STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395552	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethlen Hm of the Hungarian Rf of America	66 Carey School Road Ligonier, PA 15658

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 facility policies, review of clinical records, observations, and staff interviews, it was determined that the facility failed to maintain the dignity of one of 42 residents reviewed (Resident 102) who had an indwelling urinary catheter.Findings include: A facility policy for considerate and respectful treatment, dated June 19, 2025, indicated that staff will refrain from practices that are demeaning to patients, such as keeping urinary catheter bags uncovered. Physician's orders for Resident 102, dated August 29, 2025, included an order for staff to place a foley catheter (flexible catheter used to drain urine from the bladder into a drainage collection bag) for urinary drainage. Observations of Resident 102 on September 2, 2025, at 11:37 a.m. revealed the resident was lying in bed with her urinary drainage bag hooked to the side of his bed visible from the door. It was not covered, and yellow urine was visible in the bag. Interview with Registered Nurse 1 on September 2, 2025, at 11:37 a.m. confirmed that Residents 102 did not have a privacy cover on her urinary catheter bag. Interview with the Nursing Home Administrator on September 2, 2025, at 1:03 p.m. revealed that all urinary drainage bags should have privacy covers on them per the facility policy. 28 Pa. Code 201.29(c) Resident Rights.

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to maintain a clean and homelike environment for one of 42 residents reviewed (Resident 66). Finding include:The facility's policy regarding resident's rights, dated June 19, 2025, indicated that the facility was to provide a clean comfortable and homelike environment. A quarterly Minimum data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 66, dated August 8, 2025, revealed that the resident was cognitively intact and had diagnoses that included congestive obstructive pulmonary disease (a lung disease that makes it difficult to breath) and diabetes. Observations on September 1, 2025, at 10:45 a.m. and 2:30 p.m., September 2, 2025 at 1:30 p.m., September 3, at 11:50 a. m. and September 4, 2025, at 8:24 a.m., revealed that the resident was in his room lying on his bed facing the television. It was noted that the wall directly behind his bed, that was visible when you walked into his room, had approximately 20 black and white gouges in the drywall. These gouges varied in length from approximately eight to 22 inches long and covered an area that measured approximately 30 inches wide. Interview with the Director of Maintenance on September 5, 2025, at 8:24 a.m. revealed that he was not aware of the markings in the drywall in Resident 66's room. He indicated that the previous headboards in that room had bolts on the back of them, and when staff moved the bed up and down it apparently gouged the wall. He indicated that the drywall should not be in such poor condition, and that he will be covering the area with a textured recycled plastic.Interview with the Director of Nursing on September 5, 2025, at 8:53 a. m. confirmed that the drywall behind Resident 66's bed should be free of discoloration, scratches and gouges, and it was not. 28 Pa. Code 201.29(j) Resident Rights.28 Pa. Code 207.2(a) Administrator's Responsibility.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from unnecessary psychotropic medications for two of 42 residents reviewed (Resident 39, Resident 40).Findings include: The facility's policy regarding psychotropic medications (any medication that affects brain activities associated with mental processes and behavior), dated June 19, 2025, indicated that residents only receive psychotropic medications when other nonpharmacological interventions are clinically ineffective. A Quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 39, dated June 23, 2025, revealed that the resident was cognitively impaired, usually understood, able to sometimes understand others, was dependent on staff for care needs, had verbal, physical, and other behaviors, and had diagnoses that included anxiety and depression. Physician's orders for Resident 39, dated September 10, 2024, included an order for medication monitoring of anti-anxiety medication every shift to monitor for side effects of medications and documentation of non-pharmacological interventions. Physician's orders for Resident 39, dated June 22, 2025, included an order for the resident to receive 0.5 milligrams (mg) of Ativan (a psychotropic medication used to treat anxiety) every four hours as needed for anxiety. Review of the Medication Administration Record (MAR) for Resident 39 for June 2025, July 2025, and August 2025 revealed that the resident was administered 0.5 mg of Ativan on the following dates and times: June 15, 2025, at 12:52 a.m.; June 17, 2025, at 3:28 a.m.; July 13, 2025, at 6: 50 p.m.; August 3, 2025, at 7:12 p.m.; August 5, 2025 at 6:43 a.m.; August 7, 2025 at 6:41 p. m.; August 8, 2025 at 12:06 p.m.; August 19, 2025 at 2:29 p.m.; August 20, 2025 at 12:28 a.m.; August 28, 2025 at 7:11 a.m. and 9:53 p.m.; and August 31, 2025 at 9:47 a.m. There was no documented evidence that non-pharmacological interventions were attempted prior to administering Ativan on the above stated dates and times. A quarterly MDS assessment for Resident 40, dated August 28, 2025, revealed that the resident was cognitively impaired, was sometimes understood, able to sometimes understand others, was dependent on staff for care needs, had verbal, physical, and other behaviors, and had diagnoses that included non-Alzheimer's Dementia. Physician's orders for Resident 40, dated May 14, 2025, included an order for medication monitoring of anti-anxiety medication every shift to monitor for side effects of medications and documentation of non-pharmacological interventions. Physician's orders for Resident 40, dated December 17, 2024, included an order for the resident to receive 0.5 milligrams (mg) of Ativan (a psychotropic medication used to treat anxiety) every eight hours as needed for anxiety. Review of the Medication Administration Record (MAR) for Resident 40 for July 2025 and August 2025 revealed that the resident was administered 0.5 mg of Ativan on the following dates and times: July 6, 2025, at 3:35 a.m.; July 7, 2025, at 7:06 p.m.; July 9, 2025, at 6:54 a.m.; July 15, 2025 at 10:15 a.m.; July 16, 2025 at 12:04 a.m. and 5:06 p.m.; August 3, 2025, at 7:12 p.m.; August 5, 2025 at 6:43 a.m.; August 7, 2025, at 6:41 p.m.; August 8, 2025 at 12:06 p.m.; August 13, 2025 at 11:49 a.m. and 8:22 p.m.; August 19, 2025 at 2:29 p.m.; August 20, 2025 at 12:28 a.m.; August 28, 2025 at 7:11 a.m. and 9:53 p.m.; and August 31, 2025, at 9:47 a.m. There was no documented evidence that non-pharmacological interventions were attempted prior to administering the Ativan on the above dates and times. Interview with the Nursing Home Administrator on September 5, 2025, at 12:50 p.m. confirmed that non-pharmacological interventions were not attempted prior to administering 0. 5mg Ativan for Resident 39 and Resident 40 on the above dates and times. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to notify the resident and the resident's representative, in writing regarding the reason for transfer to the hospital, to ensure that a bed-hold notice was provided to the resident's responsible party and that the ombudsman was notified of the transfer to the hospital, for three of 42 residents reviewed (Residents 4, 84, 94). Findings include:The facility's policy regarding bed-holds and returns, dated June 19, 2025, indicated that residents and/or representatives are informed (in writing) of the facility bed-hold policies. The facility's policy regarding discharge/ transfer notices indicated that a written notice will be provided to the resident and the resident's representative.A quarterly MDS assessment for Resident 4, dated July 12, 2025, indicated that the resident was cognitively intact, required assistance from staff for all daily care needs, and had a diagnoses that included chronic obstructive pulmonary disease with a history of respiratory failure.Nursing notes for Resident 4, dated July 2, 2025, at 10:00 a.m., revealed that the resident presented with involuntary jerking movements, lethargy and increased swelling of the legs, she was transferred to the hospital and was admitted .There was no documented evidence that written notification of transfer was provided to Resident 4 or the resident's representative, no documented evidence that a bed-hold notice was provided to the resident's responsible party, and no documented evidence that the ombudsman was notified of her transfer to the hospital as required.Interview with the Director of Nursing on September 3, 2025, at 3:12 p.m. confirmed that for Resident 4, there was no written notification of hospital transfer provided to them or their representatives, that a bed-hold notice was not provided to their responsible party, and that the ombudsman was not notified of the transfer to the hospital as required. An annual MDS assessment for Resident 84, dated May 3, 2025, indicated that the resident was cognitively intact, required minimal assistance from staff for all daily care needs, and had diagnoses that included heart failure and end stage renal (kidney) disease.A nursing note for Resident 84, dated April 28, 2025, at 9:17 a.m., revealed that the resident was not responding as normal. She stated that she had fallen but couldn't remember when and had a visible bruise on her forehead. Her son requested she be sent to the hospital for evaluation. She was admitted to the hospital with a diagnosis of anemia, hematoma (bruise) on the forehead post fall, Gastro-intestinal bleed, and diverticulosis (a medical condition where bulging pouches form in the walls of the intestine).There was no documented evidence for Resident 84 that a written notification of transfer was provided to the ombudsman, or that a bed-hold notice was provided to the resident's responsible party.A discharge MDS assessment for Resident 94, dated June 9, 2025, revealed that the resident was cognitively impaired and required maximum assistance from staff for daily care needs.A nursing note for Resident 94, dated June 4, 2025, at 10:49 a.m., revealed that the resident was coughing up blood, had blood coming from her rectum, and to send the resident to the emergency room.There was no documented evidence for Resident 94 that written notification of transfer was provided to the resident's representative and ombudsman, or that a bed-hold notice was provided to the resident's responsible party.Interview with the Director of Nursing on September 5, 2025, at 11:12 a.m. confirmed that for Residents 84 and 94 there was no written notification of hospital transfers provided to the ombudsman, that a bed hold notice was provided, or that a written notice of transfer was provided to the responsible party for Resident 94. 28 Pa. Code 201.29(j) Resident Rights.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on 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 assessments for four of 42 residents reviewed (Residents 5, 40, 41, 69). Findings include:The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated that the intent of Section N0415B Antianxiety, Section N0415C Antidepressant, Section N0415F Antibiotic, and Section N0415I Anticonvulsant Medications were to be coded if the resident took the medication during the seven-day lookback period. Section O0110H1b was to be coded if the resident received IV medications (medication that goes through the veins) while a resident within the last 14 days.Physician's orders for Resident 5, dated July 1, 2025, included an order for the resident to receive 500 milligrams of Metronidazole (an antibiotic) one time a day. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated July 28, 2025, revealed that Section N0415F indicated that the resident did not receive an antibiotic in the last seven days. However, a review of Resident 5's July 2025 Medication Administration Record (MAR) revealed that the resident did receive 500 mg of Metronidazole during the last seven days of the look-back period.Physician's orders for Resident 40, dated December 17, 2025, included an order for the resident to receive 0.5 mg Ativan (an anti-anxiety medication) every 8 hours as needed. A Quarterly MDS for Resident 40, dated August 5, 2025, revealed that Section N0415B indicated the resident did not receive an antianxiety medication in the last seven days. However, a review of Resident 40's July and August, 2025 MAR revealed that the resident did receive 0.5mg Ativan during the last seven days of the look-back period.Physician's orders for Resident 41, dated July 2, 2025, included an order for the resident to receive 2 grams of Ceftriaxone (an antibiotic) Intravenously (IV) one time a day for one administration. An admission MDS assessment for Resident 41, dated July 9, 2025, revealed that Section O0110H1b indicated the resident did not receive IV antibiotics during the last 14 days of the look-back period. However, a review of Resident 41's, July 2025 MAR revealed that the resident did receive 2 grams of Ceftriaxone IV during the last 14 days of the look-back period.Physician's orders for Resident 69, dated November 26, 2024 included an order for the resident to receive 75 mg of Topiramate (an anticonvulsant) daily. Physician's orders for Resident 69, dated October 14, 2023 included an order for the resident to receive 150 mg of Wellbutrin (an antidepressant). Physician's orders for Resident 69, dated May 3, 2023, included an order for the resident to receive 5 mg of Buspirone (an antianxiety) twice a day An annual MDS assessment for Resident 69, dated July 23, 2025, revealed that Section NO415B, Section NO415C, and Section NO415I indicated that the resident did not receive the medications during the seven-day look-back period. However, a review of Resident 69's MAR for July 2025, revealed that the resident did receive 75 mg of Topiramate, 150 mg of Wellbutrin and 5 mg of Buspirone during the seven-day look-back period.Interview with the Nursing Home Administrator on September 4, 2025 at 12:28 p.m. confirmed that the MDS assessments for Residents 5, 40, 41, and 69 were coded inaccurately. 28 Pa. Code 211.5(f) Clinical records.

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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 review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders were followed for one of 42 residents reviewed (Resident 114).Findings include:Physician's orders for Resident 114, dated August 27, 2025, included an order for the resident to receive 1000 milligrams (mg) of Acetaminophen by mouth three times a day for pain and 650 mg of Acetaminophen by mouth every 4 hours as needed for pain, not to exceed 3,000 mg's per 24 hours.Review of the Medication Administration Record (MAR) for Resident 114 for August and September 2025 revealed that the resident received 3,650 mg of Acetaminophen on August 30, 2025 and September 1, 2025.Interview with the Director of Nursing on September 3, 2025, at 11:14 a.m. confirmed that Resident 114's dose of Acetaminophen did exceed the maximum dose for a 24 hour period on the above mentioned dates.28 Pa. Code 211.12(d)(1)(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 clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure that each resident received assistance devices to prevent accidents for one of 42 residents reviewed (Resident 110). Findings include:An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 110, dated August 30, 2025, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included abnormalities of gait and mobility.Physician's orders for Resident 110, dated August 23, 2025, included an order to ensure wheelchair leg rests are in place to secure resident's feet when transported. Observation on September 5, 2025, at 10:45 a.m. revealed that the resident was transported in his chair by Registered Nurse 2 down the hallway to the activity room. Interview with Registered Nurse 2 at the time of the observation confirmed that she did not apply leg rests to Resident 110's chair prior to transporting the resident, and she should have. Interview with the Nursing Home Administrator on September 5, 2025, at 12:25 p.m. confirmed that leg rests should have been in place as ordered when transporting Resident 110.28 Pa. Code 211.10(c)(d) Resident Care Policies.28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 review of policies and clinical records, as well as resident and staff interviews, it was determined that the facility failed to provide appropriate care for one of 42 residents reviewed (Resident 102) who had an indwelling urinary catheter. Findings include: The facility's policy regarding catheter care (a tube placed and held in the bladder to drain urine), dated June 19, 2025, indicated that residents with indwelling catheters should receive appropriate catheter care.A care plan for urinary catheter for Resident 102, dated August 29, 2025 included that staff will perform foley catheter care every shift and staff are to monitor urinary output every shift.Physician's orders for Resident 102 dated August 29, 2025, included an order for foley catheter care every shift.Resident 102's Treatment Administration Records (TAR's) for August 2025 and September 2025 revealed no documented evidence that catheter care was completed or that urinary output was being documented. Interview with the Nursing Home Administrator on September 5, 2025, at 10:49 a.m. confirmed that Resident 102's urinary catheter output should have been documented and catheter care should have been completed, and it was not. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure an oxygen concentrator and filter was cleaned and tubing and humidification were changed per physician's orders for one of 42 residents reviewed (Resident 74), and failed to obtain an order for oxygen for one of 42 residents reviewed (Resident 97). Findings include:A Quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 74, dated July 31, 2025, indicated that the resident was cognitively impaired, was dependent on staff for daily care needs and had a diagnoses that included Chronic Obstructive Pulmonary Disease (a progressive lung disease that causes ongoing inflammation and narrowing of the airways, making it difficult to breathe). Physician's orders for Resident 74, dated December 4, 2024, included an order for the night nurse to check every week on Wednesdays, if oxygen used, to makesure filter is cleaned and oxygen tubing and humidifier has been changed every night shift every 7 day(s) for oxygen maintenance. Review of Resident 74's Treatment Administration Record (TAR) for September 2025 revealed that on September 3, 2025 it was documented that the concentrator filter was cleaned and that the tubing and humidifier was changed on the night shift. Physician's orders for Resident 74, dated April 8, 2025, included an order to change oxygen tubing and humidifier, clean concentrator and filter every night shift every Tuesday. Review of Resident 74's TAR for September 2025 revealed that on September 2, 2025, it was documented that the oxygen tubing and humidifier were changed and that the concentrator and filter was cleaned.Observation September 3, 2025, at 10:03 a.m. revealed that the oxygen concentrator and filter had a thick removable substance on them and the oxygen tubing and humidifier were dated August 27, 2025.Interview with the Director of Nursing on September 3, 2025, at 11:14 a.m. confirmed that the oxygen concentrator and filter did have a thick removable substance on them and the oxygen tubing and humidifier were dated August 27, 2025, indicating that they were not cleaned or changed as documented in Resident 74's September TAR.The facility's policy regarding oxygen therapy, dated June 19, 2025, indicated that oxygen was to be administered in accordance with physician's orders. An admission MDS assessment for Resident 97, dated September 3, 2025, revealed that the resident was cognitively intact and had diagnoses that included pleural effusion (excess fluid between the lungs and chest wall) and atrial fibrillation (an irregular heart rate causing poor blood flow). Review of the clinical record revealed that Resident 97 was admitted on [DATE] with no oxygen in place. A nursing note dated August 31, 2025, revealed that Resident 97 developed wheezing and a moist cough, the physician ordered a chest x-ray and breathing treatments. A progress note dated September 1, 2025, indicated that Resident 97 had oxygen running at 2 liters per minute via nasal cannula (a thin flexible tube under the nose to deliver oxygen).Observations of Resident 97 on September 1, 2025, at 11:10 a.m. and 1:50 p.m. on September 2, 2025 at 2:23 p.m. and September 3, 2025, at 10:48 a.m. revealed that the resident was in her room receiving oxygen from an oxygen concentrator (electrical machine that concentrates oxygen from the air) that was set at 2.0 liters per minute. A review of physician orders for Resident 97, revealed no order for oxygen. Interview with the Nursing Home Administrator on September 3, 2025, at 12:26 p.m. confirmed that Resident 97 had oxygen flowing at a rate of 2 liters per minute continuously without a physician's order, and that there should have been an order for oxygen on the resident's chart, and there was not.28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on review of policy and clinical records, as well as staff interviews, it was determined that the facility failed to respond timely to a pharmacy recommendation for one of 42 residents reviewed (Resident 84). Findings include: A facility policy for drug regimen review, dated June 19, 2025, revealed that a summary of all recommendations is provided to the Director of Nursing and Facility Medical Director every month. The timing of the recommendations should be responded to prior to the next medication review. A Quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 84, dated August 15, 2025, revealed that the resident was cognitively intact, required partial care from staff, and was medicated with an antianxiety medication. A pharmacy consultant note for Resident 84, dated May 15, 2025, revealed that the pharmacist recommended that the physician attempt a Gradual Dose Reduction for the residents order of 25mg Zoloft. A pharmacy consultant note for Resident 84, dated August 15, 2025, revealed that the pharmacist recommended that the physician attempt a Gradual Dose Reduction for the residents order of 25mg Zoloft since August 2025.An interview with the Nursing Home Administrator on September 5, 2025, at 12:57 p.m. confirmed that there was no documented evidence the pharmacist medication regimen review was addressed by the physician from May 2025 until August 2025 and should have been addressed sooner.28 Pa. Code 211.9(f)(3) Pharmacy Services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395552	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethlen Hm of the Hungarian Rf of America	66 Carey School Road Ligonier, PA 15658

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 facility policies and medication package inserts, as well as observations and staff interviews, it was determined that the facility failed to discard expired medical supplies/biologicals, and failed to label multi-dose containers of medications with the date they were opened in one of two medication rooms reviewed (tri west medication room). Findings include: The facility's policies regarding medication storage and disposal, dated [DATE], revealed that the facility would not use outdated supplies, and properly date medication vials after they were opened. An undated package insert for tubersol (medication used to test for tuberculosis) indicated that the medication was to be discarded 30 days after it was entered.Observations in the Tri west medication room on [DATE], at 9:54 a.m. revealed that there were 47 packets of blood collection sets that expired [DATE], three blood collection tubes, two blue and one purple which expired [DATE], and one vial of tuber sol that was open and not dated with the open date.Interview with Licensed Practical Nurse 3 on [DATE], at 10:08 a.m. confirmed that the blood collection sets and blood collection tubes were in current circulation for staff to use, and they were expired. She also confirmed that the tubersol was opened and not dated with an opened date on the box or vial. Interview with the Nursing Home Administrator on [DATE], at 12:49 a.m. confirmed that the 47 vacutainer blood collection sets and three blood collection tubes should not be in circulation if they were expired, and the vial of tubersol should have been dated when it was opened. 42 CFR 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals.28 Pa. Code 211.9(a)(1) Pharmacy services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of facility policies, as well as observations and staff interviews, it was determined that the facility failed to serve food in accordance with professional standards for food service safety by failing to ensure that dietary staff wore beard coverings that completely covered their beard during food handling, and failed to ensure that food items were stored in accordance with professional standards for food service safety in one of three nursing unit pantry refrigerators (100 hall).Findings include:The facility's dietary policy regarding personal hygiene, dated June 19, 2025, revealed that all dietary staff are to wear a hair restraint (hairnet, hat and/or beard restraint) to prevent hair from contacting food.Observations in the kitchen on September 4, 2025, at 12:01 p.m. revealed that the dietary director was in the kitchen where food was being plated without a beard guard.Interview with the Dietary Director on September 4 ,2025, at 12:05 p.m. revealed that he only wears a beard guard when he is cooking and not in the food preparation area.Interview with the Nursing Home Administrator on September 5, 2025, at 12:46 p.m. confirmed that the Dietary Director should have had all of his beard covered.Observations inside the residents' food refrigerator in the medication room on the 100 unit on September 4, 2025, at 10:23 a.m. revealed 2 open, unnamed and undated containers of macaroni salad and an open and undated container or coleslaw.Interview with Licensed Practical Nurse 4 on September 4, 2025, at 10:25 a.m. revealed that the food for the residents should have their name and date on the containers.Interview with the Dietary Director on September 5, 2025, at 12:05 p.m. revealed that food stored in the residents' refrigerators should have a resident's name and date on them.28 Pa. Code 211.6(f) Dietary services.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on a review of clinical records and facility investigations, as well as staff interviews, it was determined that the facility failed to ensure that residents' clinical records were complete and accurately documented for one of 42 residents reviewed (Resident 6).Findings include: A Quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated June 16, 2025, indicated that the resident was cognitively impaired, required substantial assistance with care needs, and was receiving enteral nutrition PEG feedings (a method of providing nutrients directly into the gastrointestinal (GI) tract through a feeding tube into the stomach or intestines). Review of nurse aide documentation for Resident 6, dated August and September 2025, revealed that there was no nurse aide documentation completed for PEG feeds and amount consumed of pleasure feeds on August 1, 2025 for day shift, August 3, 2025 for day and evening shift, August 9, 2025 for day shift, August 18, 2025 for day shift, August 20, 2025 for day and night shift, August 23, 2025 for night shift, August 31, 2025 for night shift. September 3, 2025 for night shift, and September 4, 2025, for evening shift. Not applicable (NA) was documented for PEG feeds and amount of pleasure feeds consumed for day shift on August 3, 4, 6, 7, 10, 11, 13, 14, 15, 17, 19, 21, 22, 23, 24, 29, 31, 2025, September 1, 2, 3, 5, 2025; for evening shift on August 3, 4, 6, 7, 9, 10, 11, 12, 14, 15, 16, 17, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 2025, September 1, 2, and 3, 2025; for night shift on August 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 24, 25, 26, 27, 28, 29, 30, 2025. Review of nurse aide documentation for Resident 6, dated August and September 2025, revealed that there was no nurse aide documentation for providing a pleasure feed to the resident on the day shift of August 1, 2, 9, 2025 and September 4, 2025; for evening shift on August 1 and 18, 2025, and September 4, 2025. NA was documented for night shift on August 23, 2025; for day shift on August 15 and 25, 2025; for evening shift on August 25, 2025; and for night shift on August 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 16, 17, 18, 19, 21, and 25, 2025. Interview with the Registered Dietician on September 3, 2025, at 12:13 p.m. revealed that the amounts of tube feed and pleasure feeds ingested by the resident should be documented in the resident's chart. Interview with the Nursing Home Administrator on September 3, 2025, at 1:52 p.m. confirmed that Resident 6 was receiving her tube feeds and pleasure feeds however, staff were not documenting in the clinical record and should have been.28 Pa. Code 211.5(f) Clinical Records.

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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 a State Survey and Certification (Department of Health) survey ending August 15, 2024, 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 September 5, 2025, identified repeated deficiencies related to safe, clean, comfortable, homelike environment, accurate Minimum Data Set assessments, labeling storage drugs and biologicals, and food procurement. The facility's plan of correction for a deficiency regarding safe, clean, comfortable, homelike environment, cited during the survey ending August 15, 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 F584, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding safe, clean, comfortable, homelike environment. The facility's plan of correction for a deficiency regarding completing accurate MDS assessments, cited during the survey ending August 15, 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 F641, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding accurate MDS assessments. The facility's plan of correction for a deficiency regarding labeling storage drugs and biologicals, cited during the survey ending September 21, 2023, 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 F761, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding labelingstorage drugs and biologicals. The facility's plan of correction for a deficiency regarding proper food procurement, cited during the survey ending August 15, 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 F812, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding food procurement. Refer to F584, F641, F761, F812. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.