STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395568	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Julia Pound Care Center	1155 Indian Springs Road Indiana, PA 15701

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to provide care for pressure ulcers in accordance with professional standards of practice, by failing to ensure that recommendations from a wound consultant were reviewed with the attending physician and treatments for pressure ulcers were provided as ordered by the physician for four of 30 residents reviewed (Resident 2, 45, 46, 58) who had pressure ulcers. Findings include: A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated May 18, 2026, revealed that the resident had severe cognitive impairment, required assistance from staff, had diagnoses that included dementia and other psychotic disorder, had a stage three pressure ulcer (tissue damage that results in full-thickness loss of skin and the layer of fat under the skin may be visible), and received hospice services. A wound consultant note for Resident 2, dated June 11, 2026, included the recommendation for a new wound treatment for staff to turn and reposition per pressure prevention protocol with a bed wedge. The wound measurement was 0.6 centimeters (cm) by 0.5 cm by 0.3 cm. A wound consultant note for Resident 2 dated June 18, 2026, included the recommendation for staff to turn and reposition per pressure prevention protocol with a bed wedge. The wound measurement was 0.9 cm by 0.5 cm by 0.3 cm. Physician's orders for Resident 2, dated June 18, 2026, included an order for the resident to have her coccyx cleansed with normal sterile saline (NSS-sterile salt water), apply silver gelling fiber (a highly absorbent wound, fibers transform into a cohesive soft gel) to the wound base and cover with bordered foam every day shift. Observations of Resident 2 on June 22, 2026, at 11:15 a.m. revealed that the resident was laying in bed and her blue bed wedge was observed in the corner of the room. A review of Resident 2's clinical record revealed that there was no documentation that the wound consultant's recommendations were reviewed with the physician. A review of the Treatment Administration Record (TAR) and Nurse Aide documentation in the task record for Resident 2 for June 2026 revealed no documented evidence that the wedge was used for turning and repositioning as recommended by the wound consultant. Interview with the Assistant Director of Nursing on June 25, 2026, at 1:52 a.m. confirmed that wound care recommendations were made by the wound nurse practitioner and the physician was to review the recommendations and accept or decline the recommendation. Staff received verbal orders from the physician to accept or decline the recommendations. There was no documented evidence that the physician reviewed the wound care notes or recommendations for approval or changes for Resident 2 on the above-mentioned dates. A significant change MDS assessment for Resident 45, dated April 9, 2026, revealed that the resident was cognitively impaired, required minimal assistance for daily care needs and had diagnoses that included hemiplegia (a form of paralysis that causes the severe or complete loss of motor function) and unstageable pressure ulcer coccyx. Physician's orders for Resident 45 dated May 24, 2026, included an order for the resident to have coccyx cleansed with normal sterile saline, apply Manuka hd (a sterile medical grade wound dressing impregnated with 100% active Manuka honey) to wound base and cover with dry dressing every day shift and as needed for soilage and dislodgement. Observations of treatment administration for Resident 45 on June 23, 2026, at 1:32 p.m. revealed that (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed Practical Nurse 2 entered resident 45's room with supplies for ordered treatment. Resident 45 was positioned on his left side and did not have treatment in place to coccyx per physician's orders. Interview with Licensed Practical Nurse 2 June 23, 2026, at 1:35 p.m. confirmed that resident 45 did not have a have a treatment in place to coccyx per physician's orders. Review of the TAR for Resident 45 dated June 2026 indicated that the treatment was signed as being completed on June 22; however, there was no documented evidence in the clinical record to indicate that it became dislodged or was removed. Interview with the Assistant Director of Nursing on June 23, 2026, at 2:06 p.m. confirmed that Resident 45 should have had a treatment in place to coccyx per physician's orders. An admission Minimum Data Set (MDS) assessments (a mandated assessment of a resident's abilities and care needs) for Resident 46, dated May 22, 2026, revealed that the resident was admitted to the facility on [DATE], was cognitively impaired, and had one unstageable pressure ulcer. Physician's orders for Resident 46 dated May 29, 2026, included an order for the resident to have her left heel wound cleansed with normal sterile saline (NSS-sterile salt water), apply calcium alginate (a highly absorbent wound dressing made from alginate, a natural polymer derived from the cell walls of brown seaweed) to the wound base, cover the wound with four by four and rolled gauze every day shift. Physician's orders for Resident 46 dated June 12, 2026, included an order for betadine (an antiseptic used to treat and prevent skin infections) to be applied to the resident's left heel and left open to air every day shift. Physician's orders for Resident 46 dated June 19, 2026, included an order to cleanse the left heel with Dakins, cover the wound with calcium alginate and then cover with a foam border dressing every day shift. A wound consultant note for Resident 46, dated May 28, 2026, included a recommendation for the left heel wound to be cleansed with 0.25% Dakins solution (used to prevent and treat skin and tissue infections), apply silver alginate (an advanced medical wound dressing that combines highly absorbent, natural seaweed fibers (alginate) with antimicrobial silver) to the base of the wound, secure with a four by four and rolled gauze, and change daily and as needed. A wound consultant note for Resident 46, dated June 11, 2026, included a recommendation for the left heel wound to be cleansed with soap and water, pat dry, apple betadine to the base of the wound, and leave open to air twice per day. A wound consultant note for Resident 46, dated June 18, 2026, indicated that a new wound treatment recommendation was provided for the left heel wound that included cleanse the wound with 0.25% Dakins solution, apply silver alginate to the base of the wound, secure with a dry dressing, change daily and as needed and recommended an Xray to rule out osteomyelitis (an infection in a bone). A review of the Treatment Administration Record (TAR) for Resident 46 dated May 2026 and June 2026 revealed that on May 29, 2026, through June 9, 2026, the resident's left heel wound was cleansed with NSS, and calcium alginate was applied instead of the recommended cleanse with Dakins solution and apply silver alginate. A review of the TAR for Resident 46 dated June 2026 revealed that on June 12, 2026, through June 17, 2026, the resident's left heel wound had betadine applied once a day instead of the recommended twice per day. A review of the TAR for Resident 46 dated June 2026 revealed that on June 19, 2026, through June 23, 2026, the resident's left heel received calcium alginate instead of the recommended silver alginate. There was no documented evidence that an Xray to rule out osteomyelitis was ordered or completed. Interview with the Assistant Director of Nursing on June 23, 2026, at 2:19 p.m. confirmed that wound care recommendations were made by the wound nurse practitioner and the physician was to review the recommendations and accept or decline the recommendation. Staff received verbal orders from the physician to accept or decline the recommendations. There was no documented evidence that the physician reviewed the wound care notes or recommendations for approval or changes for Resident 46 on the above-mentioned dates. A significant change MDS assessment for Resident 58, dated March 17, 2026, revealed that the resident had moderate cognitive impairment, required assistance from staff for daily care needs, had a diagnoses that included dementia, and had one Stage 3 pressure ulcer (a severe skin injury featuring full-thickness skin loss where the underlying fat is visible). Physician's orders for Resident 58 dated April 2, 2026, included for the resident to have her left (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	buttocks wound cleansed with NSS, apply Bactroban (an antibiotic) to the wound base, cover with calcium alginate with silver, and apply a foam border dressing every day and evening shift. Physician's orders for Resident 58 dated May 22, 2026, included to cleanse the left buttocks with NSS, apply Manuka HD to the wound base, and cover with a gauze bordered dressing every day and evening shift and as needed. A wound consultant note for Resident 58, dated April 30, 2026, indicated that a wound treatment recommendation was provided for the left ischium pressure ulcer (a type of wound that develops on the skin and tissue over the ischial tuberosity (sitting bones)) that included to cleanse the wound with NSS, apply Manuka HD Super Lite (a wound dressing that combines high-potency, medical-grade Manuka honey with a super-absorbent, cross-linked gelling mesh), Calcium Alginate with Silver to base of the wound, secure with bordered gauze, and change daily and as needed. A wound consultant note for Resident 58, dated May 21, 2026, indicated that a new wound treatment recommendation was provided for the left ischium wound that included to cleanse with NSS, apply Manuka HD Super Lite to base of the wound, and secure with Bordered gauze daily and as needed. A review of the TAR for Resident 58 dated April 2026 and May 2026 revealed that on April 30, 2026, through May 6, 2026, the resident's wound received Bactroban instead of the recommended Manuka HD Super Lite. A review of the TAR for Resident 58 dated May 2026 and June 22 revealed that on May 22, 2026, through June 22, 2026, the resident's wound treatment was completed every day and evening shift instead of the recommended once a day treatment. Interview with the Assistant Director of Nursing on June 24, 2026, at 10:46 a.m. confirmed that wound care recommendations were made by the wound nurse practitioner and the physician was to review the recommendations and accept or decline the recommendation. Staff received verbal orders from the physician to accept or decline the recommendations. There was no documented evidence that the physician reviewed the wound care notes or recommendations for approval or changes for Resident 58 on the above-mentioned dates. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of policies, observations, and staff interviews, it was determined that the facility failed to ensure that food was served under sanitary conditions, in accordance with professional standards for food service safety. Findings include: The facility's policy regarding general sanitization of the kitchen, dated June 10, 2026, indicated that the food and nutrition services staff will maintain the sanitation of then kitchen through compliance with a written, comprehensive cleaning schedule. Cleaning and sanitation tasks for the kitchen will be outlined in a written cleaning schedule. The prep table shelves are scheduled to be cleaned 3 times a week.Observations in the main kitchen on June 25, 2026, at 9:20 a.m. revealed that the shelves under the food preparation tables where clean pots and baking trays were kept had dust, debris and a thick removable substance on them. The baking trays had and pink, removable substance around the edges.Interview with the Production Manager Assistant on June 25, 2026, at 9:25 a.m. confirmed that the shelves under the food preparation tables and the baking pans should be clean and free of debris and they were not. 28 Pa. Code 211.6(f) Dietary Services.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, observations and staff interviews, it was determined that the facility failed to provide dependent residents the necessary services to maintain nutritional status for one of 30 residents reviewed (Resident 45).Findings include: A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) assessment for Resident 45, dated April 9, 2026, revealed that the resident was cognitively impaired, required minimal assistance for daily care needs and diagnoses that included hemiplegia (a form of paralysis that causes the severe or complete loss of motor function) and unstageable pressure ulcer coccyx. The resident's care plan, most recently reviewed June 7, 2026, indicated that she required extensive assistance with meals and snacks. Observations June 23, 2026, at 10:45 a.m. revealed that Resident 45 was being fed by her daughter. Resident 45's daughter revealed that when she entered the room at 10:30 a.m. breakfast was on the bedside table and was not touched, so she was feeding her mother breakfast, and the staff was supposed to be assisting her with her meals. Observations June 24, 2026, at 9:06 a.m. revealed that Resident 45 was feeding herself breakfast and was observed having difficulty lifting her cup and getting food into her mouth using utensils. There were no staff present to assist her. Interview with Occupational Therapist 1 on June 25, at 1:29 p.m. confirmed that Resident 45 does require extensive assistance with eating as documented on her Discharge summary dated [DATE]. Interview with Nursing Home Administrator on June 25, 2026, at 1:35 p.m. confirmed that Resident 45 should have extensive assistance from staff with meals and snacks. 42 CFR 483.24(a)(2) ADL Care Provided for Dependent Residents. 28 Pa. Code 211.12(d)(1) Nursing services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on review of facility policy and clinical record reviews, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders were followed for two of 30 residents reviewed (Resident 3 and 4). Findings include: A policy dated January 22, 2026, indicated that glucose meter checks are obtained per physician order or as needed if resident is displaying signs and symptoms of hypoglycemia or hyperglycemia. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated May 11, 2026, revealed that the resident was cognitively intact, required assistance from staff for daily care needs and had medical diagnoses that included diabetes mellitus. A nursing note for Resident 3, dated May 28, 2026, at 11:01 p.m. revealed that the resident's blood glucose was 453 mg/dl. Physician's orders for Resident 3 dated April 26, 2026, included orders to monitor blood glucose two times a day and call physician if blood glucose levels were less than 70 mg/dl or greater than 450 mg/dl. A nursing note for Resident 3, dated May 28, 2026, at 11:59 p.m. revealed that the physician was notified of the resident's blood sugar of 453 mg/dl and gave an order to allow time for the resident's long-acting insulin to take effect and to recheck the residents blood sugar at 12:00 a.m. and contact the physician of the results. A review of Resident 3's clinical record revealed that there is no documentation that the residents' blood sugar was rechecked at 12:00 a.m. per physician orders. An interview with the Assistant Director of Nursing on June 24, 2026, at 10:03 a.m. confirmed that there was no documentation that Resident 3's blood sugar was rechecked per physician's orders. An annual MDS assessment for Resident 4, dated April 9, 2026, revealed that the resident was cognitively impaired, required minimal assistance for personal hygiene needs; and had diagnoses that included psychosis (a collection of symptoms that indicate a disconnection from reality) and mood disorder. Review of a psychiatric visit note for Resident 4, dated January 8, 2026, revealed that the resident was seen for a mental status exam that included a review of medications, behaviors and an order for the resident to follow up in one month. A review of Resident 4's clinical record revealed no documented evidence that Resident 4 had a follow up since January 8, 2026, per physician orders. Interview with the Assistant Director of Nursing on June 23, at 1:35 p.m. confirmed that Resident 4 should have had a psychiatric follow up visit one month after January 8, 2026, and she did not 28 Pa. Code 211.12(d)(1)(5) Nursing Services. 28 Pa. Code 211.12(d)(1)(5) Nursing Service

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from significant medication errors for one of 30 residents reviewed (Resident 3).Findings include: A policy dated January 22, 2026, indicated that glucose meter checks are obtained per physician order or as needed if resident is displaying signs and symptoms of hypoglycemia or hyperglycemia. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated May 11, 2026, revealed that the resident was cognitively intact, required assistance from staff for daily care needs and had medical diagnoses that included diabetes mellitus. Physician's orders for Resident 3 dated March 31, 2026, included orders for the resident to receive 10 units of Novolog (fast-acting insulin) with meals and to hold if she does not eat. A review of Resident 3's clinical record on eating April through June 2026 revealed that on April 5 she ate 26-50% of lunch; April 16 she ate 26-50% of dinner; April 17 she ate 76-100% of dinner; April 19 she ate 76-100% of lunch and ate 76-1005 of dinner; April 22 she ate 76-100% of dinner; May 1 she ate 25-50% of breakfast; May 2 she at 76-100% of dinner; May 10 she ate 76-100% of breakfast; May 14 she ate 51-75% dinner; May 16 she ate 26-50% of breakfast and 26-50% of dinner; June 17 she ate 51-75% of breakfast; June 20 she ate 76-100% of lunch; and June 21 she ate 76-100% of breakfast. A review of Resident 3's Medication administration record April through June 2026 revealed that 10 units of Novolog was held on April 5; April 16; April 17; April 19; April 22; May 1; May 2; May 10; May 14; May 16; June 17; June 20; and June 21, 2026. An interview with the Assistant Director of Nursing on June 24, 2026, 10:03 a.m. confirmed that physician's orders for Resident 3 to receive 10 units of Novolog were not followed per order. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that medications were stored in a secure manner and failed to provide a separately locked, permanently affixed compartment in the refrigerator for medication storage.Findings include: The facility's policy regarding storage of medication, dated June 10, 2026, medications and biologicals are stored safely, securely and properly. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel and staff members lawfully authorized to administer medications. Observations on June 24, 2026, at 9:10 a.m. revealed that the medication cart for the Highlands unit was in the hall, unattended and unlocked. Licensed Practical Nurse 3 was observed walking out of a resident room. The medication cart was not in sight of the resident room. Interview with Licensed Practical Nurse 3 at that time confirmed that she left the medication cart unattended and not in sight to administer medications and that she should have locked the cart before walking away. Observations in the facility's medication room refrigerator in the Highlands unit on June 24, 2026, at 9:36 a.m. revealed a multidose injector pen of Ozempic (a medication used to improve blood sugar) inside a locked box attached to the refrigerator shelf. The shelf was not permanently affixed to the inside of the refrigerator. Interview with Licensed Practical Nurse 4 at that time revealed that Ozempic is supposed to be stored in a locked box in the refrigerator and the shelf that the box is attached to should be permanently affixed to the inside preventing it from being removed. Interview with Assistant Director of Nursing on June 24, 2026, at 10:04 a.m. revealed that medication carts should be locked when unattended and not in sight of the nurse and shelves that have locked boxes attached should be affixed to the inside of the refrigerator. 28 Pa. Code 211.9(a)(1) Pharmacy services.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on a review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that laboratory services were obtained as ordered by the physician for one of 30 residents reviewed (Resident 43).Findings include: Facility policy for Laboratory Services dated January 22, 2026, indicated that the facility will provide or obtain laboratory services to meet the needs of the residents, and will promote practices to ensure the quality and timeliness of laboratory services. The day shift unit nurse will fill out and send laboratory requests for newly ordered laboratory tests. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 43, dated May 20, 2026, indicated that the resident was cognitively intact, required assistance with daily care needs and had diagnoses that included diabetes mellitus. A Certified Nurse Practitioner note for Resident 43 dated May 15, 2026, at 1:00 a.m. revealed that the resident complained of urinary discomfort, and orders were received to obtain a UA flex to culture (diagnostic test that performs a standard urine analysis first, and automatically orders a urine culture if specific indicators of infection are present) to rule out a urinary tract infection. Nurse's note for Resident 43 dated May 16, 2026, at 7:46 p.m. revealed that the physician was notified of the urinalysis results and ordered 100 milligrams (mg) of Macrobid (an antibiotic) to be given every other day for five doses pending the culture and sensitivity (C&S-laboratory procedure that identifies infectious germs (culture) and determines the most effective antibiotic (sensitivity) to treat the infection) results. Review of Resident 43's lab results for May 2026 revealed no documented evidence that a C&S was obtained from the resident's urine sample on May 15, 2026, as ordered by the certified nurse practitioner. Interview with the Assistant Director of Nursing on June 23, 2026, at 12:40 p.m. revealed that a urine C&S was not obtained for Resident 43 as ordered and it should have been. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that each resident received pneumococcal immunizations for one of 30 residents reviewed (Residents 46).Findings include: The facility's pneumococcal vaccine policy, dated January 22, 2026, indicated that each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated, or the resident has already been immunized. The resident or the resident's legal representative have the right to accept or refuse immunization. The resident's medical record includes documentation that indicates the following: a) The resident or the resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization on the Vaccine Informed Consent and Screening Form. b) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal on the Vaccine Informed Consent and Screening Form. An admission Minimum Data Set (MDS) assessments (a mandated assessment of a resident's abilities and care needs) for Resident 46, dated May 22, 2026, revealed that the resident was admitted to the facility on [DATE]. The sections of the MDS assessment related to the resident's pneumococcal vaccination revealed that the resident's pneumococcal vaccination was not up to date due to not being offered. Pneumococcal Vaccine Authorization Release for Resident 46 dated May 16, 2026, revealed education was provided to the resident's responsible party and authorization to administer the pneumococcal vaccine was obtained. Physician's order for Resident 46 dated May 16, 2026, included that the resident may receive the pneumococcal vaccine. There was no documented evidence that the pneumococcal vaccine was administered. Interview with the Assistant Director of Nursing/Infection Control Nurse on June 23, 2026, at 12:40 p.m. confirmed that Resident 46's responsible representative signed consent for the pneumococcal vaccine on May 16, 2026, however, as of June 23, 2026, there was no documented evidence that it was administered. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.