STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395556	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shenandoah Senior Living Community	101 E. Washington St Shenandoah, PA 17976

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and staff interviews, it was determined the facility failed to consistently implement person-centered care plan interventions for pressure injury prevention for one of 24 residents reviewed (Resident 2).Findings include: Clinical record review revealed that Resident 2 was admitted to the facility on [DATE], with diagnoses to include Diabetes Mellitus (a chronic disorder characterized by consistently high blood sugar levels) and hemiplegia (paralysis) and hemiparesis (weakness) following a cerebral infarction (stroke) affecting the resident's right side. Review of Resident 2's current comprehensive care plan, initiated September 20, 2023, and revised January 12, 2026, indicated the resident was at risk for impaired skin integrity related to impaired mobility, advanced age, moisture, and pressure. Interventions included the use of a specialty mattress, Protekt Proactive air mattress (a therapeutic mattress designed to prevent and treat pressure injuries by alternating pressure and reducing moisture), with staff to check the function every shift. Review of a physician's order dated November 11, 2025, confirmed an order for a Protekt Proactive specialty air mattress with instructions for staff to check the function every shift. Observation on April 29, 2026, at 8:40AM revealed Resident 2 in bed without a specialty air mattress in place. A follow-up observation on April 30, 2026, at 11:12AM, conducted in the presence of Employee 4 (Licensed Practical Nurse) and Employee 5 (Licensed Practical Nurse), confirmed a standard mattress was in use rather than the ordered specialty air mattress. Review of the April 2026 Treatment Administration Record (TAR) revealed nursing staff documented each shift that the air mattress function check was completed, despite the absence of the ordered specialty mattress. Interview with the wound care nurse on April 30, 2026, at 11:55AM revealed that although Resident 2's prior pressure areas had resolved, the physician order and care plan intervention for the Protekt Proactive air mattress remained in place for ongoing prevention. The wound care nurse confirmed the resident continued to require the intervention due to persistent risk factors. The nurse further indicated the facility had experienced prior issues with malfunctioning air mattresses but was unaware that Resident 2 did not have the ordered mattress in place. During an interview on April 30, 2026, at 1:30PM, the Nursing Home Administrator and Director of Nursing acknowledged that staff failed to implement the physician-ordered and care planned intervention for pressure injury prevention. They further acknowledged the TAR documentation was inaccurate and were unable to provide documented evidence explaining why staff recorded completion of air mattress checks when the intervention was not in place. 28 Pa. Code 211.12 (d)(5) Nursing services.

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 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** Based on clinical record review, select facility policy review, and resident and staff interviews, it was determined the facility failed to ensure that pain management was provided in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for one of 24 residents reviewed (Resident 80). Findings include: A review of the facility policy titled Pain Management Policy, last reviewed June 13, 2025, revealed it is the facility policy that the provider and staff will identify individuals who have pain or who are at risk of having pain. It includes a review for any treatments the resident is currently receiving for pain including implementing pharmacological (medication) and non-pharmacological (non-medication) interventions and evaluating the effectiveness of interventions. Clinical record review revealed Resident 80 was admitted on [DATE], with diagnoses including mechanical loosening of an internal right hip prosthetic joint (a condition in which an artificial hip joint becomes unstable or loose, causing pain and difficulty moving) and Reiter's Disease (also known as reactive arthritis, an inflammatory condition affecting joints and other body systems following infection). A review of Resident 80's current plan of care identified acute and chronic pain related to right hip surgery. Interventions included assessing pain, administering medications as ordered, implementing non-pharmacological interventions, and monitoring effectiveness of treatment. A review of a quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 20, 2025, revealed that Resident 80 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). A physician's order dated February 14, 2026, directed Oxycodone HCL 5 mg by mouth every four hours as needed for severe pain rated 7 to 10 (pain rating refers to a standard numeric pain scale of 0 to 10, where 0 indicates no pain and 10 indicates the worst pain imaginable; a rating of 7 to 10 is generally considered severe pain requiring stronger interventions), for 14 days. Oxycodone is an opioid (narcotic) pain medication classified as a Schedule II controlled substance, meaning it has an accepted medical use but carries a high potential for misuse and requires close monitoring. An additional order dated February 25, 2026, directed Acetaminophen 975 mg every eight hours for moderate pain (rated 4 to 6). Acetaminophen (commonly known as Tylenol) is a non-opioid analgesic used to relieve mild to moderate pain. A CRNP (Certified Registered Nurse Practioner) progress note dated February 25, 2026, at 1:21 PM documented the resident reported pain rated 8 out of 10 and that pain medication had not been administered as ordered overnight. Review of the Medication Administration Record (MAR, a legal record documenting medications administered to a resident) confirmed no pain medication was administered during the overnight shift. Nursing progress notes dated February 28, 2026, at 11:56AM; March 20, 2026, at 11:48AM; March 28, 2026, at 11:41AM; and April 2, 2026, at 7:13AM consistently documented that Oxycodone 5 mg was administered for right hip pain with only short-term or minimal effectiveness. A review of the clinical record revealed no documented evidence that the physician was notified that the prescribed Oxycodone regimen was consistently ineffective in relieving the resident's pain. During an interview on April 29, 2026, at 11:00AM, Resident 80 reported the Oxycodone was causing me to be more anxious, and that seems to increase my pain, so why take it. I've told them the medication was not working more than once but nothing got changed. The resident reported that during a recent orthopedic consultation (a specialist evaluation for bone and joint conditions), the provider recommended a trial of Dilaudid (hydromorphone, a stronger opioid medication used to treat severe pain when other medications are ineffective). The resident stated I haven't gotten it yet. I am just taking Tylenol now, but that does nothing. A review of an orthopedic consultation record dated April 28, 2026, revealed documented post-operative care instructions and treatment recommendations. The (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	record indicated the surgical incision staples were removed and steri-strips (adhesive wound closure strips used to support healing) were applied, with instructions to keep the area dry for one week. The resident could begin showering after one week but was not to submerge the surgical site in water for three months post-operatively (after surgery). The consultation included orders for Doxycycline (an antibiotic medication used to treat or prevent infection) for 12 weeks post-operatively and Eliquis (an anticoagulant medication used to prevent blood clots) for 12 weeks. Activity restrictions included non-weight bearing status (inability to place weight on the affected leg) and no range of motion exercises (movement of the joint) at that time due to right knee pain and swelling. The consultation further indicated that, per the resident's request, a trial of Dilaudid (hydromorphone, an opioid medication used to treat severe pain) by mouth could be considered in place of Oxycodone, with a recommendation to avoid continued opioid use beyond three months post-operatively. The record also indicated Acetaminophen (Tylenol) could be administered as needed for pain and that non-steroidal anti-inflammatory drugs (NSAIDs, such as ibuprofen, used to treat pain and inflammation) were not recommended. A follow-up appointment was scheduled in two weeks. A review of a physician progress note dated April 29, 2026, at 7:46AM revealed the resident returned from the orthopedic appointment in stable condition. The note documented that follow-up instructions were acknowledged, including a scheduled appointment on May 12, 2026, and permission to begin showering on May 8, 2026, with continued non-weight bearing status to the right leg. The note further documented the resident requested Dilaudid for pain management; however, the physician elected not to change the current pain medication regimen and to continue Oxycodone at that time, and the resident was informed. An interview conducted with Resident 80 on May 1, 2026, at 9:30AM revealed the resident reported she was only taking Acetaminophen for pain management. Resident 80 stated, I am going to file a grievance over this; my pain is a 9 today. I've been suffering for days, and my medication still has not been changed. An interview with the Director of Nursing (DON) on May 1, 2026, at 10:00AM confirmed that the orthopedic consultation record indicated the resident's pain medication could be changed; however, the facility physician elected not to change the resident's pain medication from Oxycodone to Dilaudid (hydromorphone, a stronger opioid medication used to treat severe pain). The DON further confirmed that nursing staff had contacted the physician regarding the resident's ongoing complaints of pain. An additional interview was conducted with the DON on May 1, 2026, at 11:15AM to review the above findings related to the facility's failure to ensure pain management was provided in accordance with professional standards of practice, including ongoing assessment, monitoring, and adjustment of the pain management regimen. 28 Pa. Code 211.10 (c) Resident care policies. 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, investigative documentation provided by the facility, and resident and staff interviews, it was determined the facility failed to maintain a safe and homelike environment by not ensuring a bathroom safety handrail (grab bar) was securely affixed to the wall for one resident out of 24 residents reviewed (Resident 31).Findings include: A review of a facility policy titled Falls Management System, last reviewed by the facility on June 13, 2025, revealed it is the policy of the facility to provide each resident with appropriate evaluation and interventions to prevent falls and to minimize complications if a fall occurs. A review of Resident 31's clinical record revealed the resident was admitted to the facility on [DATE], with a diagnosis that included morbid obesity (a chronic disease that's characterized by a body mass index of 40 or higher, or a body mass index of 35 or higher with obesity-related health issues) and generalized muscle weakness. A review of Resident 31's Quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 16, 2026, revealed that Resident 31 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13 through 15 indicates cognition is intact). A review of Resident 31's comprehensive plan of care initiated on August 16, 2025, and last revised on April 20, 2026, indicated the resident had an ADL self-care performance deficiency related to generalized weakness and obesity (ADLs, fundamental self-care tasks required for independent living such as bathing, dressing, toileting, and feeding oneself). Interventions included assistance from one person for toilet use. The care plan also identified the resident as high risk for falls with interventions that included bed and chair alarms and an alarm to the bathroom door. A review of facility investigative documentation dated April 17, 2026, at 11:30 AM, revealed the resident was found on the floor in front of the toilet. The bathroom grab bar (a fixed safety handrail designed to provide stability during transfers) had detached from the wall and floor. The resident reported self-transferring when the bar came out of the wall. The resident's chair alarm was documented as being in the off position. A hematoma (a localized collection of blood under the skin) with surrounding bruising was observed on the left forehead; no measurements were documented. A review of a witness statement from Employee 6, Certified Nurse Aide, dated April 17, 2026, revealed the employee heard the resident calling out, entered the bathroom, and found the resident on the floor with the bathroom grab bar pulled out of the wall and floor. The chair alarm was noted to be off. A review of a nurse progress note completed by Employee 7 Licensed Practical Nurse (LPN) on April 17, 2026, at 11:52 AM, revealed the nurse responded after the resident was found on the floor. The note documented that the grab bar had come out of the wall and floor during the resident's attempt to transfer. A hematoma with bruising to the left forehead was recorded. Maintenance was notified and responded to assess the detached equipment. An interview with Resident 31 on April 28, 2026, at 1:00 PM, revealed the resident reported that while using the bathroom on April 17, 2026, the grab bar pulled out of the wall as the resident attempted to rise, causing the fall. The resident was observed to have residual bruising that appeared black and yellow around both eyes. The resident stated after the fall, maintenance had come in and fixed her grab bar in the bathroom. An interview with the Maintenance Director on May 1, 2026, at 11:05 AM, revealed he responded after the incident and confirmed the grab bar had detached from the wall and floor. He stated this had occurred previously and attributed it to the manner in which the resident used the bar to pull upward. He reported that larger screws were installed following the incident to secure the bar. No documented evidence was provided to demonstrate that prior reinforcement, inspection, or corrective measures had been implemented to ensure the grab bar remained secure before the fall. An interview with the Physical Therapy Director (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on May 1, 2026, at 1:10 PM, revealed the resident had previously been educated on safe use of the grab bar. The above findings were reviewed with the facility's Nursing Home Administrator and Director of Nursing on May 1, 2026, at 12:30 PM, and confirmed that resident bathrooms are expected to be maintained in a safe condition. 28 Pa Code 201.18(b)(1) (e)(1) Management. 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa Code 211.12(c)(d)(1)(3)(5) Nursing Services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, select facility policy review, investigative documentation provided by the facility, and staff interviews, it was determined the facility displayed past noncompliance by failing to ensure the safety and supervision of one resident from exiting through unsecured doors for one out of 24 residents reviewed (Resident 99).Findings include: A review of the facility policy titled Elopement/Wandering Risk Guideline, last reviewed by the facility on June 13, 2025, revealed it is the policy of the facility to provide a safe and secure environment for the residents and be proactive in preventing resident elopement. Elopement is defined as a resident leaving a safe area of the facility without authorization. Upon admission, readmission, quarterly, and with a significant change of condition, residents will be assessed for elopement risk. A review of the facility policy titled Wandering, Unsafe Resident, last reviewed by the facility on June 13, 2025, revealed it is the policy of the facility to identify residents who are at risk for harm because of unsafe wandering. A review of the clinical record revealed that Resident 99 was admitted to the facility on [DATE], with diagnoses to include cerebral infarction (brain damage that results from a lack of blood) and cognitive-communication deficit (difficulties in communication arising from impairments in cognitive processes such as attention, memory, or problem-solving). A review of Resident 99's Quarterly Minimum Data Set Assessment (MDS, a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated January 28, 2026, revealed the resident was severely cognitively impaired with a BIMS score of 02 (Brief Interview for Mental Status, a tool to assess the residents' attention, orientation, and ability to register and recall new information; a score of 0 through 7 indicates severe cognitive impairment). A review of an elopement risk assessment dated [DATE], identified the resident as being at low risk for elopement. Review of facility-provided investigative documentation dated August 2, 2025, at 11:05AM, revealed Resident 99 was observed ambulating unattended in the parking lot outside the facility. Documentation indicated the resident was last seen at approximately 9:00AM during morning medication administration. A Nurse Aide (Employee 8) observed the resident outside near the rear doors of C hall and re-entered the building to assist the resident back inside through a side emergency exit. A head-to-toe assessment (body audit) revealed no injuries. Documentation revealed Resident CR1 reported observing Resident 99 exit through the front entrance, sitting on the porch, then ambulate through the parking lot toward the personal care area and out of view. A written witness statement dated August 4, 2025, at 1:22PM, indicated the resident remained outside unsupervised for approximately 30 minutes. A witness statement from Employee 8, NA dated August 4, 2025, at 1:38PM, confirmed the resident was observed outside through the rear door windows and was not authorized to be outside independently. The employee exited the building and escorted the resident back inside. A written statement from Employee 9 (Licensed Practical Nurse), dated August 4, 2025, indicated the resident had been seen earlier at approximately 9:00AM for medication administration and was later reported to be outside. The nurse turned off the door alarm to allow re-entry and subsequently applied a wander guard device. A review of a physician order dated August 2, 2025, at 12:03PM, revealed an order was obtained after the incident for a Wander Guard (an electronic monitoring device worn by a resident that triggers an alarm if the resident approaches or exits through secured doors) and for staff to monitor placement each shift. A nursing progress note documented by the Assistant Director of Nursing (ADON) on August 2, 2025, at 12:34PM, confirmed Resident 99 was found outside the facility and that a Wander Guard was applied after the incident. The note indicated the resident had previously gone outside with his sister but was not permitted to exit independently. Staff re-educated the resident regarding this restriction following the event. A subsequent elopement risk assessment dated [DATE], identified the resident as moderate risk for elopement, indicating a change in risk (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	status following the incident. During an interview on April 29, 2026, at 1:00 PM, the ADON confirmed the resident exited the facility unsupervised on August 2, 2025. The ADON stated the resident had a history of going outside with a family member but should not have been exiting independently. The ADON further confirmed there was no staff assigned to monitor the front entrance on weekends, which limited oversight of resident exits. During a telephone interview on May 1, 2026, at 12:45 PM, Employee 8 NA confirmed observing the resident outside the building and escorting him back inside after determining he was not permitted to be outdoors independently. An observation on April 28, 2026, at 11:00 AM, of Resident 99 revealed a Wander Guard to their left wrist as ordered by the physician. Observation on April 28, 2026, at 11:00AM, revealed Resident 99 had a Wander Guard device in place as ordered. These findings demonstrated the facility failed to implement adequate supervision and monitoring systems, including door monitoring and staff oversight, to prevent a cognitively impaired resident from exiting the facility unsupervised and remaining outside for an extended period. The failure to recognize and address elopement risk prior to the incident, despite significant cognitive impairment, and the lack of environmental safeguards (including consistent monitoring of exit points) resulted in the resident leaving the facility without staff awareness. This deficiency is cited as past noncompliance. The facility's corrective action plan was to identify other residents with the potential to be affected and to identify those listed at risk for elopement. Elopement assessments were initiated and completed on all residents. Any newly identified residents with moderate or high scores for risk of elopement had their plans of care reviewed to ensure accuracy and appropriate interventions, and wander guards were applied if applicable. New signage was posted encouraging families and visitors not to let residents out and ask staff for assistance. To prevent this from recurring, the NHA and Interdisciplinary Team (IDT) provided re-education to facility staff regarding the facility's elopement policy, including procedures and protocols, initiated on August 4, 2025, with completion on August 5, 2025. To monitor and maintain ongoing compliance, the facility performed audits on all new admissions to determine if risk was present and is ongoing at the facility on a daily basis during the morning meetings. The findings of the plan of correction were submitted to QAPI for review. Documentation provided by the facility indicated corrective actions were completed on August 5, 2025, and no further similar incidents were identified, demonstrating the facility achieved substantial compliance after that date. Therefore, this deficiency is cited as past noncompliance. 28 Pa Code 201.14(a) Responsibility of Licensee. 28 Pa Code 201.18(b)(1) (e)(1) Management. 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa Code 211.12(c)(d)(1)(3)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, select facility policy review, and staff interviews, it was determined the facility failed to ensure that appropriate physician orders, a documented medical justification, and an individualized plan of care were in place for the use and management of an indwelling urinary catheter for one of 24 residents reviewed (Resident 83).Findings include: A review of a facility policy titled Urinary Continence and Incontinence Assessment and Management, last reviewed by the facility on June 13, 2025, revealed it is the policy of the facility that indwelling urinary catheters will be used sparingly, for appropriate indications only. If the resident is admitted from the hospital with a newly placed indwelling catheter, the attending physician and staff will evaluate the potential for removing it, depending on the current condition and the rationale for its original placement. The physician will identify and refer, as appropriate, individuals who might benefit from urological procedures to improve continence. The physician will identify situations in which an indwelling catheter is indicated and will document why other alternatives are not feasible. If a catheter is used, the physician and staff will document the clinical indications for use of the catheter and utilize a standardized tool to document its ongoing need. A review of Resident 83's clinical record revealed that the resident was admitted to the facility on [DATE], with a diagnosis that included dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and overactive bladder (a condition causing a sudden and frequent urge to urinate). A review of Resident 83's Quarterly Minimum Data Set Assessment (MDS, a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated April 25, 2026, revealed the resident was severely cognitively impaired with a BIMS score of 05 (Brief Interview for Mental Status, a tool to assess the residents' attention, orientation, and ability to register and recall new information; a score of 0 through 7 indicates severe cognitive impairment). A review of Resident 83's comprehensive care plan, initiated November 16, 2021, and last revised January 28, 2026, indicated the resident had urinary incontinence (involuntary loss of urine) with interventions including a scheduled toileting program (a structured plan to assist the resident to the bathroom at regular intervals) upon rising, at meal times, at bedtime, and as needed and a urology appointment on February 5, 2026. The care plan did not include any interventions related to the use or management of an indwelling urinary catheter. A review of a urology consultation report dated February 5, 2026, revealed the resident was evaluated for urinary retention (inability to fully empty the bladder). The report indicated a cystometrogram (CMG, a test that measures how well the bladder stores and releases urine) was completed. The urologist recommended placement of a Foley catheter (a thin, flexible tube inserted through the urethra into the bladder to continuously drain urine) due to an atonic bladder (a bladder with weakened muscle function) and significant residual urine (urine remaining in the bladder after voiding). The report also recommended a follow-up appointment in one month, along with initiation of medications including Urecholine (a medication used to stimulate bladder contraction) and Flomax (a medication used to improve urine flow). The consultation was signed as acknowledged by the facility on February 5, 2026. A review of the clinical record failed to reveal evidence that the recommended follow-up urology appointment was scheduled or completed. A review of physician orders revealed an order dated March 30, 2026, for an 18 French Foley catheter (the term French refers to the diameter size of the catheter; 18 French is a relatively larger size used for drainage) with a 10 cubic centimeter (cc) balloon (a small inflatable balloon at the tip of the catheter used to keep it in place inside the bladder) attached to a drainage bag to gravity (a collection bag that allows urine to drain continuously without suction). The order included instructions to change the catheter monthly and as needed for leakage, dislodgement (movement out of place), or occlusion (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(blockage), and to check placement and patency (whether the catheter remains open and draining) every shift. Further review of physician orders failed to reveal any documented clinical justification (medical reason) for the continued use of the indwelling catheter. An observation conducted on April 28, 2026, at 12:50PM revealed Resident 83 had a Foley catheter in place with a drainage bag. Despite the presence of the indwelling catheter, a review of the care plan failed to include the catheter, lacking interventions for catheter care (such as monitoring for infection, ensuring proper positioning, and maintaining hygiene), and did not address the ongoing need for the device. An interview with the Director of Nursing and Regional Nurse Consultant on May 1, 2026, at 10:30AM confirmed the facility did not have documented physician justification for the catheter, did not ensure follow-up with urology as recommended, and did not include the catheter in the resident's plan of care. They acknowledged the care and treatment provided to Resident 83 were not consistent with facility policy or acceptable standards of practice. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing Services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395556	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shenandoah Senior Living Community	101 E. Washington St Shenandoah, PA 17976

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of controlled drug shift count records, clinical records, facility policy, and staff interviews, it was determined the facility failed to implement procedures to ensure accurate accountability and documentation of controlled medications on three of four medication carts observed and failed to maintain accurate records related to the administration and reconciliation of controlled medications for one of 24 residents reviewed (Resident 80).Findings include: A review of the facility policy titled, Controlled Substances, (medications regulated by state and federal law due to the potential for abuse, dependence, misuse or diversion) last reviewed June 13, 2025, revealed controlled substance inventory is monitored and reconciled to identify loss or potential diversion (the unauthorized redirection or misuse of medications) in a manner that minimizes the time between loss or diversion and detection and follow up. The policy indicated the nurse coming on duty and the nurse going off duty are to complete the controlled medication count together and document and report any discrepancies to the Director of Nursing Services. The policy indicated that the facility would comply with all laws, regulations, and requirements related to the handling, storage, disposal, and documentation of controlled medications. The policy identified the system of reconciling the receipt, dispensing, and disposition of controlled substances includes records of personal access and usage, medication administration records, declining inventory records, and destruction, waste, and return-to-pharmacy records. A review of the facility Shift Change Narcotic Audit for the Blue Unit B Hall medication cart serving Rooms 002 through 015 revealed the following: On April 27, 2026, the day shift off-going nurse failed to sign the narcotic count record indicating the controlled medication count was completed and correct. An interview conducted with Employee 1, Licensed Practical Nurse on April 29, 2026, at 9:13 AM confirmed the off-going nurse failed to sign the Shift Change Narcotic Audit for the identified date. A review of the facility Shift Change Narcotic Audit for the Blue Unit A Hall medication cart serving Rooms 001 through 017 revealed the following: On April 9, 2026, the off-going evening shift nurse failed to sign the narcotic count record indicating the controlled medication count was completed and correct. An interview conducted with Employee 2, LPN, on April 29, 2026, at 9:28 AM confirmed the off-going nurse failed to sign the Shift Change Narcotic Audit for the identified date. A review of the facility Shift Change Narcotic Audit for the Yellow Unit C Hall medication cart serving Rooms 001 through 017 revealed the following: On April 22, 2026, both the on-coming day shift nurse and the off-going nurse failed to sign the narcotic count record indicating the controlled medication count was completed and correct. An interview conducted with Employee 3, LPN, on April 29, 2026, at 9:41 AM confirmed the identified nurses failed to sign the Shift Change Narcotic Audit for the identified date. A review of Resident 80's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including mechanical loosening of an internal right hip prosthetic joint (a condition occurring after hip replacement surgery when the artificial joint becomes loose causing pain, instability, and discomfort) and Reiter's Disease (an inflammatory condition triggered by an infection somewhere else in the body affecting joints, eyes, and urinary tract). A review of the clinical record revealed a physician's order for Resident 80 to receive Oxycodone HCL oral tablet 5 milligrams (Schedule II controlled narcotic medication with a high potential for abuse and dependence) was initiated on February 14, 2026, with instructions to administer one tablet every four hours as needed for pain levels of seven through ten (a standardized pain rating scale in which zero indicates no pain and ten indicates the worst possible pain) for 14 days. A review of facility records revealed the facility utilized a Controlled Substance Record Form to track, monitor, and reconcile controlled medications, including Oxycodone. A review of facility clinical records revealed the facility tracked medication administration for each resident through the Medication Administration Record (MAR, a legal medical record used to document medications administered to a resident). The MAR indicated (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the medication administered, time and date of administration, staff administering the medication, pain level prior to medication administration, and the clinical rationale for administering the medication. A comparison of Resident 80's Controlled Substance Record Form with the resident's Medication Administration Record (MAR) from February 14, 2026, through April 17, 2026, revealed 68 instances in which Oxycodone 5 milligram tablets were documented on the Controlled Substance Record Form as removed from the medication supply; however, there was no corresponding documentation on the MAR indicating the medication was administered to Resident 80. The following dates and times reflected discrepancies between the Controlled Substance Record Form and the MAR documentation: February 14, 2026, at 12:00 AM, and 6:30 AMFebruary 15, 2026, at 6:00 AMFebruary 17, 2026, at 3:45 PMFebruary 18, 2026, at 3:45 PMFebruary 19, 2026, at 5:00 PM and 9:00 PMFebruary 21, 2026, at 8:00 PMFebruary 23, 2026, at 5:00 PM and 9:00 PMFebruary 24, 2026, at 6:30 PM and 10:30 PMFebruary 25, 2026, at 6:00 AM and 7:30 PMFebruary 26, 2026, at 3:30 PM and 8:30 PMFebruary 27, 2026, at 4:30 PM and 10:00 PMMarch 1, 2026, at 3:00 AMMarch 3, 2026, at 7:20 PM and 9:20 PMMarch 4, 2026, at 6:38 PMMarch 5, 2026, at 4:10 PM and 9:00 PMMarch 6, 2026, at 10:00 PMMarch 7, 2026, at 8:00 PMMarch 10, 2026, at 6:30 AMMarch 11, 2026, at 2:00 AM, 5:00 AM, 5:25 PM and 9:25 PMMarch 12, 2026, at 6:15 PM and 10:16 PMMarch 13, 2026, at 6:55 AMMarch 15, 2026, at 1:50 AMMarch 19, 2026, at 7:00 PM and 11:00 PMMarch 21, 2026, at 5:30 PM and 9:30 PMMarch 23, 2026, at 1:30 PM and 7:00 PMMarch 24, 2026, at 1:05 AMMarch 25, 2026, at 7:00 PMMarch 26, 2026, at 5:12 PM and 9:12 PMMarch 28, 2026, at 3:35 AMMarch 30, 2026, at 5:30 PM and 9:30 PMApril 1, 2026, at 4:30 PM and 8:30 PMApril 2, 2026, at 5:11 PM and 9:11 PMApril 4, 2026, at 8:00 PMApril 5, 2026, at 1:00 AM, 5:00 PM, and 9:00 PMApril 8, 2026, at 5:34 PM and 9:34 PMApril 10, 2026, at 10:00 PMApril 11, 2026, at 5:10 AMApril 13, 2026, at 8:40 PMApril 14, 2026, at 6:00 PM and 10:00 PMApril 15, 2026, at 06:34 AM and 7:00 PMApril 17, 2026, at 4:10 AM 5:00 PM and 9:00 PM An interview was conducted on May 1, 2026, at 10:05 AM with the Director of Nursing (DON) and Nursing Home Administrator (NHA) during which the above findings related to the reconciliation and documentation of controlled medications, including Resident 80's Oxycodone records, were reviewed. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing service. 28 Pa Code 211.9 (c)(k) Pharmacy services. 28 Pa Code 211.5(f)(x) Clinical records. 28 Pa. Code 211.10(a) Resident Care Policies.

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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 clinical record review, consultant pharmacist documentation review, and staff interview, it was determined the facility failed to ensure the attending physician responded to and acted upon consultant pharmacist recommendations regarding identified irregularities in the medication regimen for one of 24 residents reviewed (Resident 13).Findings include: Review of Resident 13's clinical record revealed admission to the facility on October 20, 2018, with diagnoses to include schizoaffective disorder (mental health condition characterized by a combination of hallucinations, delusions, disorganized speech and mood disorder symptoms), major depressive disorder (major loss of interest in pleasurable activities), anxiety disorder, and dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning). Review of the consultant pharmacist's Note to Attending Physician/Prescriber dated November 5, 2025, addressed the physician's orders for Olanzapine (an antipsychotic medication used to treat schizophrenia and bipolar disorder) 5 mg every 12 hours and Fluoxetine (an antidepressant used to treat major depressive disorder)10 mg daily. The consultant pharmacist recommended a Gradual Dose Reduction (GDR, a systematic process of slowly tapering a medication's dosage to determine if a lower dose or discontinuation is possible while managing symptoms) or trial discontinuation, noting that CMS guidelines require a periodic review of psychoactive medications. The pharmacist further noted that if the drug therapy is clinically contraindicated (inadvisable because it could be harmful or dangerous to the resident), the physician must document the clinical rationale. This recommendation indicated the physician documentation must include the reason(s) why an attempted GDR would likely impair the resident's' function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. The clinical record failed to provide written documented evidence the attending physician responded to, acknowledged, or acted upon the consultant pharmacist's recommendation regarding the resident's psychoactive medications. During an interview on May 1, 2026, at 1:00 PM, the Regional Nurse Consultant confirmed that the facility was unable to provide documented evidence the attending physician responded to or acted upon the consultant pharmacist's recommendations.28 Pa. Code 211.9 (k) Pharmacy services. 28 Pa Code 211.5 (f)(vii) Medical records. 28 Pa. Code 211.2 (d)(7) Medical director.

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F 0585 Level of Harm - Potential for minimal harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on a review of select facility policies, clinical records, and staff and resident interviews, it was determined that the facility failed to ensure an ongoing grievance system was maintained to track resident grievances, including the date and time the grievance was lodged and the date of resolution, for one of 24 residents reviewed (Resident 103). Findings include: Review of the facility's grievance policy, reviewed June 13, 2025, revealed that residents have the right to prompt efforts to resolve grievances they may have. The grievance process is overseen by the grievance official who is responsible for overseeing the grievance process, which includes receiving and tracking grievances through their conclusion. A reasonable timeframe the resident can expect a completed review of the grievance is within 5 to 7 days. Evidence shall be maintained, demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. Clinical record review of Resident 103 revealed a Significant Change Minimum Data Set assessment, (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 30, 2026, which indicated that Resident 103 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information as score of 13-15 indicates intact cognition). An interview with Resident 103 on April 30, 2026, at 9:40 AM revealed the resident had lodged several complaints with the nursing home administrator within the past three months concerning call bell timeliness and had verbally spoken to the nursing home administrator on a weekly basis. The resident indicated the issue has been ongoing. The resident reported waiting up to one hour for assistance, particularly during the 3:00 PM to 11:00 PM shift, including weekends, and expressed concern that the facility did not have sufficient staff to meet residents' needs. During an interview with the nursing home administrator on April 30, 2026, at 12:00 PM, the surveyor requested the facility's grievance tracking records for the prior three months. Review of the records provided revealed the facility did not maintain a complete and ongoing system for tracking resident grievances. The documentation lacked essential elements, including the identity of the individual who made the grievance, the nature of the grievance, the date and time the grievance was lodged, and the date of resolution. Review of the facility's call bell policy dated June 13, 2025, revealed that it is the policy for the employees to respond to resident call bells within 15 minutes or less.During the interview on April 30, 2026, at 12:00 PM, the nursing home administrator was unable to provide call bell audit records upon request and was unable to provide evidence that Resident 103's concerns were being monitored, investigated, or trended through the grievance process. The administrator was further unable to provide documented evidence that the resident's verbal grievances were recorded, tracked, or processed in accordance with facility policy to ensure timely resolution. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(3) (5) Nursing services.