on June 9, 2026, at 2:30 PM. Review of an admission history and physical provided for Resident 26 dated April 12, 2022, indicated advance directives were discussed: the patient is a DNR. There was no indication as to whom the advance directives were discussed with as to whether it was the resident/resident representative as to determine the resident's DNR status. No further documentation was provided during the survey as to who decided the resident was to be a DNR. During an interview with the Nursing Home Administrator on June 11, 2026, at 10:40 AM, it was confirmed that no further documentation was available for the above-mentioned residents. Review of Resident 10's clinical record revealed an active physician's order dated January 1, 2025, for staff to implement a DNR. There was no evidence of an advance directive in Resident 10's clinical record. Further review revealed no supporting documentation that the facility had obtained or offered to assist in formulating an advanced directive with Resident 10 or Resident 10's representative. Review of Resident 's 38's clinical record revealed an active physician's order dated January 1, 2025, for staff to implement a DNR. There was no evidence of an advance directive in Resident 38's clinical record. Further review revealed no supporting documentation that the facility had obtained or offered to assist in formulating an advanced directive with Resident 38 or Resident 38's representative. Supporting documentation related to the advanced directives for Residents 10 and 38 was requested during an interview with the Nursing Home Administrator and the Director of Nursing on June 9, 2026, at 2:00 PM, and again on June 10, 2026, at 2:00 PM, but none was provided. Interview with the Nursing Home Administrator on June 11, 2026, at 10:12 AM, confirmed that the facility had no evidence that Residents 10 and 38, or their representatives were provided documentation or given the opportunity to formulate an advance directive. Review of resident 7's clinical record on June 9, 2026, revealed an active code status of DNR. There was no supporting documentation that the facility had obtained or offered to assist Resident 7 in formulating an advance directive. Review of an admission history and physical encounter document dated April 30, 2025, for Resident 7 indicated Advanced Directives were discussed: The patient is a DNR. There was no indication as to whom the advance directives were discussed with as to whether it was the resident/resident representative as to determine the resident's DNR status. No further documentation was provided during the survey as to who decided the resident was to be a DNR. Review of Resident 46's clinical record on June 9, 2026, revealed the resident was actively listed as a DNR. There was no supporting documentation that the facility had obtained or offered to assist Resident 46 in formulating (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an advanced directive. Further review of Resident 46's clinical record revealed an admission history and physical dated November 3, 2021, provided by the facility which indicated Advanced Directives were discussed: The patient is a DNR. There was no indication as to whom the advance directives were discussed with as to whether it was the resident/resident representative as to determine the resident's DNR status. No further documentation was provided during the survey as to who decided the resident was to be a DNR. Additional documentation related to the advanced directives for Resident 7 and Resident 46 was requested during an interview with the Nursing Home Administrator and the Director of Nursing on June 9, 2026, at 2:15 PM, and again on June 10, 2026, at 2:15 PM, but was no further information was provided. During an interview with the Nursing Home Administrator on June 11, 2026, at 10:40 AM, it was confirmed that no further documentation was available for the above-mentioned residents. 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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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. Based on review of facility documentation and staff interview, it was determined that the facility failed to ensure that nursing staff possessed the appropriate competencies and skill sets related to the care and assessment of residents who utilize a lift, PICC line, catheter care, medication administration, intravenous therapy, and dressing changes for three of three employees reviewed for competencies (Employees 13, 14, and 15).Findings include: A review of the facility documentation revealed that the facility had a total of 88 residents receiving medications, 28 residents that utilize lifts (transfer equipment), four residents with indwelling urinary catheters (insertion of a tube into the bladder to remove urine), 10 residents with dressing changes, one resident with IV therapy (intravenous therapy, a medical procedure that delivers fluids, medications, nutrients directly into a vein), and one resident with a PICC line (peripherally inserted central catheter inserted into a vein in the arm that reaches a large central vein near the heart to deliver medications, fluids, or nutrition). A request for nursing staff competencies for medication administration, lifts, wound vac, catheter care, dressing changes, IV therapy, and PICC line care revealed the facility was unable to provide any of these competencies for Employees 13 (licensed practical nurse), 14 (licensed practical nurse, and Employee 15 (registered nurses) in the last year. The findings were reviewed with the Nursing Home Administrator and Director of Nursing on June 11, 2026, at 9:58 AM. Further interview with Employee 6 (assistant director of nursing) on June 11, 2026, at 11:57 AM confirmed the facility could provide no documentation that ensured Employees 13,14 and 15 had specific competencies and skill sets to care for the residents' needs listed above. 28 Pa. Code 201.20 (a) Staff Development

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on a review of employee personnel and education records and staff interview, it was determined that the facility failed to ensure that each nurse aide received 12 hours of in-service training annually for three of three nurse aides reviewed (Employees 3, 4, and 5).Findings include: Review of Employee 3's (nurse aide) personnel record revealed that the facility hired her on April 14, 2025. Review of training records provided by the facility for Employee 3 revealed that she completed only six hours and 30 minutes of in-service education in the last year. Review of Employee 4's (nurse aide) personnel record revealed that the facility hired her on March 12, 2025. Review of training records provided by the facility for Employee 4 revealed that she had not completed any in-service education in the last year. Review of Employee 5's (nurse aide) personnel record revealed that the facility hired her on March 12, 2025. Review of training records provided by the facility for Employee 5 revealed that she had not completed any in-service education in the last year. Interview with Employee 6 (assistant director of nursing) on June 11, 2026, at 11:57 AM confirmed the facility failed to ensure Employees 3, 4, and 5 received 12 hours of in-service training annually. 28 Pa. Code 201.19(7) Personnel policies and procedures 28 Pa. Code 201.20(a)(6)(d) Staff development

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on review of select facility policies and procedures, observation and staff interview, it was determined that the facility failed to ensure that care and services were provided in a manner that enhanced resident dignity for one of 18 residents sampled (Resident 3). Findings include: Review of a current facility policy titled Dignity indicated demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: helping the resident to keep urinary catheter bags covered. Observation of Resident 3 on June 8, 2026, at 12:05 PM revealed they were in their bed with a urinary catheter bag (a bag that connects to a tube inserted into the bladder, used to collect urine) hanging from the side of the bed, with yellow urine visible. There was nothing covering the bag. Observation of Resident 3 on June 9, 2026, at 11:35 AM revealed that they were sitting in their wheelchair in their room with their catheter bag on their feet. There was nothing covering the catheter bag. Observation of Resident 3 on June 10, 2026, at 1:05 PM revealed they were in their bed with a urinary catheter bag hanging from the side of the bed, with yellow urine visible. During an interview with Employee 7, licensed practical nurse, they revealed that the resident should have a cover over their catheter bag, and they believed it was soiled and had been thrown away. The Nursing Home Administrator and the Director of nursing were made aware of the above information for Resident 3 on June 10, 2026, at 2:15 PM. 28 Pa. Code 201.29(a) Resident rights

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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. Based on a review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to ensure residents' medication regime was free from potentially unnecessary medications for one of five residents reviewed for medication regimen review (Resident 1).Findings include: The facility policy entitled Antipsychotic Medication Use, last reviewed without changes on January 28, 2026, revealed residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, medical condition, specific symptoms, and risks to the resident and others. Nursing staff will monitor for and report side effects and adverse consequences of antipsychotic medications to the attending physician. Clinical record review for Resident 1 revealed that the facility admitted him on March 18, 2025. Review of Resident 1's medication regime included the use of the following psychotropic medication: Risperidone (an antipsychotic medication) 2 mg (milligrams), one tablet in the morning and at bedtime. Review of Resident 1's plan of care initiated on March 31, 2026, revealed Resident 1 has psychotropic medications ordered and staff were instructed to administer his medications as ordered and monitor and document for side effects and effectiveness. Interventions also included monitoring, recording, and reporting to Resident 1's physician side effects and adverse reactions of the psychotropic medications including : unsteady gait, tardive dyskinesia, extrapyramidal symptoms (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to Resident 1. Resident 1's clinical record did not contain evidence that the facility implemented ongoing monitoring of target behavior symptoms for the use of the antipsychotic medication. Further review of Resident 1's clinical record did not contain evidence that the facility implemented ongoing assessment for potential side effects from the use of his antipsychotic medication. Interview with the Director of Nursing on June 11, 2026, at 10:22 AM confirmed that the facility could not provide evidence of ongoing tracking of Resident 1's target behavioral interventions and the monitoring of potential side effects for the antipsychotic medication. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to ensure assessments accurately reflected a resident's status for three of 18 residents reviewed (Residents 1, 6, and 10).Findings include: Observation of Resident 1 on June 8, 2026, at 1:51 PM revealed that he did not have any teeth. Clinical record review for Resident 1 revealed a MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated November 17, 2025, that facility staff assessed Resident 1 as not edentulous (having no teeth), indicating the resident had natural teeth. Interview with the Director of Nursing on June 11, 2026, at 9:54 AM confirmed Resident 1's MDS was coded in error regarding his oral/ dental status. Clinical record review for Resident 6 revealed a MDS dated [DATE], that facility staff assessed Resident 6 as receiving an insulin injection during the last seven days in the assessment period. Further clinical record review revealed no evidence that Resident 6 received an insulin injection during the assessment period for the MDS noted above. Interview with the Director of Nursing on June 10, 2026, at 12:34 PM confirmed Resident 6's MDS was coded in error regarding receiving an insulin injection. Observation of Resident 10 on June 8, 2026, at 11:41 AM revealed that she did not have any teeth. Clinical record review for Resident 10 revealed a dental progress note dated February 5, 2026, noting Resident 10 is edentulous. Further review of Resident 10's clinical record revealed a MDS dated [DATE], that facility staff assessed Resident 10 as not edentulous, indicating the resident had natural teeth. Interview with the Director of Nursing on June 10, 2026, at 11:00 AM confirmed Resident 10's MDS was coded in error regarding her oral/ dental status. The facility failed to accurately assess Residents 1, 6, and 10's MDS assessments as noted above. The above findings for Residents 1, 6, and 10 were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on June 10, 2026, at 2:00 PM. 28 Pa. Code 211.5(f)(ix) Medical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on clinical record review, review of facility documentation, and staff interview, it was determined that the facility failed to implement a comprehensive person-centered hospice care plan for two of two hospice residents reviewed (Residents 2 and 6); and failed to develop and implement an individualized person-centered care plan to address dementia and cognitive loss displayed for one of four residents reviewed with dementia (Resident 1). Findings Include: Review of the facility documentation titled, Hospice and Nursing Facility Services Agreement, revealed a section of the document titled, Design and Maintenance of Nursing Facility Plan of Care (POC), that noted (in part) that the nursing facility shall develop a nursing facility POC for each new residential hospice patient. The document further noted that promptly upon consent of the residential hospice patient, or their legal representative, the nursing facility shall furnish hospice with a copy of the nursing facility POC. Clinical record review for Resident 2 on June 11, 2026, revealed an active physician order for hospice for end-of-life care. Nursing documentation dated June 6, 2026, at 10:46 AM revealed that Resident 2 was admitted to hospice services on May 30, 2026. Clinical record review for Resident 2 revealed no comprehensive person-centered hospice care plan developed by the facility and coordinated with hospice services. During an interview with the Director of Nursing on June 11, 2026, at 11:15 AM a copy of Resident 2's care plan was requested. The facility provided their care plan for Resident 2 which had an initiated date of June 11, 2026 (after being requested by the surveyor). The facility failed to implement a comprehensive, person-centered, and coordinated hospice care plan for Resident 2. Review of the active physician orders for Resident 6 revealed an order for hospice-initiated on March 18, 2026. Further review of Resident 6's clinical record revealed a comprehensive person-centered hospice care plan was not developed by the facility until April 1, 2026. The facility failed to implement a comprehensive, person-centered, and coordinated hospice care plan for Resident 6 timely. Interview with the Director of Nursing on June 11, 2026, at 12:10 PM confirmed the above findings for Resident 6. Clinical record review revealed the facility admitted Resident 1 on March 18, 2025. Resident 1 received a diagnosis of dementia with mood disturbance on November 5, 2025. The facility failed to develop and implement an individualized person-centered care plan to address Resident 1's dementia and cognitive loss. Interview with the Director of Nursing on June 11, 2026, at 10:34 AM confirmed the above findings for Resident 1. 28 Pa. Code 211.10(a) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, clinical record review, and resident family and staff interview, it was determined that the facility failed to provide a dependent resident with activities of daily living assistance for one of three residents reviewed (Resident 8).Findings include Observation of Resident 8 on June 8, 2026, at 10:29 AM revealed she had her own teeth, and there was a large amount of buildup on Resident 8's teeth. Interview with Resident 8 stated that sometimes staff help her brush her teeth or set her up so she can brush her own teeth. She stated that she hasn't been to the dentist in a long time. Observation of Resident 8 on June 9, 2026, at 10:25 AM revealed Resident 8 again had a large amount of buildup on her teeth. Clinical record review revealed the facility admitted Resident February 18, 2026. Review of Resident 8's admission MDS (Minimum Data Set, an assessment completed at specific intervals to determine care needs) dated February 20, 2026, revealed staff assessed Resident 8 as dependent on staff for oral hygiene. Review of Resident 8's plan of care revealed Resident 8 has the potential for oral and dental health problems and an intervention-initiated March 3, 2026, noted staff would provide mouth care as per her activities of daily living personal hygiene, and encourage or assist Resident 8 to complete mouth care twice daily, and as needed. The facility failed to provide oral hygiene assistance to Resident 8. The above findings for Resident 8 were reviewed with the Nursing Home Administrator and Director of Nursing during a meeting on June 10, 2026, at 2:00 PM. Further interview with the Director of Nursing on June 11, 2026, at 11:14 AM, confirmed these findings. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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	395533	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Ridge Senior Living at Windy Hill	100 Dogwood Drive Philipsburg, PA 16866

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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. Based on clinical record review and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician ordered weights for one of two residents reviewed for nutritional concerns (Resident 4).Findings include: Clinical record review for Resident 4 revealed a diagnosis list that included a history of dysphagia (difficulty swallowing) and moderate protein calorie malnutrition. Clinical record review for Resident 4 revealed a current physician order dated October 13, 2025, for staff to weigh resident weekly (weekly every Monday per the order). Resident 4's current care plan revealed the resident has a nutritional care plan related to the medical history and PEG (percutaneous endoscopic gastrostomy tube; a feeding tube placed through the abdomen and into the stomach). An intervention included monitor weights at least monthly and/or as ordered/needed and to notify the medical provider of any significant changes in weight status initiated on January 3, 2025. Further review of Resident 4's care plan revealed a care plan for hypertension (high blood pressure). An intervention included weight per protocol, order, and/or as needed initiated on January 14, 2025. Review of Resident 4's documented weights from March 2026 to June 2026 in the electronic health record (EHR) revealed that weights were documented on the following dates: June 2 and 8, 2026.May 5 and 11, 2026 (no weights were noted for the week of May 18 and May 25, 2026).April 7, and 27, 2026 (no weights were noted for the week of April 13 and April 20, 2026).March 2, 3, 9, and 30, 2026 (no weights were noted for the week of March 16 and March 23, 2026). Review of the medication administration record (MAR) and treatment administration record (TAR) for Resident 4 for May and April 2026 revealed that no additional weights were being documented on the MARs/TARs). Further review of the clinical record for Resident 4 revealed no evidence that the weekly ordered weights were completed for the above dates. A copy of Resident 4's weekly weights were requested during a meeting with the Nursing Home Administrator and Director of Nursing on June 10, 2026, at 10:46 AM. A follow-up interview with the Nursing Home Administrator and Director of Nursing on June 11, 2026, at 12:00 PM revealed that the facility could provide any further documentation that the missing weights were completed as per the order. 483.25 Quality of Care Previously Cited 7/10/25 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, clinical record review and resident and staff interview, it was determined that the facility failed to implement interventions to prevent future falls or accidents for one of three residents reviewed for falls (Resident 9).Findings include: During an Interview with Resident 9 on June 8, 2026, at 12:05 PM, they were observed to have a soft cast on their left arm. The resident stated that a while ago they had fallen in the bathroom and fractured their arm. Clinical record review for Resident 9 revealed that on March 15, 2026, the resident had a fall in the shower room when a nurse aide was assisting the resident in pulling up their pants. The x-ray report revealed that the resident had suffered fractures to their left humerus bone. Review of the accident report revealed that the immediate intervention at the time of the fall was to educate the nurse aide who was assisting the resident at that time to ensure that the resident was holding onto something when dressing their lower body. Further review of the residents' care plan (an outline of an individual's health needs, specific care requirements, and the actions necessary to achieve desired health outcomes) and Kardex (documentation system used by staff to organize and reference key resident information essential for resident care) revealed no presence of this intervention. Interview with the director of nursing on June 11, 2026, at 12:00 PM, revealed that no other staff who provide care for Resident 9, except the nurse aide caring for the resident at the time of the fall, had been educated on the above noted intervention. Interview with the Nursing Home Administrator and the Director of Nursing June 11, 2026, at 1:05 PM confirmed that the facility did not have evidence of the implementation of any new fall prevention interventions following Resident 9's fall on March 15, 2026. 28 Pa. Code 211.12(d)(1)(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. Based on observation and staff interview, it was determined that the facility failed to properly store resident medications on one of three nursing units reviewed (first floor North Cherry Blossom Lane) and properly dispose of resident medications on one of three nursing units reviewed (second floor Magnolia Lane). Findings include: Observation during the medication pass on the first floor North Cherry Blossom Lane Nursing Unit on June 11, 2026, at 9:06 AM revealed a medication cart being utilized by Employee 9, licensed practical nurse. Observation of the medication cart revealed the following: There were several unsecured and unidentified medication tablets found at the bottom of the drawers that included: at least three white colored round pills, one capsule, one blue oblong tablet, a white oblong tablet, and a red and clear capsule. These medications were observed at the bottom of the drawers that held the pre-packaged pill blister packets. There was also an accumulation of debris at the bottom of the drawers that held the loose medications. The above findings were reviewed in a meeting with the Nursing Home Administrator on June 11, 2026, at 10:20 AM. Observation on June 8, 2026, at 11:45 AM on the second floor Magnolia Lane nursing unit revealed an oblong blue capsule stuck to the lid of the disposable sharp's container (container for needles, syringes, lancets, razors and sharp objects used in medical facilities) located on the side of the hallway treatment cart. During a concurrent interview with Employee 7, licensed practical nurse, they stated that sometimes nurses throw pills into the sharps container if a resident refuses them. The above concerns noted on Magnolia Lane were reviewed with the Nursing Home Administrator and the Director of Nursing on June 10, 2026, at 2:15 PM. 28 Pa. Code 211.9(k) Pharmacy services 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on clinical record review and resident and staff interview, it was determined that the facility failed to provide routine dental services for two of 18 residents (Residents 44 and 9).Findings include: Observation of Resident 44's mouth on June 8, 2026, at 11:35 AM revealed several missing and broken teeth. Interview with Resident 44's friend at this time revealed that she used to have a partial (artificial teeth designed to replace one or more missing teeth while preserving remaining natural teeth) but indicated that Resident 44's partial no longer fits her. She stated that Resident 44 is served food cut up due to her partial not fitting and stated Resident 44 does not like her mechanically altered diet. Clinical record review revealed the facility admitted Resident 44 on January 9, 2025. Review of Resident 44's plan of care-initiated January 20, 2025, revealed Resident 44 has the potential for oral and dental issues. There was no evidence in Resident 44's clinical record that the facility offered or assisted Resident 44 dental care since admission. Interview with the Director of Nursing on June 11, 2026, at 10:02 AM confirmed the above findings for Resident 44. She stated the facility obtains consent for dental services on admission. The Director of Nursing reached out to Resident 44's responsible party on June 10, 2026 (after surveyor's questioning) and he consented to dental evaluations and routine dental services. During an interview on June 8, 2026, at 12:02 PM with Resident 9, they stated that they have not seen a dentist since their admission (on March 13, 2025), and that they have multiple cavities that need to be filled. Clinical record review revealed Resident 9 has a care plan initiated on April 4, 2025, stating they have a potential for oral/dental issues. Further review revealed a nursing note dated April 13, 2026, that states Resident 9 has carious teeth with no dental issues. There was no evidence in Resident 9's clinical record that the facility offered or assisted in receiving dental care. Documentation indicating Resident 9 was offered dental services was requested on June 9, 2026, at 2:30 PM and again on June 10, 2026. The above findings were confirmed with the Nursing Home Administrator on June 11, 2026, at 10:40 AM. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing Services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on review of select facility policies and procedures, observation, and staff interview, it was determined that the facility failed to prevent the potential spread of infection during medication administration pass for two of five residents observed (Residents 72 and 88), and ensure an environment free from the potential spread of infection on one of three nursing units (300-Unit).Findings include: Review of the facility's current policy entitled Handwashing/Hand Hygiene revealed facility staff are to use an alcohol-based hand rub. or alternatively soap. and water for the following situations, which include; before and after direct contact with residents, before preparing or handling medications, after contact with objects (like medical equipment), in the immediate vicinity of a resident, and after removing gloves. Observation on June 9, 2026, at 11:45 AM revealed the freezer in the 300-unit pantry refrigerator was being used to store ice cream. Two medical type ice packs with resident names on them were observed in the freezer with the ice cream. Concurrent interview with Employee 8, licensed practical nurse, revealed that the ice packs with names on them had been used by the residents when requested for medical use (pain relief, reduction in inflammation/swelling) on their body and were not for food service use. Observation of Employee 8 during a medication administration pass on June 10, 2026, at 8:50 AM revealed that during the medication preparation for Resident 72, Employee 8 used their ungloved hands to obtain an 81 mg (milligram) aspirin tablet, and two 25 mcg (microgram) vitamin D tablets, from a stock bottle, by reaching their fingers into the open lid with their right hand while tilting the bottle held in their left hand. Employee 8 entered Resident 72's room without performing hand hygiene. Resident 72 stated that they would like to also have their prescribed stool softeners this morning. Employee 8 administered the prepared medications, whole with water, and left the resident's room. Without performing hand hygiene, Employee 9 prepared 17GM (grams) of polyethylene glycol powder (laxative) for solution with water and two Senna S tablets (laxative) and returned to Resident 72's room and administered the medication. Without performing hand hygiene, Employee 8 returned to the medication cart and reviewed the medications that were due. Employee 8 noticed that there were two additional medications that were scheduled to be given in the morning. Without performing hand hygiene, the nurse prepared a 40mg Furosemide (pill to remove excess fluid) tablet and half a tablet of zinc sulfate 220mg (mineral supplement). Without performing hand hygiene, Employee 8 entered Resident 72's room and administered the remaining medications and exited the room. Consecutively transitioning to care for Resident 88, Employee 8, without completing hand hygiene, removed the supplies necessary to check the blood sugar for the resident, including a disposable needle for a finger stick, a blood glucose monitor (medical equipment that tests blood for glucose), a glucose strip (attached to a glucose monitor and collects the blood to be tested), alcohol pad (used to cleanse the skin prior to a needle stick), and a pair of disposable gloves. Without performing hand hygiene, Employee 8 applied gloves, entered Resident 88's room, and used the disposable needle to collect a blood sample on the test strip to evaluate Resident 88's current blood glucose level. Upon completion of this task, Employee 8 wrapped the soiled test strip in her used glove as she removed the glove and threw it into the resident's trash can. Without performing hand hygiene, Employee 8 exited the room to begin preparing the insulin for Resident 88 at the medication cart. During a concurrent interview with Employee 8, they confirmed the above noted findings and stated that they did not wash their hands after collecting a blood glucose level from Resident 88 because the sink was in use by the nurse aide at the time. Employee 8 acknowledged that there was hand sanitizer on the medication cart, which could have also been utilized. Employee 8 stated they were not aware that used glucose test strip are considered medical waste and must be disposed of in an appropriate receptable. The Nursing Home Administrator and Director of Nursing were made aware of the above concerns on June 10, 2026, at 2:15 PM. 483.80(a)(1)(2)(4)(e)(f) Infection Prevention and ControlPreviously cited deficiency 7/10/25 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident's representative received written notice of transfer and written notice of the facility bed-hold policy as soon as practicable for two of five residents reviewed for hospitalizations (Residents 7 and 23).Findings include: Clinical record review for Resident 7 revealed the resident was transferred to the emergency room on April 18, 2026, at her request. There was no evidence Resident 7's responsible party received a written notice of transfer or written notice of the bed hold policy as soon as practicable for Resident 7's transfer. Further clinical record review for Resident 7 revealed the resident was also transferred to the emergency room on May 20, 2026, for evaluation and treatment of pain. There was no evidence Resident 7's responsible party received a written notice of transfer or written notice of the bed hold policy as soon as practicable for Resident 7's transfer. Interview with the Nursing Home Administrator and Director of Nursing on June 11, 2026, at 12:50 PM, confirmed that the facility did not provide Resident 7's responsible party written transfer or bed-hold notices for her April 18, 2026, and May 20, 2026, hospitalizations. Clinical record review for Resident 23 revealed the resident was sent to the hospital on June 2, 2026. Further review revealed that the form entitled, ?Bed Hold Acknowledgement and Notice of Transfer' indicated that Resident 23's responsible party was notified by phone. A request for documentation to indicate the resident representative received the above-named form in writing was made to the Nursing Home Administrator and the Director of Nursing on June 10, 2026, at 2:15 PM. The facility was unable to provide any further documentation that indicated the responsible party received a written notification of Resident 23's rights related to the hospital transfer. The Nursing Home Administrator was made aware of the above findings on June 11, 2026, at 10:40 AM. S483.15(c)(3) Notice before transfer.Previously cited 7/10/25 28 Pa. Code 201.14(a) Responsibility of license