STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395564	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Ridge Rehabilitation & Healthcare Center	500 West Hospital Street Taylor, PA 18517

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, the facility's abuse prohibition policy, facility investigative documentation, and staff interviews, it was determined the facility failed to ensure a resident was free from neglect by failing to provide care and services in accordance with the resident's plan of care. Specifically, staff failed to utilize the required sliding board with assistance of one staff member during a transfer from wheelchair to bed, as planned to ensure safety and prevent injury. As a result of this failure, one resident (Resident CR147) sustained an acute distal femur fracture that progressed to an above-the-knee amputation, representing actual harm to one resident out of 3 discharged residents sampled. This deficiency is cited as past noncompliance.Findings include: A review of the facility Abuse Policy last reviewed on January 14, 2026, indicated it was the facility's policy for residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. The facility's policy defined neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress. Some examples of individual failures noted in the facility's abuse policy included the following: failure to provide sufficient, qualified, competent staff to meet resident's needs, failure to provide orientation and/or training to staff, failure to provide training on new equipment or new procedures or medications required for the care of a specified resident or required due to changes in acceptable standards, failure of staff to implement resident interventions, even when residents are assessed, and interventions are identified in the care plan. A closed clinical record review revealed Resident CR147 was admitted to the facility on [DATE], with diagnoses that included a history of a right BKA (below-knee amputation, a surgical procedure performed to remove a part of the lower leg that is not viable or healthy), Type II diabetes mellitus (a chronic condition affecting the body's ability to regulate blood sugar), chronic pain syndrome (a complex condition characterized by persistent pain lasting for at least three months, often accompanied by emotional and psychological symptoms such as depression and anxiety), and unspecified lack of coordination (a medical condition that affects the body's ability to coordinate movements and maintain balance). A review of a quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 12, 2025, revealed Resident CR147 had a BIMS score of 14 (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 intact cognition). The assessment revealed the resident required substantial to maximal assistance from staff for bed mobility, transfers, toileting, and movement from sitting to standing positions. A review of Resident CR147's care plan, initiated April 15, 2025, identified an activity of daily living self-care performance deficit related to impaired mobility secondary to right BKA. Planned interventions included transfers using a sliding board (a rigid (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 0600 Level of Harm - Actual harm Residents Affected - Few	transfer device placed between two surfaces to allow a resident to move safely from one surface to another while minimizing twisting, weight bearing, and shear forces). The care plan required assistance of one staff member during transfers, use of a wheelchair with positioning supports, and use of a prosthetic limb (an artificial device designed to replace a missing limb and restore some degree of function). A review of investigative documentation and clinical records dated December 31, 2025, revealed that Employee 1, a Registered Nurse (RN), documented that Resident CR147 reported pain in their right leg following a transfer from wheelchair to bed performed by a Nurse Aide (NA) Employee 2. The documentation reflected that the transfer involved a pivot assist (a transfer technique in which a staff member assists a resident to stand, turn or rotate on one or both feet, and then sit on another surface, requiring the resident to bear weight and maintain balance during the movement) while the resident was wearing a prosthetic to the right lower extremity. The resident reported that her right knee twisted during the transfer and stated, My right knee twisted when I was getting into bed. The resident reported a pain level of 7 (a standardized numeric pain scale ranging from 0 to 10, where 0 indicates no pain and 10 indicates the worst pain imaginable. A pain rating of 6 to 7 is considered severe pain and may interfere with concentration and functional ability). Review of the investigative documentation revealed that the Certified Registered Nurse Practitioner (CRNP) assessed Resident CR147 and observed swelling of the right knee. New orders were issued to obtain an x-ray of the right knee, elevate the right leg on a pillow, apply ice for 15 minutes, and medicate for pain as ordered. A review of the resident's x-ray report dated December 31, 2025, at 4:29 PM revealed an acute comminuted distal femur fracture of her right leg (a recent fracture of the thigh bone near the knee involving multiple fracture fragments). The resident's attending physician was notified of the results and ordered transfer to the hospital for further evaluation and treatment of the right leg. A review of a written statement completed by Employee 2, NA, dated December 31, 2025, no time recorded , revealed Employee 2 reported, I was transferring Resident CR147 into bed to change her, she refused the slide board so I put the wheelchair close to the bed, stood her up straight, and pivoted her to a sitting position on the bed, she had her prosthetic on her right leg. When I got her on the bed, she said that her right leg twisted, but when I looked her right leg was straight and while turning her the leg moved the way it should, the prosthetic remained straight. A review of a written statement provided by Resident CR147 dated December 31, 2025, no time recorded revealed the resident reported that Employee 2, NA, did not use the sliding board during the transfer. The resident stated, I didn't refuse it (the slide board), the Nurse Aide said hug me and I put my arms around her neck and she pulled me up, turned me but my foot didn't turn, I said ouch it hurt by my knee, then she went to get the nurse. A review of investigative documentation included a written statement completed by Employee 3, the Occupational Therapist treating Resident CR147, dated January 2, 2026, at 11:27 AM. Employee 3 reported that on December 30, 2025, the day prior to the injury, Employee 2 requested assistance with transferring the resident. The Occupational Therapist documented that the resident expressed a preference to transfer using her prosthetic limb instead of the sliding board. In the presence of Employee 3, Employee 2 transferred the resident from the wheelchair with the right armrest removed using a low pivot transfer with hands-on assistance. Employee 3 documented that both Employee 2 and Resident CR147 were educated on the requirement to continue transfers using the sliding board from the wheelchair to the bed until all staff were trained and educated on alternative transfer methods. The Occupational Therapist documented that understanding was verbally acknowledged by both the staff member and the resident. A review of Resident CR147's hospital records revealed a vascular surgery consultation dated January 1, 2026, at 9:56 PM. The consultation documented that the resident was an established vascular surgery patient with a prior BKA, who presented with a right distal femur fracture. The consulting provider documented that surgical repair was indicated due to the severity of the fracture. However, the resident declined open reduction and internal fixation (ORIF, a surgical procedure used to realign and stabilize broken bones using internal hardware such as plates or screws) and instead elected to undergo an above-the-knee (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	amputation (AKA, surgical removal of the leg above the knee). Hospital records revealed the resident underwent the AKA procedure on January 2, 2026. A review of the facility's investigative documentation dated January 2, 2026, regarding allegations of abuse and neglect, revealed the facility determined Employee 2 failed to follow Resident CR147's plan of care by not utilizing the required sliding board during a transfer from the wheelchair to the bed. The documentation reflected that this failure resulted in Resident CR147 sustaining a right distal femur fracture requiring surgical intervention. The facility substantiated neglect related to this event, and Employee 2 was terminated from employment. During an interview on February 4, 2026, at 1:35 PM the Director of Nursing confirmed the facility failed to ensure staff consistently utilized the care-planned transfer device, specifically the sliding board, to safely transfer Resident CR147 from the wheelchair to bed and prevent physical harm. The Director of Nursing confirmed that Employee 2's failure to follow the resident's plan of care directly resulted in the resident sustaining a right distal femur fracture that required surgical intervention in the form of an above-the-knee amputation. This deficiency is cited as past non-compliance. The facility's corrective action plan included the following: Post incident on December 31, 2025, the Employee 2, NA, was suspended due to failure to utilize a slide board to transfer Resident CR147 from the wheelchair to the bed that resulted in the resident experiencing pain in the right knee with an order from the MD to obtain an x-ray. Employee 2 was terminated due to Resident CR147 sustaining a fracture due to the employee neglecting to follow the resident's plan of care. Results of the x-ray were obtained on December 31, 2025, at 4:29 PM and revealed an acute comminuted distal femur fracture. The resident's attending physician was notified of the results with an order to transfer the resident to the hospital for evaluation and treatment of the right leg. Cognitively intact residents in Employee 2's assignment area were interviewed to ensure transfers were done as per their plan of care correctly and no complaints/concerns were reported. To prevent future incidents, all nursing staff were re-educated on the facility's Abuse Policy and educated on the importance of following resident's plan of cares for transfers to prevent injuries. To monitor and maintain ongoing compliance, the Director of Nursing or designee will review a sample of five residents to ensure transfers based on their care plan are followed by direct observation. Audits will continue for thirty days and then re-evaluated. The facility's compliance date was January 6, 2026, and completion of the corrective action plan noted above was confirmed during the survey ending February 6, 2026. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 201.29 (a)(c) Resident Rights. 28 Pa. Code 211.10 (a)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(5) Nursing Services.

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical records, review of hospital records, and resident and staff interview, it was determined that the facility failed to provide care and services consistent with professional standards of practice by failing to follow physician-ordered bowel protocol for one of 26 residents (Resident 75) reviewed, which resulted in hospitalization and actual harm. Additionally, the facility failed to follow professional standards of practice related to medication administration management for one of three closed residents (Resident CR3) sampled.Findings include: According to the American Academy of Family Physicians (The American Academy of Family Physicians is one of the largest medical organizations in the US founded to promote the science and art of family medicine) the primary goal of constipation management should be symptom improvement. The secondary goal should be the passage of soft, formed stool without straining at least three times per week. Clinical record review revealed that Resident 75 was admitted to the facility on [DATE], with diagnosis to include, hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting the right dominant side (hemiplegia refers to the complete paralysis of one side of the body, while hemiparesis indicates partial weakness on one side. a nontraumatic intracerebral hemorrhage, which is bleeding within the brain tissue itself, typically due to the rupture of a blood vessel). A quarterly Minimum Data Set Assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 2, 2025, revealed that Resident 75 was severely cognitively impaired, required extensive assistance of staff for activities of daily living, and was frequently incontinent of bladder and bowel. Review of the clinical record revealed that physician orders dated July 1, 2023, included the following bowel protocol for Resident 75: Milk of Magnesia (MOM, Magnesium Hydroxide an oral laxative used to treat constipation) Suspension 400 mg (milligrams)/5 mL: Give 30 mL (milliliters) by mouth as needed for constipation if no bowel movement after the third day or nine shifts. Bisacodyl suppository (stimulant laxative) 10 mg: Insert one suppository rectally as needed for constipation if no bowel movement 24 hours after Milk of Magnesia is ineffective. Fleet's Enema (liquid laxative for severe constipation), insert one application rectally as needed for constipation if no bowel movement on the fifth day and no result from the suppository; notify the physician if no bowel movement occurs. Review of Resident 75's bowel movement tracking documentation for December 2025 revealed that 11 shifts passed between December 6, 2025, and December 9, 2025, without a documented bowel movement. The review revealed that 11 additional shifts passed between December 25, 2025, and December 28, 2025, without a bowel movement. A small, liquid, non-formed bowel movement was documented on December 29, 2025. A review of Resident 75's Medication Administration Record (MAR) for December 2025, revealed no documented evidence that nursing staff administered the physician-ordered bowel protocol during the periods when Resident 75 had no bowel movements. A review of the clinical record revealed Resident 75 was transferred to the hospital on December 30, 2025, for evaluation of respiratory symptoms. Review of a hospital diagnostic report dated December 30, 2025, revealed a computed tomography (CT) scan (a diagnostic imaging test that produces detailed cross-sectional images of the body) of the abdomen and pelvis was ordered due to abdominal pain. The CT scan of the resident's abdomen and pelvis completed on December 30, 2025, revealed marked distention (enlargement) of the rectum and distal rectosigmoid colon (part of the large intestine that connects to the rectum) with a large fecal burden (fecal impaction is a hard, immobile mass of stool lodged in the rectum due to prolonged constipation), with bowel wall thickening suspicious for stercoral colitis (a serious inflammatory condition of the colon caused by prolonged fecal impaction that can lead to bowel perforation and life-threatening infection). The report further indicated that the uterus (pear shaped organ in lower abdomen of a woman responsible for nourishing and housing a fetus) was displaced anteriorly and to the right due to severe colonic distention with stool. Review of the hospital record revealed that manual (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	disimpaction (physical removal of impacted stool) was attempted on December 30, 2025, and was unsuccessful. Surgical consultation recommended an aggressive bowel regimen, including multiple enemas. Hospital documentation indicated that the resident received enemas at 3:00 PM and 6:00 PM. on December 30, 2025, after which the resident had a bowel movement. During an interview with the Director of Nursing (DON) on February 6, 2026, at 9:20 AM the DON was unable to provide evidence that the physician-ordered bowel protocol was followed for Resident 75 during the periods without bowel activity described above. The facility failed to implement the physician-ordered bowel protocol for Resident 75, which resulted in actual harm, as evidenced by hospitalization and a large fecal impaction causing marked enlargement of the rectum and colon, stercoral colitis, and displacement of the uterus. A closed clinical record review revealed Resident CR3 was admitted to the facility from the hospital on January 23, 2026, with the primary diagnosis of wedge compression fracture of the first lumbar vertebra (the front of a bone in the back collapses). Review of the facility policy titled Medication Administration, last reviewed January 14, 2026, revealed medications are to be administered in a safe and timely manner as prescribed. The policy stated that if a medication is withheld, refused, or administered at a time other than scheduled, the administering staff member must document this on the Medication Administration Record and provide supporting documentation. Review of the electronic medication administration record revealed an order for Enoxaparin Sodium Injection 90 mg, to be administered subcutaneously once daily (subcutaneous means injected under the skin). Enoxaparin is an anticoagulant medication used to prevent deep vein thrombosis (blood clots in the veins, typically in the legs) that may travel to the lungs and cause a pulmonary embolism (a potentially life-threatening blockage of blood flow to the lungs). The medication was ordered to start on January 24, 2026, at 9:00 a.m., with an end date of January 26, 2026, at 10:31 AM. The medication administration record indicated that the medication was not administered as ordered on January 24, 2026, and directed the reviewer to nursing narrative notes. A review of the narrative nurses' notes did not include any information, rationale, or insight regarding why the medication was not administered or what other measures were taken when the medication was not administered. During an interview with the Director of Nursing on February 5, 2026, at 11:12 AM., the DON confirmed Resident CR3 did not receive the prescribed dose of Enoxaparin due to medication unavailability. The DON was unable to provide evidence that the medication was obtained from the facility's emergency supply, that the physician was notified, or that appropriate documentation was completed to reflect the missed dose. 28 Pa. Code 211.12 (d)(1)(5) Nursing services. 28 Pa Code 211.10 (a)(c) Resident care policies.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, the Resident Assessment Instrument (RAI), Minimum Data Set (MDS) assessments, and staff interviews, it was determined the facility failed to ensure the MDS accurately reflected the clinical status and services provided for two of 26 sampled residents (Residents 12 and 8).Findings include: A review of Resident 12's clinical record revealed the resident was admitted on [DATE], with diagnoses that included dementia without behavioral disturbance (a chronic disorder affecting memory and thinking) and anxiety (a condition involving excessive worry or nervousness). A physician's order dated December 19, 2025, at 5:22 PM, revealed an order written by the facility's Certified Registered Nurse Practitioner (CRNP) for intravenous micronutrient hydration therapy provided by an outside contracted nursing service. The order included an intravenous infusion (fluid delivered directly into a vein through a catheter) containing the following substances: B-Complex (a combination of B vitamins that support energy metabolism and nerve function)Vitamin C 5,000 milligrams (a vitamin that supports immune function and tissue repair)Methyl-cobalamin (Vitamin B12, a vitamin important for nerve function and red blood cell production)Zinc 10 milligrams (a mineral involved in immune function and wound healing)Magnesium chloride 600 milligrams (a mineral involved in muscle and nerve function)Calcium chloride 100 milligrams (a mineral important for bone strength and muscle function)Taurine 100 milligrams (an amino acid that supports neurological and cardiovascular function)Glycine 100 milligrams (an amino acid involved in protein synthesis and nervous system function)Folic acid 5 milligrams (a B vitamin necessary for cell growth and red blood cell production) These substances are classified as vitamins or micronutrients. Vitamins are organic compounds required in small amounts for normal body function and are typically obtained through diet or oral supplements. They are not considered parenteral nutrition (intravenous feeding that provides calories, protein, fats, carbohydrates, vitamins, and minerals as a primary nutritional source). The micronutrients were added to 500 milliliters (ml) of 0.9 percent normal saline (a sterile saltwater solution commonly used for hydration) and infused at 250 ml per hour on December 20, 2025. A review of the December 2025 Medication Administration Record (MAR) revealed the infusion was administered and completed on December 20, 2025, at 8:30 AM. The Resident Assessment Instrument (RAI) Manual is the federally issued instruction manual that provides specific coding guidance for each item on the Minimum Data Set (MDS). Facilities are required to code the MDS exactly as instructed in the RAI Manual to ensure accuracy, consistency, and regulatory compliance. The RAI Manual for Section K0520 (Nutritional Approaches, Parenteral/IV Feeding) instructs that parenteral feeding refers to intravenous nutrition that provides calories and nutrients when a resident cannot receive adequate nutrition by mouth or through the gastrointestinal tract. The Manual specifically states that IV fluids administered only for hydration or IV fluids used to reconstitute or dilute medications must not be coded as parenteral/IV feeding. The RAI Manual for Section O0110H1 (Special Treatments, Procedures, and Programs, IV Medications) instructs that this item includes drugs or biological agents administered intravenously by IV push (direct injection into a vein), continuous infusion (drip), or through a central or peripheral IV line (a catheter inserted into a vein). The Manual further clarifies that IV fluids without medication and flushes used only to maintain IV line patency (to keep the line open) must not be coded in this item. A review of Resident 12's annual MDS dated [DATE], revealed that: Section K0520 (Parenteral/IV Feeding) was coded yes, indicating the resident received IV feeding during the seven-day look-back period (the seven days preceding the assessment reference date).Section K0710 (Percent Intake by Artificial Route) was coded 25 percent or less of total calories received through parenteral or tube feeding during the seven-day look-back period.Section K0710B (Average fluid intake per day by IV or tube feeding) was coded 500 milliliters per day or less during the seven-day look-back period.Section O0110H1 (IV Medications) was coded yes.However, review of Resident 12's clinical record revealed documentation of a one-time (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	condition, or medication interfering with the resident's ability to maintain normal fluid balanceDocumentation that oral hydration interventions were attempted and unsuccessfulA documented plan of care addressing hydration needs requiring intravenous therapy Additionally, the records did not demonstrate that the intravenous infusion provided artificial nutritional support (intravenous feeding supplying calories as a primary source of nutrition), as defined under Section K0520 of the RAI Manual. Although the contracted service's educational material suggested the therapy could be coded under Section K0520A, the RAI Manual requires that coding decisions be based on the resident's clinical condition and supporting documentation in the medical record. In the absence of documentation demonstrating medical necessity for hydration consistent with RAI criteria, the coding of Sections K0520, K0710 (Percent Intake by Artificial Route), and O0110H1 (IV Medications) on the respective MDS assessments was not supported by resident-specific clinical documentation. During an interview with the facility's Nursing Home Administrator (NHA) on February 6, 2026, at 11:30 AM, the above findings were reviewed. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical record review, and staff interview, it was determined the facility failed to develop and implement a comprehensive, person-centered care plan that included measurable objectives and individualized interventions to address a resident's diagnosed medical condition for one of 30 residents reviewed (Resident 13).Findings include:A review of the facility policy titled Care Plans, Comprehensive Person Centered, last reviewed by the facility on January 14, 2026, revealed that a comprehensive person-centered care plan with measurable objectives and timeframes is to be developed and implemented to meet each resident's physical, psychosocial (mental and social), and functional (ability to perform daily activities) needs. Clinical record review revealed Resident 13 was admitted to the facility on [DATE], with diagnoses that included Viral Hepatitis C (a contagious infection that causes inflammation or damage to the liver, most commonly spread through contact with infected blood) without hepatic coma (a severe complication of liver failure resulting in decreased brain function due to toxin buildup in the bloodstream). Review of Resident 13's comprehensive care plan, initiated October 25, 2025, revealed there were no identified problems, goals, or interventions addressing the resident's diagnosis of Viral Hepatitis C. The care plan did not include monitoring for potential symptoms or complications, infection control considerations, laboratory monitoring, medication management, or education related to the liver condition. An interview was conducted with the Director of Nursing (DON) on February 5,2026, at 1:45 PM to review the above findings related to the facility's failure to develop a comprehensive care plan related to this resident's specific diagnosis. 28 Pa. Code 211.12(d)(1)(5) Nursing services. 28 Pa. Code 211.10(c)(d) Resident care policies.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of select facility policy and interviews with residents and staff, it was determined the facility failed to review and revise a resident's plan of care in response to a significant weight loss for one resident out 26 residents reviewed (Resident 8).Findings include: Review of the facility policy titled Weight Assessment and Intervention last reviewed January 26, 2026, revealed care planning for weight loss should include identification of the cause of weight loss, goals with measurable time frames for improvement and interventions and approaches. Review of the clinical record of Resident 8 revealed admission to the facility on November 21, 2025, with diagnoses to include dementia (the loss of cognitive functioning; thinking, remembering, and reasoning; to such an extent that it interferes with a person's daily life and activities). On January 5, 2026 the resident weighed 122.5 pounds and on January 21, 2026 the resident weighted 115. 6 which was a 5.63% weight loss in less than 30 days. A nutritional note dated January 21, 2026, revealed the dietitian continued to implement interventions to address the residents weight loss, however a review of the resident's care plan, dated as last revised on December 30, 2025, revealed the resident was nutritionally at risk related to dementia, poor intakes, meal refusals and weight gain, there was no focus on the residents care plan regarding the resident's recent weight loss. Upon review during the days of the survey, February 3-6, 2026, there were no updates or revisions to this resident's care plan related to the resident's nutritional risk and weight status since December 30, 2025. There was no documented evidence that Resident 8's care plan had been reviewed and revised related to current individualized interventions to address the resident's significant weight loss and continued need to monitor the resident's weights. Interview on February 5, 2026, at 2:30 PM the Nursing Home Administrator (NHA) confirmed the facility failed to review and revise Resident 8's plan of care to accurately reflect the resident's current status and needs. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa Code 211.12(d)(3) Nursing services.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, select facility policies, observations, and staff interviews, it was determined the facility failed to consistently monitor residents' nutritional and hydration status to timely identify declines, failed to implement and document effective non-invasive interventions, and implemented invasive measures (intravenous therapy) without documented evidence that less invasive approaches were attempted or optimized for two of 26 residents reviewed (Resident 58 and Resident 12). Findings include: A review of a facility policy entitled Nutrition (Impaired)/Unplanned Weight Loss-Clinical Protocol, last reviewed by the facility on January 14, 2026, indicated the nursing staff will monitor and document weights and dietary intakes of resident in a format which permits comparisons over time. The staff and physician will define the individual's current nutritional status (weight, food/fluid intakes, and pertinent laboratory values) and identify individuals with anorexia, weight loss/gain, and significant risk for impaired nutrition. The facility staff will report to the physician significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake. The physician will review medical causes for weight changes, anorexia, and weight loss before ordering interventions. A review of Resident 58's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included Alzheimer's dementia (a gradually progressive type of brain disorder that causes problems with memory, thinking and behavior) and adult failure to thrive (a process of physical and psychological decline associated with advanced age, manifesting as a pronounced overall deterioration that encompasses a wide range of vague symptoms, including unexplained loss of appetite, weight loss, cognitive and functional decline, and social isolation, complicated by multiple medical comorbidities and psychiatric factors).A review of Resident 58's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 2, 2025, revealed the residents Brief Interview for Mental Status score of 7 (BIMS, 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 0-7 indicates severe cognitive impairment) that indicated severe cognitive impairment. The resident was not on a therapeutic diet and required set-up assistance for meals. Resident 58's nutrition plan of care initiated July 7, 2025, and last revised July 29, 2025, identified the resident at risk for altered nutritional status related to Alzheimer's disease and adult failure to thrive with a history of dehydration (a condition that occurs when the body loses more fluids than it takes in). Goals included maintaining hydration status, laboratory values within physician-determined parameters, and absence of signs and symptoms of dehydration. Interventions included monitoring meal percentages, encouraging fluids, notifying the registered dietitian (RD), family, and physician of changes, obtaining labs, and providing feeding assistance and supplements as ordered. Planned interventions included administering medications and vitamin or mineral supplements as ordered by the physician; encouraging and providing fluids throughout the day, if not medically contraindicated (not advised due to a medical condition); monitoring and documenting meal intake percentages to identify changes in eating habits; notifying the registered dietitian (RD), family, and physician of any signs or symptoms of dehydration; obtaining laboratory tests as ordered that relate to nutritional status and reporting results to the physician while ensuring the RD was informed; initiating referrals to occupational therapy (OT) and speech-language A review of a Certified Registered Nurse Practitioner (CRNP) progress notes dated November 25, 2025, at 3:00 PM, indicated Resident 58 was evaluated for increased shortness of breath, increased confusion, decreased eating and drinking, and progressive decline following a COVID-19 infection in late October 2025. Laboratory results obtained that day revealed a BUN of 44 mg/dL (Blood Urea Nitrogen, a blood test that measures waste products in the blood that are normally removed by the kidneys; normal range approximately 7-20 mg/dL). An elevated BUN may indicate dehydration (not enough body fluid) or (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impaired kidney function.; a creatinine of 1.2 mg/dL (creatinine is a waste product from normal muscle activity that is filtered by the kidneys; normal range approximately 0.6-1.3 mg/dL). Elevated creatinine levels may suggest reduced kidney function, and a blood glucose of 56 mg/dL (glucose is the amount of sugar in the blood; normal fasting range approximately 70-100 mg/dL). A level of 56 mg/dL is considered low and may cause confusion, weakness, or altered mental status. The CRNP documented stable vital signs, notified the resident's son of the resident's decline, and ordered intravenous (IV) hydration (fluids administered directly into a vein), specifically D5W (dextrose 5% in water, a sterile IV solution used for hydration) 1 liter at 75 milliliters per hour, along with continued encouragement of oral fluids and repeat laboratory testing, BMP (basic metabolic panel measures basic metabolic functions like kidney health and electrolytes) for November 28, 2025 A review of a nutrition progress note completed by the facility's registered dietitian (RD) dated November 26, 2025, at 10:23 AM, indicated meal intake percentages ranged from 26% to 100% of a regular diet with regular texture and thin liquids. The RD documented awareness that the resident was receiving intravenous fluids (IVF, fluids administered directly into a vein) and recommended initiation of a 2.0 supplement (a high calorie, high protein oral nutritional supplement) 120 milliliters twice daily due to inconsistent intake. The note indicated the RD would monitor and follow. Further review of a Certified Registered Nurse Practitioner (CRNP) follow-up progress notes dated November 28, 2025, at 12:20 PM, documented continued decline since late October following COVID-19 infection. Nursing reported that the resident's oral (PO) intake (food and fluids taken by mouth) was very poor, with intermittent shortness of breath and increased confusion. The residents received IV fluids on November 26, 2025. Repeat laboratory results indicated additional IV fluids were appropriate. The CRNP ordered 1 liter of normal saline (NS, a sterile saltwater solution used for hydration) at 75 milliliters per hour intravenously and continued encouragement and assistance with oral intake. Orders were also given for the 2.0 supplement 120 milliliters twice daily. A quarterly nutrition assessment completed by the RD dated December 1, 2025, at 12:44 PM, continued to show meal intake variability of 26% to 100% of a regular diet with thin liquids, supplemented with 2.0 supplement 120 milliliters twice daily with medication administration. Estimated hydration requirements were documented as 1272-1527 milliliters per day. The resident's weight on November 1, 2025, was 112.2 pounds, reflecting no change in one month, a gain of one pound in three months, and a gain of 8.6 pounds since admission. Body Mass Index (BMI, a measurement of body weight in relation to height used to assess nutritional status) was 21.9, which falls within normal range. The plan was to continue the current plan of care and monitor. A review of a Hydration Screening Tool completed by the CRNP on December 16, 2025, identified persistent low fluid intake, decreased perception of thirst, difficulty communicating needs, lethargy (abnormal drowsiness), confusion, recent weight loss, poor appetite, and malnutrition (a condition resulting from inadequate nutrient intake). Physical findings included cracked lips and decline in activities of daily living (ADLs, basic self-care tasks such as eating and bathing). The CRNP ordered IV hydration with 0.9% normal saline 500 milliliters at 250 milliliters per hour via peripheral IV (a small catheter inserted into a vein), along with Hydration Plus (overall hydrational support with supplemental micronutrients)and vitamin supplementation (B-Complex ,Vitamin C 5,000 mg, methyl-cobalamin B12, zinc 10 mg, magnesium chloride 600 mg, and calcium chloride 100 mg, plus Cognitive Support of Taurine 100 mg, glycine 100 mg, and folic acid 5 mg). A review of the December 2025 Medication Administration Record (MAR, the legal record documenting medications and treatments administered) revealed the IV infusion was completed on December 20, 2025, four days after documentation of persistent low fluid intake and visible signs of dehydration. A subsequent Hydration Screening Tool dated January 13, 2026, again documented persistent low fluid intake, confusion, lethargy, poor appetite, cracked lips, and decline in ADLs. IV hydration with supplementation was again ordered. The January 2026 MAR indicated the IV infusion was completed on January 19, 2026, at 8:20 AM, six days after identification of dehydration concerns. Further review of the clinical record failed to reveal documented evidence of additional or intensified oral hydration (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	strategies, structured fluid intake monitoring, increased staff feeding assistance, or alternative non-invasive interventions prior to repeated intermittent (once per month) IV therapy. Further review of Resident 58's clinical record failed to reveal any follow up from the facility's RD with the residents' continued declined oral fluid intake and failed to reveal documented evidence of additional or intensified oral hydration strategies, structured fluid intake monitoring, increased staff feeding assistance, or alternative non-invasive interventions prior to repeated intermittent IV therapy. Observation of Resident 58 on February 5, 2026, at 12:05 PM, revealed the resident in bed with an untouched breakfast tray consisting of a toasted bagel, scrambled eggs, and a 4-ounce yogurt. An interview with Employee 6, a licensed practical nurse (LPN), on February 5, 2026, at 12:15 PM, confirmed the resident did not complete her breakfast and probably needed to be assisted more with meals. The facility was unable to provide documented evidence of alternative, non-invasive measures implemented to improve and maintain Resident 58's nutritional and hydration status prior to reliance on intermittent IV therapy. A review of Resident 12's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses of dementia without behavioral disturbance, schizoaffective disorder bipolar type (is a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania), feeding difficulties (difficulty consuming adequate nutrition and hydration), and anxiety disorder (excessive and persistent worry and fear about everyday situations and often involve repeated episodes of sudden feelings of intense anxiety and fear or terror that reach a peak within minutes resulting in panic attacks). A review of a quarterly MDS dated [DATE], revealed Resident 12 was severely cognitively impaired and was not on a therapeutic diet. Resident 12's nutrition plan of care initiated on September 9, 2023, last revised December 23, 2025, identified risk for altered nutritional status related to variable intake and psychiatric diagnoses. Interventions included encouraging fluids, providing supplements, notifying the RD and physician of dehydration signs, and providing feeding assistance. A review of a quarterly nutrition assessment completed by the facility's registered dietitian (RD) dated October 21, 2025, at 10:42 AM, indicated Resident 12 consumed 51% to 100% of a regular diet with regular texture and thin liquids. The resident received fortified foods (foods enhanced with additional calories and protein), a 2.0 supplement (a high calorie, high protein oral nutritional supplement) 120 milliliters three times per day with 100% acceptance, and a Magic Cup (a frozen high calorie, high protein supplement) with meals, also documented as 100% accepted. The resident's weight on October 1, 2025, was 112.8 pounds, reflecting a one-pound loss in one month, two-pound loss in three months, and 2.8-pound loss in six months, which was documented as not significant. The RD noted no changes in food or beverage preferences and indicated the current plan of care would continue with monitoring. However, review of the weight record revealed that on November 1, 2025, the resident's weight had decreased to 107.4 pounds, representing a 5.4-pound loss in one month. A subsequent nutrition progress note completed by the RD on November 6, 2025, acknowledged the 5.4-pound weight loss. Meal intake continued to vary between 51% and 100% of meals with supplements accepted. The RD questioned the overall downward weight trend despite documented supplement acceptance and discussed obtaining a TSH (thyroid-stimulating hormone, a blood test used to evaluate thyroid function) to rule out a metabolic cause. The note indicated the RD would monitor and follow. A review of a Hydration Screening Tool completed by the Certified Registered Nurse Practitioner (CRNP) on December 16, 2025, identified persistent low fluid intake, decreased perception of thirst, difficulty communicating needs, lethargy (abnormal drowsiness), recent weight loss, poor appetite, and malnutrition (a condition caused by inadequate intake of nutrients). Physical findings included cracked lips and recent falls or increased fall risk. New orders were issued for intravenous (IV) consisting of 0.9% normal saline (a sterile saltwater solution used for hydration) 500 milliliters at 250 milliliters per hour via peripheral IV (a small catheter inserted into a vein), along with vitamin and micronutrient supplementation (B-Complex ,Vitamin C 5,000 mg, methyl-cobalamin B12, zinc 10 mg, magnesium (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	chloride 600 mg, and calcium chloride 100 mg, plus Cognitive Support of Taurine 100 mg, glycine 100 mg, and folic acid 5 mg). A review of Resident 12's Medication Administration Record (MAR) for December 2025, revealed the IV infusion was completed on December 20, 2025, four days after the CRNP documented persistent low fluid intake and visible signs and symptoms of dehydration. Further review of the clinical record failed to reveal documented evidence that oral hydration strategies were intensified, that structured fluid intake monitoring was implemented, that feeding assistance was increased, or that other non-invasive interventions were trialed or evaluated prior to initiating IV therapy. During an interview on February 6, 2026, at 10:10 AM, the RD reported that resident weight changes and poor oral intake were discussed each morning with the interdisciplinary team. However, the RD was unable to provide documented evidence that the nutritional plan of care for Resident 12 or Resident 58 was revised or intensified to improve hydration status prior to repeated intermittent IV infusions. During an interview on February 6, 2026, at 10:30 AM, the CRNP reported that the Director of Nursing (DON) and Assistant Director of Nursing (ADON) communicated concerns regarding decreased intake to determine the need for additional IV hydration and vitamin therapies. The CRNP further stated that measured fluid intake records were not reviewed to determine actual oral fluid consumption; rather, visual assessment and laboratory results were used to determine the need for IV therapy. During an interview on February 6, 2026, at 11:00 AM, the Nursing Home Administrator reviewed the above findings and acknowledged that less invasive nutrition and hydration measures should have been attempted and documented prior to implementing invasive IV therapy for cognitively impaired residents. 28 Pa Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility policies and procedures, observation, and staff interview, it was determined the facility failed to ensure intravenous therapy was provided and monitored in accordance with physician orders and professional standards of practice failed to obtain physician orders for monitoring of the PICC line and failed to ensure physician-ordered intravenous antibiotic therapy was administered as prescribed for one of 3 residents reviewed (Resident 5) who required care and monitoring of a Peripherally Inserted Central Catheter (PICC) line (a long, flexible tube inserted into a vein in the arm and advanced to a large vein near the heart to allow administration of intravenous medications and fluids).Findings include: Review of the facility policy titled Administering Medications last reviewed by the facility on January 14, 2026, revealed that medications are administered as prescribed and in a safe and timely manner. Medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meals). The individual administering the medication initials the resident's electronic medication administration record (eMAR) after each medication is given. Review of the facility policy titled Peripheral and Midline IV Dressing Changes and Central Venous Catheter Care and Dressing Changes last reviewed by the facility on January 14, 2026, revealed the purpose of the procedure is to prevent complications associated with intravenous therapy. Licensed staff, as identified by the State Nurse Practice Act, are responsible to measure the arm circumference (measurement of the arm at the midpoint between the shoulder and the elbow) and compare the arm circumference to the baseline when clinically indicated to assess for edema (swelling caused by fluid buildup) and possible deep-vein thrombosis (a dangerous blood clot that forms deep in the vein). The policy indicated licensed nursing staff are to measure the length of the external central vascular catheter (portion of the catheter visible outside the body) with each dressing change or when catheter dislodgement (unintended movement of the catheter from the original insertion position) is suspected and compare findings to the length documented at insertion.Clinical record review revealed Resident 5 was admitted to the facility on [DATE], with diagnoses that included intraspinal abscess (a rare, dangerous collection of pus within or around the spinal cord) and granuloma (inflamed tissue). Review of a hospital procedure note dated February 18, 2026, revealed that Resident 5 underwent placement of a single-lumen PICC line (a peripherally inserted central catheter, also called a PICC line, is a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near the heart, used for intravenous fluids and medications) in the right arm for intravenous administration of fluids, including antibiotics. Documentation indicated a catheter length of 42 centimeters (cm) with an external length of 0 cm at the time of insertion.Review of Resident 5's Nursing admission Evaluation dated February 18, 2026, failed to identify the presence of the PICC line. Review of physician orders failed to identify orders addressing PICC line monitoring, including measurement of external catheter length, measurement of arm circumference, or instructions to monitor for catheter migration (movement of the catheter from the original location) or dislodgement. Review of the Medication Administration Record (MAR) for February 2026 and March 2026, and nursing progress notes dated February 18 through March 20, 2026, failed to provide documented evidence licensed nursing staff measured or recorded PICC line external length or arm circumference upon admission or during weekly dressing changes as indicated in facility policy.During an observation on March 20, 2026, at 3:25 PM, Employee 1 (Registered Nurse) measured the external catheter length at 12 cm and the arm circumference at 28 cm. Employee 1 confirmed the hospital documented an external catheter length of 0 cm and was unable to provide documented evidence the current measurement did not reflect catheter migration due to the absence of baseline and ongoing assessments. Review of a physician order dated February 18, 2026, indicated Cefazolin Sodium (an antibiotic medication used to treat (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bacterial infection) injection solution 2 grams intravenously three times daily for treatment of spinal infection through March 27, 2026. Review of the MAR for February 2026 and March 2026 indicated the medication was scheduled for administration at 6:00 AM, 2:00 PM, and 10:00 PM. Documentation failed to confirm the medication was administered as ordered on the following dates: February 20, 2026, at 2:00 PM dose not documented as administeredMarch 9, 2026, at 10:00 PM dose not documented as administeredMarch 19, 2026, at 10:00 PM dose not documented as administered Interview with the Director of Nursing (DON) on March 20, 2026, at 3:45 PM confirmed the facility failed to obtain a physician order for PICC line monitoring in accordance with facility policy and failed to ensure and document administration of ordered intravenous antibiotic therapy. The DON acknowledged that the absence of documentation indicated the medications were not administered per policy and professional standards. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services.28 Pa. Code 211.10 (a)(c)(d) Resident care policies.28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing Services.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical records, observations, and staff interviews, it was determined the facility failed to ensure the ready availability of necessary emergency dialysis supplies for two of two residents reviewed who received hemodialysis (Residents 72 and 83), and failed to develop and implement an individualized, person-centered care plan for one of two residents receiving hemodialysis (Resident 83).Findings include: According to the National Kidney Foundation, patients receiving hemodialysis, (a life-sustaining treatment for individuals with kidney failure that removes waste and excess fluids from the blood) and utilize central venous hemodialysis catheters, (tubes placed into large veins to allow blood to flow to and from a dialysis machine), are associated with serious complications including infection and bleeding. The Centers for Disease Control and Prevention further identifies central lines as devices that can result in significant complications such as bloodstream infection and hemorrhage (severe bleeding). Standard dialysis emergency guidance indicates that if a dialysis catheter becomes dislodged (moves out of place) or begins to bleed, immediate firm pressure must be applied to the site and emergency medical care must be obtained to prevent life-threatening blood loss. Therefore, residents who receive hemodialysis through a central venous catheter require immediate access to appropriate emergency supplies, such as clamps and pressure dressings, to ensure prompt intervention in the event of catheter-related complications. A review of the policy Care of Resident with End-stage Renal Disease last reviewed January 4, 2024, indicated that staff caring for residents with ESRD (End Stage Renal Disease) including residents receiving dialysis care outside of the facility shall be trained in the care and special needs of these residents, including the ability to recognize the signs and symptoms of worsening conditions and /or complications of ERSD. The policy also indicated that the resident's comprehensive care plan will reflect the resident's needs related to dialysis care and ESRD. A review of the clinical record revealed that Resident 72 was admitted to the facility on [DATE], with diagnoses to include End-Stage Kidney Disease with dependence on dialysis (a life-sustaining treatment that removes waste products and excess fluid from the blood when the kidneys no longer function). The record documented the presence of a right chest Tessio catheter (a specialized double-lumen central venous catheter that provides immediate vascular access for hemodialysis). Physician orders dated January 29, 2026, identified dialysis treatments on Tuesday, Thursday, and Saturday at 5:30 AM and included transfer instructions utilizing a Hoyer lift (a mechanical lifting device used to safely transfer individuals with limited mobility). Observations conducted on February 2, 2026, at 11:15 AM and again on February 3, 2026, at 8:43 AM revealed no emergency dialysis supply kit, clamps, pressure dressings, or other catheter-related emergency equipment present at the bedside, mounted on the wall, or otherwise visible and readily accessible in Resident 72's room. During an interview on February 3, 2026, at 8:45 AM, Employee 4, Registered Nurse (RN), stated that an emergency kit with appropriate supplies should have been present and easily accessible in the resident's room. On February 4, 2026, at 9:30 AM, the above findings were reviewed with the Director of Nursing (DON) (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding the absence of required emergency supplies for residents receiving hemodialysis. Clinical record review revealed Resident 83 was admitted on [DATE], with diagnoses including End-Stage Renal Disease and dependence on dialysis. A hospital Discharge summary dated [DATE], documented a dialysis double-lumen catheter located in the right internal jugular vein (a major vein in the neck that carries blood back to the heart), with the external access site observed on the right upper chest. A physician's order dated December 31, 2025, required dialysis treatments three times weekly (Tuesday, Thursday, and Saturday) and daily inspection of the dialysis access site for signs of infection, including localized pain, redness, warmth, swelling, or drainage. Observation on February 4, 2026, at 10:40 AM confirmed the presence of a dialysis access site on the right upper chest. No emergency dialysis supply kit, clamps, pressure dressings, or other catheter-related emergency equipment were present at the bedside, mounted on the wall, or otherwise readily accessible in the resident's room. During an interview on February 4, 2026, at 10:41 AM, Employee 5, Registered Nurse, stated that an emergency kit containing clamps and pressure dressings should have been present and immediately accessible in the resident's room based on the resident's dialysis access needs. Review of Resident 83's comprehensive care plan, initiated January 5, 2026, revealed no individualized interventions addressing hemodialysis treatment, monitoring of the dialysis access site, emergency response measures for hemorrhage or catheter dislodgement, or location of the dialysis access site. There were no documented interventions outlining emergency procedures specific to the resident's dialysis catheter. On February 4, 2026, at 1:45 PM, the above findings were reviewed with the Nursing Home Administrator (NHA) and Director of Nursing (DON). 28Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12 (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
	395564	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Ridge Rehabilitation & Healthcare Center	500 West Hospital Street Taylor, PA 18517

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Centers for Disease Control and Prevention (CDC) guidance, facility policy, clinical records, observations, and staff interviews, it was determined the facility failed to implement Enhanced Barrier Precautions (EBP) to prevent the potential spread of infection for one of five residents reviewed (Resident 83) who had an indwelling medical device.Findings include: According to the Centers for Disease Control (CDC) Enhanced Barrier Precautions (EBP) guidance focuses on gown and glove use and other important infection control measures for prevention of multi-drug-resistant organisms (MDRO type of bacteria or microorganism that has developed resistance to multiple classes of antibiotics, making infections harder to treat). EBP are recommended for residents with any of the following: infection or colonization with a MDRO, a wound, or indwelling medical device, even if the resident is not known to be infected or colonized with a MDRO. Review of the facility Enhanced Barrier Precautions (EBP) Policy last reviewed/revised January 14, 2026, indicated EBPs are used to prevent the spread of MDROs. The policy directs the use of EBP during high-contact care activities for residents with chronic wounds (skin ulcers) or indwelling medical devices (medical instrument left inside the body temporarily or permanently to support physiological functions). The procedure includes precautions (gown and gloves) during high-contact resident care activities including dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use and wound care. According to the procedure guidelines, when EBP are in place there will be signs posted in the door or wall outside the resident room and personal protective equipment (PPE) (gowns and gloves) will be readily accessible outside the resident's room. Resident 83 was admitted to the facility on [DATE], with diagnoses including, but not limited to, endocarditis (inflammation of the inner lining of the heart valves and chambers), end stage renal disease (a condition in which the kidneys no longer function well enough to meet the body's needs), and dependence on dialysis (a treatment that performs the function of the kidneys when they are no longer able to work effectively). Review of the admission Minimum Data Set (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated January 5, 2026, revealed a Brief Interview for Mental Status score of 15. (BIMS, brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 13-15 equates to being cognitively intact. Current physician orders dated December 31, 2025, indicated Resident 83 was to receive dialysis treatments three times weekly on Tuesday, Thursday, and Saturday. The orders directed staff to inspect the dialysis access site daily for signs of infection, including localized pain, erythema (redness), warmth, edema (swelling), or abnormal drainage. Review of the clinical record identified that the dialysis access site was a double lumen catheter located in the right upper chest. A double lumen catheter is a type of central venous catheter (a flexible tube placed into a large vein) that contains two separate internal channels or lumens. One lumen allows blood to be removed from the body and sent to the dialysis machine for filtration, while the second lumen allows the filtered blood to be returned to the body. This catheter remains inserted into a large vein for ongoing treatment and is therefore considered an indwelling medical device (a medical instrument that remains inside the body either temporarily or permanently to support normal body functions or deliver treatment). The presence of this double lumen dialysis catheter constituted an indwelling medical device as defined in both CDC guidance and the facility's Enhanced Barrier Precautions policy. Review of the clinical record revealed no documented physician order or care plan intervention indicating implementation of Enhanced Barrier Precautions for Resident 83, despite the presence of an indwelling medical device as outlined in CDC guidance and facility policy.Observation conducted on February 4, 2026, at 10:41 AM, revealed there was no signage posted outside Resident 83's room indicating Enhanced Barrier Precautions. Additionally, no personal protective equipment, including gowns or gloves designated for EBP use, was observed to be readily (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accessible outside the resident's room.On February 4, 2026, at 1:45 PM, the above findings were reviewed with the Nursing Home Administrator and Director of Nursing. 28 Pa. Code 211.10(a)(c)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.