STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395539	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Anne Home	685 Angela Drive Greensburg, PA 15601

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to provide confidentiality of residents' personal health information during medication administration for one of 51 residents reviewed (Resident 89). Findings include: The facility policy regarding privacy of health information, dated October 10, 2024, indicated that the resident's health information needs to remain private. Observations during medication administration on June 25, 2025, at 9:16 a.m. revealed that Licensed Practical Nurse 1 walked away from the medication cart to assist Resident 89 to his room to administer his medication. Resident 89's personal health information was visible on the computer screen, which was facing the dining room with residents present. Interview with Licensed Practical Nurse 1 on June 25, 2025, at 9:33 a.m. confirmed that she should have covered the residents' personal information when leaving the medication cart by securing the computer screen. Interview with the Quality Assurance and Performance Improvement Registered Nurse on June 25, 2025, at 11:48 a.m. confirmed that the computer screen with Resident 89's personal health information should have been covered when the nurse was not attending the medication cart. 28 Pa. Code 211.5(b) Clinical Records.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. Based on review of policies, clinical records, and facility investigation information, as well as staff interviews, it was determined that the facility failed to prevent the misappropriation of medication for nine of 51 residents reviewed (Residents 3, 25, 50, 53, 54, 91, 121, 129, 200). Findings include: The facility's policy regarding abuse, dated October 10, 2024, indicated that the facility strictly forbids and prohibited the mistreatment, neglect, verbal, mental, physical and sexual abuse of residents; including corporal punishment or involuntary seclusion and misappropriation of resident property. Misappropriation was defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. Information submitted by the facility, dated January 27, 2025, revealed that upon review and audit of the Controlled Substance Dispense Log and interviews with residents, multiple discrepancies were observed, leading to the discovery of diversion of Residents 3, 25, 50, 53, 54, 91, 121, 129, and 200's medications by Licensed Practical Nurse 2. An annual Minimum Data Set (MDS) assessment (required assessment of a resident's abilities and care needs) for Resident 3, dated May 9, 2025, indicated that the resident was cognitively impaired, had pain frequently, and received pain medication as needed. Physician's orders for Resident 3, dated September 13, 2024, included an order for the resident to receive 5 milligrams (mg) of Oxycodone (a controlled opioid pain medication) every four hours as needed for moderate to severe pain. The resident's controlled drug record indicated that one dose of Oxycodone was signed out for administration to the resident on January 18, 2025, at 9:00 p.m. However, the resident's Medication Administration Record (MAR) and clinical record contained no documented evidence that the signed-out dose of Oxycodone was actually administered to the resident on this date and time. A quarterly MDS assessment for Resident 25, dated November 15, 2024, indicated that the resident was cognitively impaired, had no pain present, received pain medication routinely and as needed, and received an opioid (a controlled pain medication). Physician's orders for Resident 25, dated January 24, 2018, included an order for the resident to receive 5 milligrams (mg) of Oxycodone every four hours as needed for pain. The resident's controlled drug record indicated that one dose of Oxycodone was signed-out for administration to the resident on January 24, 2025, at 6:00 p.m. and 10:00 p.m. However, the resident's MAR and clinical record contained no documented evidence that the signed-out doses of Oxycodone were actually administered to the resident on this date and times. A quarterly MDS assessment for Resident 50, dated March 28, 2025, indicated that the resident was cognitively impaired, had pain frequently, and received pain medication as needed. Physician's orders for Resident 50, dated December 24, 2024, included an order for the resident to receive 5-325 mg of Norco (a controlled opioid pain medication) twice daily as needed for pain. The resident's controlled drug record indicated that one dose of Norco was signed out for administration to the resident on January 18, at 8:00 p. m. However, the resident's MAR and clinical record contained no documented evidence that the signed-out dose of Norco was actually administered to the resident on this date and time. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly MDS assessment for Resident 53, dated April 1, 2025, indicated that the resident was cognitively impaired, had pain frequently, and received pain medications routinely and as needed. Physician's orders for Resident 53, dated November 6, 2024, included an order for the resident to receive 10-325 mg of Norco every three hours as needed for moderate to severe pain. The resident's controlled drug record indicated that one dose of Norco was signed out for administration to the resident on January 18, 2025, at 9:00 p.m. However, the resident's MAR and clinical record contained no documented evidence that the signed-out dose of Norco was actually administered to the resident on this date and time. A quarterly MDS assessment for Resident 54, dated January 15, 2025, indicated that the resident was cognitively intact, had pain frequently, and received pain medications as needed. Physician's orders for Resident 54, dated September 26, 2024, included an order for the resident to receive 5-325 mg of Norco twice daily as needed for moderate to severe pain. The resident's controlled drug record indicated that one dose of Norco was signed out for administration to the resident on January 24, 2025, at 4:00 p.m. and 8:00 p. m. However, the resident's MAR and clinical record contained no documented evidence that the signed-out doses of Norco were actually administered to the resident on this date and times. An admission MDS assessment for Resident 91, dated December 9, 2024, indicated that the resident was cognitively impaired and occasionally had pain. Physician's orders for Resident 91, dated December 24, 2024, included an order for the resident to receive 5-325 mg of Norco every eight hours as needed for moderate to severe pain. The resident's controlled drug record indicated that one dose of Norco was signed out for administration to the resident on January 24, 2025, at 8:00 p.m. However, the resident's MAR and clinical record contained no documented evidence that the signed-out doses of Norco were actually administered to the resident on this date and time. A quarterly MDS assessment for Resident 121, dated January 20, 2025, indicated that the resident was cognitively intact, had pain, and received pain medications routinely. Physician's orders for Resident 121, dated September 26, 2025, included an order for the resident to receive 5-325 mg of Norco once daily for pain. The resident's controlled drug record indicated that one dose of Norco was signed out for administration to the resident on January 18, 2025, at 10:00 p.m. However, the resident's MAR and clinical record contained no documented evidence that the signed-out dose of Norco was actually administered to the resident on this date and time. A quarterly MDS assessment for Resident 129, dated January 4, 2025, indicated that the resident was cognitively intact and occasionally had pain. Physician's orders for Resident 129, dated December 29, 2024, included an order for the resident to receive 5-325 mg of Norco every four hours as needed for breakthrough pain. The resident's controlled drug record indicated that one dose of Norco was signed out for administration to the resident on January 24, 2025, at 5:15 p.m. and 9:32 p.m. However, the resident's clinical record, including the MAR's and nursing notes, contained no documented evidence that the signed-out doses of Norco were actually administered to the resident on this date and times. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly MDS assessment for Resident 200, dated December 24, 2024, indicated that the resident was cognitively intact, had pain almost constantly, and received pain medications routinely. Physician's orders for Resident 200, dated January 16, 2025, included an order for the resident to receive 5-325 mg of Norco every four hours as needed for moderate to severe pain. The resident's controlled drug record indicated that one dose of Norco was signed out for administration to the resident on January 24, 2025, at 4:30 p.m. and 8:30 p. m. However, the resident's MAR and clinical record contained no documented evidence that the signed-out doses of Norco were actually administered to the resident on this date and times. The facility's completed investigation information, dated February 3, 2025, revealed that a pattern was noted with Licensed Practical Nurse 2 signing narcotic control sheets for Residents 3, 25, 50, 53, 54, 91, 121, 129, and 200 ordered as needed Norco or Oxycodone and removed the narcotic from the blister card; however, there was no record found of the administration of the medications. Interviews with alert and oriented residents revealed that they did not receive pain medications on the dates and times noted above. Record reviews of the residents that were not alert and oriented revealed that they did not routinely request as needed pain medications. The facility's investigation concluded that Licensed Practical Nurse 2 misappropriated Norco and Oxycodone tablets for Residents 3, 25, 50, 53, 54, 91, 121, 129, and 200. Interview with the Quality Assurance and Performance Improvement Registered Nurse on June 26, 2025, at 1:05 p.m. confirmed that Licensed Practical Nurse 2 misappropriated Norco and Oxycodone tablets for Residents 3, 25, 50, 53, 54, 91, 121, 129, and 200, and the residents never received their medications. She indicated that the police were notified and Licensed Practical Nurse 2 was referred to the Pennsylvania Department of State. 28 Pa. Code 201.14(a) Responsibility of License. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.12(d)(3)(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. Based on a review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set (MDS) assessments for three of 51 residents reviewed (Residents 12, 27, 46). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (required assessments of a resident's abilities and care needs), dated October 2024, revealed that Section N0415K Anticonvulsant was to be coded if the resident took the medication during the seven-day look-back period. A quarterly MDS assessment for Resident 12, dated June 9, 2025, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, and had medical diagnoses that included bipolar and schizophrenia (mood disorders). Section N0415K of the MDS indicated that the resident did not receive anticonvulsant medication. However, physician's orders for Resident 12, dated July 20, 2024, included orders for the resident to receive 250 mg of Divalproex (anticonvulsant) twice a day, and a review of the resident's June 2025 Medication Administration Record (MAR) revealed that the resident received Divalproex twice a day for the seven-day look-back period. Interview with the Quality Assurance and Performance Improvement Registered Nurse on June 26, 2025, at 9:14 a.m. confirmed that the Resident 12's MDS assessment was coded inaccurately, and that the resident did receive anticonvulsants during the look-back period. The Long-Term Care Facility RAI User's Manual, dated October 2024, indicated that Section B0700 (make self-understood) should be coded with either clearly understood, usually understood, sometimes understood, or rarely/never understood. Section C0100 (should brief interview for mental status be conducted) should be completed if the resident is at least sometimes understood verbally, in writing, or using another method. Section C0100 was to be coded No (0) or Yes (1) to determine whether a Brief Interview for Mental Status (BIMS) (an assessment to determine a resident's cognitive status) should be attempted with the resident. The instructions for determining if a BIMS interview should be attempted indicated that if the resident was at least sometimes understood (verbally or in writing) then the BIMS interview was to be attempted with the resident and coded in Sections C0200 through C0500. If the resident was rarely/never understood, then the BIMS interview was not to be attempted, and a Staff Assessment of Mental Status was to be completed instead and coded in Sections C0600 through C1000. A significant change in status MDS assessment for Resident 27, dated May 7, 2025, indicated that the resident was sometimes understood and sometimes understands. However, Section C0100 was coded (0) No, indicating that the resident was rarely/never understood by others, and a BIMS interview was not attempted with the resident. Interview with the Quality Assurance and Performance Improvement Registered Nurse on June 26, 2025, at 11:11 a.m. confirmed that a BIMS interview should have been attempted with Resident 27. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RAI User's Manual, dated October 2024, revealed that Section N0415F1 (Antibiotics) was to be checked if the resident received an antibiotic during the seven-day assessment period; Section N0415I1 (Antiplatelet Medications) was to be checked if the resident received an antiplatelet medication during the seven-day assessment period; and Section O0110O1 was to be checked if the resident had IV (intravenous) access in the past 14 days. Physician's orders for Resident 46, dated June 6, 2025, included an order for the resident to receive 81 mg of aspirin one time a day related to coronary artery disease and 500 mg of cephalexin (antibiotic) twice a day for five days for a urinary tract infection. Physician's orders, dated June 8, 2025, included orders for the resident to have her IV port flushed with 10 milliliters (mL) of 0.9 percent Sodium Chloride (sterile salt water) every shift and before and after medication administration. The resident's MAR for 2025 revealed that the resident received aspirin every day from June 7 through 12, 2025; received Cephalexin twice day from June 6 through 11, 2025; and had her IV flushed with Sodium Chloride every shift from June 8 through 11, 2025. A significant change MDS assessment for Resident 46, dated June 17, 2025, revealed that Section N0415I1 was not checked, indicating that the resident did not receive any antiplatelet medications during the seven days of the assessment period; Section N0415F1 was not checked, indicating that the resident did not receive any antibiotic medications during the seven days of the assessment period; and Section O0110O1 was not checked, indicating that the resident did not have IV access in the past 14 days. Interview with the RNAC on June 26, 2025, at 9:14 a.m. confirmed that Resident 46's significant change MDS assessment was coded incorrectly. 28 Pa. Code 211.5(f) Clinical records.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that care plans were updated/revised to reflect specific care needs for five of 51 residents reviewed (Resident 6, 59, 64, 104, 119) Findings include: The facility's policy regarding care plans, dated October 10, 2024, revealed that care plans are evaluated at least every 90 days, annually, and if there is a change in a resident's condition which is not limited to incidents and accidents. Also, when a resident has returned from a hospital stay. A care plan must be completed if there is a significant change in condition. Otherwise it is reviewed and revised as necessary. Care plan evaluations determine the effectiveness and efficiency of the plan. Care plans can be reviewed and revised at any time it is necessary. A quarterly Minimum Data Set (MDS) assessments (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated May 29, 2025, indicated that the resident was cognitively impaired and required assistance from staff for daily care needs. The current care plan for Resident 6 revealed that the resident was to be on transmission-based precautions (the second tier of basic infection control and are to be used in addition to standard precautions for patients that may be colonized with certain infectious agents) related to VRE (a type of bacteria that is resistant to the antibiotic Vancomycin) of the urine. Physician's orders for Resident 6, dated March 20, 2025, included an order for the resident to be on transmission-based precautions every shift for VRE of the urine. Physician's orders, dated April 9, 2025, included an order to discontinue the transmission-based precautions. Observations of Resident 6's room on June 25, 2025, at 10:05 a.m. revealed that there was no signage on the resident's door to indicate that the resident was on transmission-based precautions. There was no documented evidence that Resident 6's care plan was revised to reflect that the resident was no longer on transmission-based precautions related to VRE of the urine. Interview with the Quality Assurance and Performance Improvement Registered Nurse on June 25, 2025, at 11:11 a.m. confirmed that Resident 6's care plan was not revised to reflect that the resident was no longer on transmission-based precautions. A care plan for Resident 59, dated March 17, 2025, revealed that the resident was ordered to be in transmission-based precautions related to flu. Physician's orders for Resident 59, dated March 17, 2025, included an order for the resident to be on transmission-based precautions: droplet (used to prevent the spread of pathogens transmitted through respiratory droplets produced when an infected person coughs, sneezes, or talks) every shift for Flu A (a contagious respiratory illness caused by influenza A viruses) times five days. Physician's orders, dated March 23, 2025, included an order to discontinue the transmission-based precautions. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations of Resident 59's room on June 23, 2025, at 12:26 p.m. revealed that there was no signage on the resident's door to indicate that the resident was on transmission-based precautions related to having the flu. There was no documented evidence that Resident 59's care plan was revised to reflect that the resident was no longer on transmission-based precautions related to having the Flu. Interview with the Quality Assurance and Performance Improvement Registered Nurse on June 25, 2025, at 9:47 a.m. confirmed that Resident 59's care plan was not revised to reflect that the resident was no longer on transmission-based precautions. A quarterly MDS assessment for Resident 64, dated April 8, 2025, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included anxiety and depression. Physician's orders for Resident 64, dated February 28, 2025, included an order for the resident to receive 12. 5 milligrams of Seroquel (antipsychotic) twice a day. The care plan for Resident 64, dated June 24, 2024, did not include the use of antipsychotic medication. An interview with the Quality Insurance and Performance Improvement Registered Nurse on June 26, 2025, at 9:14 a.m. confirmed that the care plan was not updated when the antipsychotic was ordered. An admission MDS assessment for Resident 104, dated April 15, 2025, revealed that the resident was cognitively impaired, used oxygen, and had diagnoses that included heart failure and pneumonia. Physician's orders, dated May 16, 2025, included orders for the resident to receive 2-10 liters per minute (lpm) of oxygen via nasal cannula (plastic tube that delivers oxygen through the nose) every shift for hypoxia (low levels of oxygen in body tissues) and staff were to titrate (adjust) the oxygen to keep the resident's oxygen saturation (percentage of oxygen in the blood) greater than 86 percent. Observations of Resident 104 on June 26, 2025, at 10:48 a.m. revealed that she was receiving oxygen at a flow rate of 10 lpm liters per minute via nasal canula. However, a current care plan revealed that the resident was to receive oxygen at 6 lpm to maintain an oxygen saturation greater than 92 percent. Interview with the Quality Assurance and Performance Improvement Registered Nurse on June 25, 2025, at 1:02 p.m. confirmed that Resident 104's care plan was not revised to remove the prior oxygen orders. A quarterly MDS assessment for Resident 119, dated November 30, 2024, revealed that the resident was usually understood and could usually understand others. A care plan for Resident 119, dated September 1, 2024, revealed that the resident was at risk of falls, and that she was an assist of two via a Hoyer lift (allows a person to be lifted and transferred with a minimum of physical effort) for transfers. A care plan dated, October 25, 2024, revealed that the resident required extensive assistance with areas of her Activities of Daily Living (ADL's) and per therapy the resident was a two-person assist for transfers. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician's orders for Resident 119, dated February 5, 2025, included an order that the resident was an assist of one for transfers. There was no documented evidence that Resident 119's care plan was revised to reflect that the resident was no longer an assist of two for her transfers. Interview with the Quality Assurance and Performance Improvement Registered Nurse on June 25, 2025, at 1:00 p.m. confirmed that Resident 119's care plan was not revised to reflect that the resident was no longer an assist of two for her transfers. 28 Pa. Code 201.24(e)(4) admission Policy.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on clinical record reviews, as well as resident and staff interviews, it was determined that the facility failed to ensure that urinary output was measured as care planned for one of 51 residents reviewed (Resident 137) who had an indwelling urinary catheter. Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 137, dated May 9, 2025, revealed that the resident was understood, could usually understand others, had an indwelling urinary catheter (a tube placed and held in the bladder to drain urine), and had diagnoses that included obstructive uropathy (a condition where there is a blockage in the urinary tract, preventing normal urine flow from the kidneys to the bladder and out of the body). A care plan, dated February 11, 2025, revealed that Resident 137 required an indwelling catheter related to his diagnosis of obstructive uropathy. Staff was to accurately measure and record the resident's output every shift. Review of Resident 137's clinical record revealed that there was no documented evidence that the resident's output was obtained during the dayshift on May, 2, 5, 7, 9, 11, 16, 19, 21, 23, 24, and 26, 2025, and on June 2, 8, 13, 21, and 22, 2025; during the evening shift on May 2, 5, 10, 16, 19, 26, through 28, 2025, and June 7, 8, 21, 22, and 25, 2025; and during the night shift on May 4, through 6, 10, 11, 13, 15, 17, 19, 23, through 26, 29, and 31, 2025, and June 1, 2, 6, through 9, 16, 19, 21, 22, and 25, 2025. Interview with the Quality Assurance and Performance Improvement Registered Nurse on June 26, 2025, at 9:50 a.m. confirmed that there was no documented evidence that Resident 137's output was obtained on the above dates. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain accountability for controlled medications (drugs with the potential to be abused) for one of 51 residents reviewed (Resident 89). Findings include: A facility policy regarding medication administration, dated October 10, 2024, indicated that the individual administering the medication will initial the resident's Medication Administration Record (MAR) on the appropriate line after giving each medication and before administering the next ones. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 89, dated June 2, 2025, revealed that the resident was cognitively intact, required assistance with daily care needs, and had medical diagnoses that included heart failure and high blood pressure. Physician's orders for Resident 89, dated August 18, 2025, included orders for the resident to receive 50 milligrams (mg) of Tramadol (opioid medication) every six hours for pain. Review of Resident 89's MAR for May 2025 revealed that one 50 mg tablet of Tramadol was signed-out for administration to the resident on May 1 at 8:00 p.m., May 2 at 8:00 p.m., May 8 at 3:00 p.m., May 13 at 8:00 p.m., May 14 at 8:00 p.m., and May 31 at 5:00 p.m. However, the resident's MAR and clinical record contained no documented evidence that the signed-out tablets of Tramadol were administered to the resident on these dates. Interview with the Quality Assurance and Performance Improvement Registered Nurse on June 26, 2025, at 9:14 a.m. confirmed that there was no documented evidence that staff administered the controlled drugs to Resident 89 on the dates mentioned above. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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	395539	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Anne Home	685 Angela Drive Greensburg, PA 15601

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on review of manufacturer's instructions and clinical records, as well as observations and staff interviews, it was determined that the facility failed to maintain a medication administration error rate of less than five percent. Findings include: Observations during medication administration on June 25, 2025, revealed that two medication administration errors were made during 35 opportunities for error, resulting in a medication administration error rate of 5.71 percent. Current manufacturer's directions for use of Metoprolol Extended Release (ER) (used to treat high blood pressure, heart failure, and chest pain) revealed that it is preferable to administer with or immediately following meals; however, may administer without regards to meals. May divide tablets in half; do not crush or chew. Crushing modified release dosage forms (e.g., ER tablets) may result in release of excessive doses, variable serum concentrations, and risk of severe adverse effects including fatalities. Physician's orders for Resident 111, dated November 7, 2024, included an order for the resident to receive one 25 milligram (mg) tablet of Metoprolol ER 25 twice a day. Observations during the medication administration on June 25, 2025, at 8:57 a.m. revealed that Licensed Practical Nurse 3 crushed Resident 111's Metoprolol ER along with the other medications that she prepared for the resident, and then administered the crushed Metoprolol ER to the resident at 8:59 a.m. Interview with Licensed Practical Nurse 3 on June 25, 2025, at 9:00 a.m. confirmed that Resident 111's Metoprolol ER should not have been crushed. Interview with the Quality Assurance and Performance Improvement Registered Nurse on June 25, 2025, at 11:50 a.m. confirmed that Resident 111's Metoprolol ER should not have been crushed. Manufacturer's directions for Voltaren 1 percent gel (diclofenac sodium-a topical gel nonsteroidal anti-inflammatory drug used to treat pain), dated March 5, 2018, revealed that in order to apply two grams, Voltaren gel was to be squeezed onto the dosing card evenly up to the two gram line (a 2.25 inch length of gel). Physician's orders for Resident 89, dated March 4, 2024, included an order for the resident to receive two grams of Voltaren 1 percent gel, applied to toes twice daily (morning and bedtime). Observations during medication administration on June 25, 2025, at 9:16 a.m. revealed that Licensed Practical Nurse 1 obtained Resident 89's tube of Voltaren 1 percent gel and squeezed it onto her gloved hand and did not measure the amount. The nurse then applied the gel onto the resident's left toes. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Licensed Practical Nurse 1 on June 25, 2025, at 9:33 a.m. revealed that she routinely applied Resident 89's diclofenac sodium gel in this manner, which was two grams to his left toes. She confirmed that she did not measure the amount of gel. Interview with the Quality Assurance and Performance Improvement Registered Nurse on June 25, 2025, at 11:50 a.m. confirmed that Resident 89's Voltaren gel should have been measured per manufacturer's instructions. 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies, manufacturer's directions for use, and clinical records, as well as observations and staff interviews, it was determined that the facility failed to label multi-dose containers of insulin with the date they were opened in one of four medication carts reviewed (Villa [NAME] Garden medication cart), and failed to discard an expired bottle of testing solution for one of four medication room refrigerators reviewed (Villa [NAME] Garden medication room refrigerator). Findings include: The facility's policy regarding medication storage, dated [DATE], revealed that medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to keep their integrity, and to support safe, effective drug administration. Outdated, contaminated, discontinued or deteriorated medications and those containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal. The facility's policy regarding medication administration, dated [DATE], revealed that staff were to check the expiration date on package/container. No expired medication will be administered to a resident. The nurse shall place a date opened sticker on the medication if one is not provided by the dispensing pharmacy and enter the date opened. Certain products or package types such as multi-dose vials have a shortened end-of-use dating, once opened, to ensure medication purity and potency. Manufacturer's directions for the use of Lantus insulin (a long-acting insulin used to lower blood sugar levels), undated, revealed that unused Lantus vials and prefilled pens should be stored in a refrigerator between 36 degrees F to 46 degrees F. After initial use it may be kept at temperatures below 86 degrees F for up to 28 days. Manufacturer's directions for the use of Insulin glargine (a long-acting insulin used to lower blood sugar levels), undated, revealed that unused Insulin glargine vials and prefilled pens should be stored in a refrigerator between 36 degrees F to 46 degrees F. After initial use it may be kept at temperatures below 86 degrees F for up to 28 days. Physician's orders for Resident 92, dated [DATE], included an order for the resident to receive 24 units of Lantus insulin daily in the a.m. and 26 units of Lantus insulin daily at bedtime. Physician's orders for Resident 119, dated [DATE], included an order for the resident to receive 10 units of Insulin glargine twice a day. Observation of the medication cart for Villa [NAME] Garden on [DATE], at 11:05 a.m. revealed that the multidose vail of Lantus insulin for Resident 92 and the prefilled pen of Insulin glargine for Resident 119 were opened and were not labeled with the date that they were opened. Interview with Licensed Practical Nurse 4 at that time confirmed that the multidose vail of Lantus insulin and the prefilled pen of Insulin glargine should have been labeled with the dates they were opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The manufacturer's instructions for Aplisol (a solution injected under the skin to test for tuberculosis - a lung infection) revealed that vials in use more than 30 days should be discarded due to possible oxidation (exposure to oxygen causing it to lose its properties) and degradation (breakdown of the substance causing it to lose its quality) which may affect potency. Observations of the Villa [NAME] Garden medication refrigerator on [DATE], at 11:12 a.m. revealed that there was one multidose vial of Aplisol solution on the top shelf in the refrigerator, with a date as being opened on [DATE] (34 days after opening). Interview with Licensed Practical Nurse 4 at the time of observation confirmed that the Aplisol multidose vial was opened and dated with [DATE], as the date that it was opened and that the Aplisol multidose vial should have been discarded. Interview with the Quality Assurance and Performance Improvement Registered Nurse on [DATE], at 1:00 p. m. confirmed that the multidose vial of Lantus insulin for Resident 92 and the prefilled pen of Insulin glargine for Resident 119 should have been dated with the date they were opened and that the Aplisol multidose vial should have been discarded. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(3) Nursing Services.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies, as well as observations and interviews with residents and staff, it was determined that the facility failed to serve food that was palatable and at proper temperatures. Findings include: The facility's policy regarding food preparation and service, dated October 10, 2024, revealed that food was to be prepared by methods which ensure retention of flavor, appearance, and nutrients. Food was to be maintained at proper temperatures during service and transported in a sanitary manner. Standardized recipes, adjusted to the proper yield for the facility, would be available and used in food preparation. Each type of food was to be served at an acceptable temperature. When holding food temporarily before serving, keep hot foods at 140 degrees Fahrenheit (F) or above and cold foods at 40 degrees F or below. Interview with Resident 63 on June 23, 2025, at 11:04 a.m. revealed that the food was not always warm and she even eats in the dining room. Interview with Resident 93 on June 23, 2025, at 11:10 a.m. revealed that the food was terrible, tasted bad, it was covered with slop, and the temperature varied. A test tray for the lunch meal on the Villa [NAME] nursing unit on June 25, 2025, revealed that the cart left the kitchen at 12:19 p.m., arrived on the nursing unit at 12:21 p.m., and the last resident was served at 12:36 p.m. The test tray was tasted at 12:36 p.m. and the oven roasted potatoes were 104.1 degrees F and the brussel sprouts were 106.2 degrees F. The potato chip chicken was tasted and it was bland and had no flavor. Interview with the Chef Manager on June 25, 2025, at 12:36 p.m. confirmed that the temperatures of the oven roasted potatoes and brussel sprouts was low and the potato chip chicken was prepared without using any seasoning. 28 Pa. Code 211.6(b) Dietary Services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to store and prepare food under sanitary conditions. Findings include: The facility's policy for cleaning the kitchen, dated October 10, 2024, revealed that the dishwasher was to be cleaned at least three times each day, prior to each meal, and cleaned more often with an increased volume of dishes; and the walls were to be cleaned monthly, and more often if needed. Observations in the dishwasher area on June 25, 2025, at 11:51 a.m. revealed that the lower wall that the dishwasher was against had a large build up of a black, removable substance on the tiles and the two upper vents on the dishwasher exhaust had a thick build up of dust and debris on them. Observations of the dishwasher temperature log, dated May and June 2025, revealed that the dishwasher wash temperatures (150-165 degrees Fahrenheit (F) and rinse temperatures (180-195 degrees F) were to be recorded three times a day, before using the dishwasher at each meal and staff were to place their initials next to the temperature. The log did not include dishwasher wash or rinse temperatures for all meals on May 1, 2, 5 through 12, 15 through 18, 20, 22 through 26, and 28 through 31, and June 3 through 14, and 16 through 23, 2025. Interview with the Dietary Manager on June 25, 2025, at 11:51 a.m. confirmed that the wall behind the dishwasher and the dishwasher vents needed cleaned and staff should have been completing the dishwasher temperature log prior to each meal. 28 Pa. Code 211.6(f) Dietary Services.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plans of corrections for State Survey and Certification (Department of Health) surveys ending June 13, 2024; October 22, 2024; and April 21, 2025, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending June 18, 2025, identified repeated deficiencies related to failure to provide confidentiality of residents' personal health information, failure to ensure that MDS assessments were accurate, care plan timing and revision, issues with urinary catheters, maintaining a medication error rate below 5 percent, label/store drugs and biologicals, and failure to serve palatable food at appropriate temperatures. The facility's plan of correction for a deficiency for not providing confidentiality of residents' personal health information, cited during the survey ending July 25, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F583, revealed that the facility's QAPI committee failed to provide confidentiality of residents' personal health information. The facility's plan of correction for a deficiency regarding inaccurate MDS assessments, cited during the survey ending July 25, 2024, revealed that the facility developed a plan of correction that included completing audits and presenting the results of the audits at the quarterly QAPI meeting. The results of the current survey, cited under F641, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding the accuracy of MDS assessments. The facility's plan of correction for a deficiency regarding care plan timing and revision, cited during the survey ending July 25, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F657, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding care plan timing and revision. The facility's plan of correction for a deficiency regarding a failure to monitor urinary output, cited during the survey ending July 25, 2024, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F690, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding incontinent/catheter care and/or toileting. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's plans of correction for deficiencies regarding failures to maintain a medication error rate below 5 percent, cited during the survey ending July 25, 2024, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F759, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding maintaining a medication error rate below 5 percent. The facility's plan of correction for a deficiency regarding storing/labeling medications properly, cited during the survey ending July 25, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F761, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to storing/labeling medications properly. The facility's plan of correction for a deficiency for not serving palatable food at appropriate temperatures, cited during the survey ending July 25, 2024 and November 21, 2025, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F804, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding palatable food and food temperatures. Refer to F583, F641, F657, F690, F759, F761, F804. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observations and staff interviews, it was determined that the facility failed to maintain the reach-in refrigerator in proper working condition in the Main Kitchen. Findings include: Observations in the dietary department's reach-in refrigerator on June 25, 2025, at 11:51 a.m. revealed that the rubber gasket at the bottom of the door was loose and hanging down, and the door would not close easily. Interview with the Chef Manager at that time confirmed that the refrigerator door's rubber gasket was loose and hanging, and should have been repaired. 28 Pa. Code 211.6(f) Dietary Services.