STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395554	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest City Nursing and Rehab Center	915 Delaware Street Forest City, PA 18421

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on a review of clinical records and staff interview, it was determined the facility failed to ensure the Minimum Data Set Assessment (MDS a federally mandated standardized assessment conducted at specific intervals to plan resident care) accurately reflected the status of 3 out of 19 sampled (Residents 7, 42, and 17). Findings included: A review of Resident 7's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included dementia and muscle weakness. A review of Resident 7's quarterly MDS assessment dated [DATE], indicated in Section K0200 - A height was coded as 62 inches, and Section K0200 - B weight was coded as 103 pounds (MDS instructions indicate to enter the weight taken within 30 days of this assessment and if the last recorded weight was taken more than 30 days prior to the assessment reference date (ARD) of the assessment or previous weight is not available, weigh the resident again). Record review revealed the weight used for coding was obtained on December 21, 2024, more than 30 days before the ARD. No weight had been obtained within the required timeframe. According to MDS coding instructions, when no weight is available within 30 days, a dash (-) should be used to indicate missing data. In an interview on February 4, 2025, at 1:15 AM, the Registered Dietitian (RD) stated she was unaware of the requirement to code a dash (-) and mistakenly used the outdated weight A review of Resident 42's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included pulmonary edema and spinal stenosis. A review of Resident 42's quarterly MDS assessment dated [DATE], indicated in Section K0200 that the resident's height was 62 inches, and the weight was 117 pounds. Review of Section K0300 indicated that Resident 42 experienced a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months. The quarterly MDS dated [DATE], coded height as 62 inches and weight as 117 pounds. Section K0300 indicated the resident had a weight loss of 5% or more in one month or 10% or more in six months. (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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record found no evidence supporting this weight loss, as the resident had been admitted on ly two days prior to the assessment. The MDS inaccurately reflected the resident's weight status. A review of Resident 17's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included dementia. A review of Resident 17's admission MDS assessment dated [DATE], indicated in Section K0200 that the resident's height was 62 inches, and the weight was 139 pounds. Review of Section K0300 indicated that Resident 17 experienced a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months. The clinical record review revealed no documented evidence that Resident 17 experienced a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months since the resident had been newly admitted to the facility 4 days prior to the MDS submission. On February 4, 2025, at approximately 1:20 PM, the RD confirmed the MDS assessments contained errors. The RD stated she had been using self-reported weights or hospital data rather than documented facility weight records to evaluate weight loss. 28 Pa Code 201.5(f)(i)Medical records. 28 Pa Code 211.12(d)(3)Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on review of clinical records and staff interview it was determined the facility failed to provide care and services in accordance with accepted professional standards of practice by inaccurately identifying a diagnosis of delusional disorder for one (1) of 19 residents (Resident 44) sampled without documented clinical evidence to support the diagnosis. Findings include: According to the American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (DSM-5), Fifth Edition, Delusional Disorder, Diagnostic Criteria includes, but is not limited to: Delusional Disorder A. Nonbizarre delusions (i.e., involving situations that occur in real life, such as being followed, poisoned, infected, loved at a distance, or deceived by spouse or lover, or having a disease) of at least 1 month's duration. A. The presence of one (or more) delusions with a duration of 1 month or longer. B. Criterion A for schizophrenia has never been met. Note: Tactile and olfactory hallucinations may be present in delusional disorder if they are related to the delusional theme. C. Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired, and behavior is not obviously odd or bizarre. D. If mood episodes have occurred concurrently with delusions, their total duration has been brief relative to the duration of the delusional periods. E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition. A review of the Resident 44's clinical record revealed the resident was admitted to the facility on [DATE], with Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks). A review of the consultant pharmacist's initial medication review on September 23, 2024, indicated the resident had an order for Olanzapine 7.5 mg daily, with a recommendation that a diagnosis be provided to justify its use. A review of the Medication Administration Record (MAR) during the survey ending February 7, 2024, revealed that the resident had an order for: Olanzapine 2.5 mg by mouth once daily for delusional disorder. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Olanzapine 5 mg by mouth once daily for delusional disorder. A review of the resident's progress notes lacked documented clinical evidence that the resident was experiencing delusions or hallucinations to support the diagnosis of delusional disorder. A review of an initial consult from the facility's Psychological Service provider dated December 12, 2024, indicated that the resident had a psychiatric history of Alzheimer's disease with behavioral disturbances but did not mention delusional disorder. The consultant further documented the resident was not experiencing delusions or hallucinations at that time. A comprehensive review of the resident's clinical record from admission (September 11, 2024) through the survey period ending February 7, 2024, revealed no documented evidence that a practitioner had diagnosed the resident with delusional disorder, nor were there supporting clinical findings to justify this diagnosis. In an interview with the Director of Nursing (DON) on February 5, 2025, at 2:00 PM, the DON confirmed that the facility did not have documented evidence of a practitioner diagnosing the resident with delusional disorder, and that the resident's medical record should reflect accurate clinical findings. The facility failed to ensure that services were provided in accordance with accepted professional standards of practice by assigning a diagnosis of delusional disorder to Resident 44 without documented clinical evidence or practitioner verification. 28 Pa. Code 211.2(d)(3) Medical director. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on clinical record review, select facility review and staff and resident interview, it was determined the failed to reassess a resident's pain status and the repeated daily use of opioid pain medication prescribed on an as-needed (PRN) basis to ensure the development and implementation of an effective, individualized pain management plan for one of 19 residents sampled. (Resident 28). Findings include: A review of the facility's policy for pain assessment and management, last reviewed in January 2025, revealed that the purpose of the pain management procedure is to assist staff in identifying pain in residents and developing interventions that align with the resident's goals and needs while addressing the underlying causes of pain. The policy requires a comprehensive pain assessment upon admission, at quarterly reviews, when there is a significant change in condition, or when there is a new onset or worsening of pain. Clinical record review revealed that Resident 28 was admitted on [DATE], with diagnoses including dementia and polyneuropathy (a condition involving damage to peripheral nerves outside of the brain and spinal cord). A quarterly Minimum Data Set assessment (MDS a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated January 22, 2025, revealed a BIMS score (Brief Interview for Mental Status. The BIMS test is used to get a quick snapshot of how well you are functioning cognitively at the moment) of 9, a score of 8-13 indicate moderate impairment, required staff assistance for activities of daily living and frequently had severe pain and was receiving both daily pain medications as well as needed (PRN) pain medications. Physician orders for pain management included: Morphine Sulfate Solution 100 mg/5ml (opioid narcotic medication)- 5 mg (0.25 mL) by mouth every 4 hours as needed (PRN) for severe pain, initiated July 11, 2023. Fentanyl transdermal patch (opioid narcotic medication) (12 mcg/hr.) - Applied every 72 hours for polyneuropathy, initiated May 21, 2024. Gabapentin 200 mg (a seizure medication used for nerve pain) - By mouth three times daily for chronic polyneuropathy, initiated March 13, 2024. Oxycodone HCL 5 mg (opioid narcotic medication) - Every 8 hours for chronic pain management, initiated October 19, 2024. A review of the resident's pain management care plan, initiated May 3, 2023, included interventions such as: Administer pain medications as ordered. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Monitor for pain each shift and attempt nonpharmacological interventions (e.g., relaxation, repositioning, music therapy). Encourage the resident to communicate pain levels and try different pain relief methods. Evaluate the effectiveness of pain interventions, including compliance, symptom alleviation, and impact on function and cognition. A review of narcotic medication reconciliation records and medication administration records (MARs) from June 2024 through February 2025 indicated the following PRN Morphine administration: 1 dose in June 2024 1 dose in August 2024 1 dose in October 2024 4 doses in November 2024 2 doses in December 2024 37 doses in January 2025 7 doses from February 1-3, 2025 The MARs also confirmed that the resident received the Fentanyl patch, Oxycodone, and Gabapentin daily as ordered. A review of a resident evaluation dated August 21, 2024, revealed Resident 28 reported chronic, continuous, bilateral knee pain, rated 6/10 worst (on a scale of 0-10 with 0 being no pain and 10 being the most severe), but the assessment did not document factors exacerbating or relieving the pain. September 10, 2024 - Resident 28 denied pain. October 22, 2024 - Resident 28 denied pain. No additional documented pain assessments were found in the clinical record at the time of the survey. During an interview on February 6, 2025, at 1:00 PM, the Director of Nursing (DON) confirmed that no additional pain assessments had been conducted to justify the significant increase in daily PRN opioid use. The DON acknowledged that there was no evidence of a comprehensive pain reassessment to determine whether the resident's pain management regimen was effective, appropriate, or in need of adjustment. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At the time of the survey, there was no documentation indicating that the facility had evaluated the causes of the resident's increased PRN opioid use or modified the pain management plan accordingly. The failure to reassess pain and adjust treatment as needed does not align with professional standards of practice, current clinical guidelines, or the facility's own pain management policy. This deficient practice resulted in the potential for unmanaged pain, unnecessary opioid exposure, or adverse medication effects, failing to ensure that Resident 28's pain management was individualized, effective, and consistent with their needs, goals, and preferences. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on review of controlled drug records and select facility policy and staff interview, it was determined the facility failed to implement procedures to promote accurate controlled medication records and failed to ensure medication availability for one of 19 residents sampled (Resident 28). Finding include: Clinical record review revealed that Resident 28 was admitted to the facility on [DATE], with diagnosis to include dementia and polyneuropathy (a condition where peripheral nerves outside the brain and spinal cord are damaged). A quarterly Minimum Data Set assessment (MDS a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated January 22, 2025 revealed a BIMS score (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information of 9, (a score of 8-12 indicate moderate impairment), required staff assistance for activities of daily living and frequently had severe pain and frequently experienced severe pain and was prescribed both daily pain medications and as-needed (PRN) pain medications A review of the clinical record revealed that Resident 28 had a current physician's order dated May 22, 2023, for Morphine Sulfate Solution 100 mg/5 ml (a narcotic opioid pain medication) to be administered 0.25 mls (5 mg) by mouth every four hours as needed for severe pain. A review of the controlled substance record for the above medication revealed that nursing staff signed out doses of 0.25 mls on the following dates and times: December 31, 2024, at 5:30 P.M. January 3, 2025, at 6:30 P.M. January 6, 2025, at 12:00 P.M. January 7, 2025, at 8:00 A.M. January 11, 2025, at 2:30 P.M. January 13, 2025, at 8:00 P.M. January 27, 2025, at 4:00 P.M. January 29, 2025, at 5:00 P.M. February 1, 2025, at 9:40 A.M. February 3, 2025, at 11:00 P.M. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	However, there was no corresponding documentation on the resident's Medication Administration Record (MAR) indicating that the medication was administered on those dates and times. During an interview conducted on February 6, 2025, at 1:00 P.M., Resident 28 was unable to provide information regarding her pain or medication regimen due to cognitive impairment. During an interview on February 6, 2025, at approximately 11:00 A.M., the Director of Nursing (DON) confirmed that there were inconsistencies in the controlled medication records, specifically that doses were signed out but not documented on the MAR to confirm administration. The facility failed to ensure that appropriate procedures were followed for controlled medication documentation and administration. Cross refer F 761 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services. 28 Pa Code 211.9(a)(1)Pharmacy services. 28 Pa Code 211.5(f)(x) Clinical records

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that residents are free from unnecessary drugs to include duplicate pain medications for one of 19 sampled residents (Resident 28). Findings include: Clinical record review revealed that Resident 28 was admitted to the facility on [DATE], with diagnosis to include dementia and polyneuropathy (a condition where peripheral nerves outside the brain and spinal cord are damaged). A quarterly Minimum Data Set assessment (MDS a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated January 22, 2025 revealed a BIMS score (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information of 9, (a score of 8-12 indicate moderate impairment), required staff assistance for activities of daily living and frequently had severe pain and frequently experienced severe pain and was prescribed both daily pain medications and as-needed (PRN) pain medications A review of the clinical record revealed that Resident 28 had current physician orders for multiple opioid and non-opioid pain medications, including: Morphine Sulfate Solution 100 mg/5ml (a narcotic opioid pain medication) solution, take 0.25 ml 5 mg by mouth every 4 hours as needed for severe pain initiated July 11, 2023. Fentanyl transdermal patch (an opioid narcotic medication) 72 hour-12 mcg/hr., Applied every 72 hours for polyneuropathy-initiated May 21, 2024. Gabapentin (a seizure medication sometimes used for nerve pain) 200 mg by mouth three times daily for chronic polyneuropathy (initiated March 13, 2024. Oxycodone HCL (a narcotic opioid pain medication) 5 mg by mouth every 8 hours for chronic pain management initiated October 19, 2024. Clinical record review did not include documentation justifying the use of duplicate opioid pain medications (Morphine, Fentanyl, and Oxycodone) for this resident. During an interview on February 6, 2025, at approximately 11:00 AM, the Director of Nursing confirmed that there was no justification for the duplicate pain medication therapy for Resident 28. Cross refer F 697 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa Code 211.9(a)(1)Pharmacy 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** 26142 Based on clinical record review, staff interviews, and observations, the facility failed to ensure medications were labeled in accordance with currently acceptable principles of medication storage and administration, including appropriate resident identification, medication information, and expiration/open dates for one of 19 sampled residents (Resident 28). Findings include: According to the FDA (federal drug administration) current as of January 21, 2025, and best practice, Expiration Dating of Multi-dose Vials indicated the date refers to the date after which an unopened multi-dose vial should not be used. The beyond-use-date refers to the date after which an opened multi-dose vial should not be used. The beyond-use-date should never exceed the manufacturer's original expiration date. Medication vials should always be discarded whenever sterility is compromised or cannot be confirmed. For example: If a multi-dose has been opened or accessed (e.g., needle-punctured) the vial should be dated with the last date that the product should be used (expiration date) and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. Labeling the vial with the 'date opened' does not meet the intent of this requirement. If a multi-dose vial has not been opened or accessed (e.g., tab removed, needle-punctured), it should be discarded according to the manufacturer's expiration date which is generally printed on the label by the manufacturer. For expiration dates that only include the month/year, the unopened product is considered usable until the end of the month unless otherwise stated by the manufacturer. Clinical record review revealed that Resident 28 was admitted to the facility on [DATE], with diagnosis to include dementia and polyneuropathy (a condition where peripheral nerves outside the brain and spinal cord are damaged). A quarterly Minimum Data Set assessment (MDS a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated January 22, 2025 revealed a BIMS score (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information of 9, (a score of 8-12 indicate moderate impairment), required staff assistance for activities of daily living and frequently had severe pain and frequently experienced severe pain and was prescribed both daily pain medications and as-needed (PRN) pain medications. Physician orders dated May 22, 2023, included an order for Morphine Sulfate Solution 100 mg/5 ml, with a dosage of 0.25 mL (5 mg) by mouth every four hours as needed for severe pain. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of narcotic sign out sheets for Resident 28 revealed a 30 mL bottle of Morphine Sulfate dispensed from the pharmacy on May 22, 2023, was still in use as of January 1, 2025, despite multi-dose liquid medications requiring disposal within 28 days of opening unless otherwise specified by the manufacturer. This bottle was in use for approximately 20 months beyond recommended guidelines. Further review of the record revealed the medication was removed from the bottle and administered to Resident 28 on the following dates and times: December 8, 2023, at 2:30 A.M., May 6, 2024, at 5:00 P.M. May 6, 2024, at 8:00 P.M. May 7, 2024, at 8:00 A.M. May 7, 2024, at 4:00 P.M. May 8, 2024, at 9:00 A.M. May 8, 2024, at 4:00 P.M. May 10, 2024, at 4:00 A.M. May 10, 2024, at 2:00 P.M. June 26, 2024, at 4:00 P.M. August 22, 2024, at 9:30 A.M. October 31, 2024, at 12:00 P.M. November 1, 2024, at 2:00 P.M. November 1, 2024, at 8:00 P.M. November 1, 2024, at 12:25 P.M. December 13, 2024, at 2:00 P.M. December 29, 2024, at 4:45 A.M. December 31, 2024, at 5:30 P.M. January 1, 2025, at 8:00 A.M. January 1, 2025, at 12:29 P.M. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The narcotic sign out record noted that 25 mls of the Morphine Sulfate Solution were destroyed by two facility licensed nurses on January 14, 2025, noting the reason for the medication destruction as, medication expired. A second 30 mL bottle dispensed on July 11, 2023, was administered to the resident through January 10, 2025, despite being open for 18 months. Further review of the record revealed the medication was removed from the bottle and administered to Resident 28 on the following dates and times: January 1, 2025, at 8:00 P.M. January 1, 2025, at 8:00 P.M. (The same licensed nurse documented that she spilled 15 mL on the floor-wasted medication.) January 3, 2025, at 6:30 P.M. January 4, 2025, at 8:31 A.M. January 4, 2025, at 1:52 P.M. January 5, 2025, at 9:26 A.M. January 5, 2025, at 5:56 P.M. January 6, 2025, at 8:00 A.M. January 6, 2025, at 12:00 P.M. January 6, 2025, at 4:00 P.M. January 6, 2025, at 8:00 P.M. January 8, 2025, at 7:15 A.M. January 9, 2025, at 3:30 P.M. January 10, 2025, at 7:00 A.M. January 10, 2025, at 3:00 P.M. The narcotic sign out record noted that 10.75 ml of the Morphine Sulfate Solution was destroyed by two facility licensed nurses on January 14, 2025, noting the reason for the medication destruction as, expired medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395554	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest City Nursing and Rehab Center	915 Delaware Street Forest City, PA 18421

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	An interview February 5, 2025, at 11:00 A.M. Employee 2 (agency LPN) indicated she was administering medications to residents on January 11, 2025, and noted Resident 28's bottle of Morphine Sulfate concentrate was faded in color. She stated that it should be a vibrant blue color and was a very faded shade of blue, almost clear. She stated she then checked the additional bottle in the locked narcotic box. The color was noted as the same. She confirmed both bottles were opened with approximately one half the medication remaining in the bottles. She indicated she had administered the Morphine Sulfate solution to Resident 28 on several previous occasions and did not check the label for expiration or open dates on either bottle. She stated that on January 11, 2025, when the discolored medication was discovered, a new bottle was retrieved from the emergency supply; however: an observation on February 5, 2025, at 8:00 A.M., in the presence of Employee 1 (LPN), of the locked narcotic drawer in the medication cart was a 30 ml plastic bottle of Morphine Sulfate Solution, 100 mg/5 cc (concentration) No label was affixed to the bottle. The resident's last name was handwritten on the cap with a marker. There was no pharmacy label or identifying information, including the medication name, concentration, dosing instructions, prescribing provider, or date of removal from the emergency supply. The controlled drug count sheet lacked essential details, including proper medication identification and tracking information. During an interview February 5, 2025, at 11:00 A.M., the Director of Nursing confirmed that both bottles the bottles of Morphine Sulfate solution had been opened and available for resident use since May 2023 (20 months) and July 2023 (18 months) and staff had not been monitoring open or expiration dates. The facility's expectation was to discard liquid medications 30 days after opening and staff failed to label the emergency supply medication and did not contact the pharmacy for proper labeling. This resulted in the administration of an unlabeled narcotic medication to Resident 28 from January 11, 2025, through February 3, 2025. During an interview on February 5, 2025, at 11:15 A.M., the DON confirmed that staff failed to label the emergency supply medication and did not contact the pharmacy for proper labeling. This resulted in the administration of an unlabeled narcotic medication to Resident 28 from January 11, 2025, through February 3, 2025. The facility failed to implement proper oversight and adherence to medication labeling protocols 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services. 28 Pa Code 211.9(a)(1)Pharmacy services. 28 Pa Code 211.5(f)(x) Clinical records

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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. 43944 Based on observation and staff interview, the facility failed to maintain proper storage and service practices for food in the dietary department and second-floor resident pantry/nourishment room. This failure created the potential for contamination, microbial growth, and an increased risk of foodborne illness. Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). A review of a facility policy entitled Storage Areas provided by the facility on November 27, 2024, indicated that sufficient storage facilities are provided to keep food safe, wholesome, and appetizing. Food is started in an area that is clean, dry, and free from contaminants. All foods should be covered, labeled, dated, and stored off the floor. When taking dietary supplements out of the freezer to defrost, they should be labeled with a use by date. Magic Cups (high calorie, high protein ice cream/pudding nutrition supplement) within five days, 4-ounce Health Shakes/Nutritious Juice (high calorie, high protein oral nutrition supplements) within 14-days. The initial tour of the dietary department was conducted with the facility's food service director (FSD) on February 4, 2025, at 9:02 AM, and revealed the following unsanitary practices with the potential to introduce contaminants into food and increase the potential for food-borne illness, including: Upon entry to the dietary department/kitchen area observed an unlidded garbage can full of trash in the cook's prep area. Observations of a metal wire storage rack revealed three plastic white bulk food storage containers with sugar and flour left uncovered and stored less than six inches from the floor. Inside of the walk-in freezer two white bins containing Magic Cup frozen supplements in direct contact with the walk-in freezer floor. Inside of the walk-in produce cooler, a wet tray of 16 thawed Mighty Shakes in the walk-in produce cooler that were not labeled with a thaw date, contrary to manufacturer instructions requiring a use by date (manufacture notes a 14-day shelf life after thawing) A clear pitcher containing an unidentified tan-colored, gritty substance and an open gallon of whole milk, both unlabeled and undated, inside the walk-in produce cooler. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The dry-storage area revealed seventeen cases of food and supplies in direct contact with the dry storage area floor post-delivery. Additional food safety concerns were noted in the food preparation area: A hole in the ceiling tile and reddish-brown splatters on multiple ceiling tiles. A drawer storing cooking equipment containing food particles and a reddish substance smeared inside. A soft, discolored (dark yellow) brick of butter with food particles adhered to the surface. Food debris and splatter on the wall behind the stove, oven, and griddle. Four uncovered knives stored on a magnetic strip in the cook's area. A red bucket with a rag left inside the prep sink. Ceiling tiles above the tray line and dish room area with visible food splatter and water staining. During an observation of the second-floor resident pantry/nourishment room on February 4, 2025, at 11:37 AM: A dirty breakfast tray was found on top of the ice machine next to an uncovered plastic bin with an ice scoop inside. Food splatter, chipping, and rust were observed inside the microwave. The pantry refrigerator/freezer contained multiple opened and unlabeled food items, including a 14-ounce bottle of ketchup, a 15-ounce container of butter, and a half gallon of ice cream and and a plastic gallon container of ice cream. A cabinet in the pantry area contained an unlabeled plastic storage container with peanut butter, a pre-portioned bag of cookies, and an opened loaf of bread, all without proper labeling. The inside of the cabinet had debris. An interview with the Nursing Home Administrator (NHA) on February 5, 2025, at 1:00 PM confirmed that the dietary department and pantry/nourishment areas should be maintained in a sanitary manner and all supplements should be labeled and stored according to manufacturer instructions. The facility's failure to adhere to proper food storage and sanitation practices increased the risk of food contamination and potential foodborne illness among residents 28 Pa. Code 201.18 (e) (2.1) Management 28 Pa. Code 211.6 (f) Dietary Services