STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395570	A. Building B. Wing	03/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milton Rehabilitation and Nursing Center	743 Mahoning Street Milton, PA 17847

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to notify the resident representative/responsible party of changes in condition or care for three of seven residents reviewed (Resident R1, R2, and R3).Findings include: Review of the facility policy, Change in Condition dated 6/1/25, indicated, The facility shall notify the resident, his or her attending physician, and representative of changes in theresident's medical/mental condition and/or status. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs dated 12/13/25, included diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and traumatic brain injury (a disruption in the normal function of the brain). Review of Section C: Cognitive Patterns, indicated that Resident R1 had severe cognitive impairment. Review of a progress note dated 1/3/26, at 4:11 a.m. indicated, Resident has history of emesis, usually small amounts of bile with occasional large amounts of vomit. He did experience a large emesis, projected onto his bed's privacy curtain. Further review of Resident R1's progress notes failed to reveal notification of Resident R1's resident representative / responsible party. Review of a progress note dated 1/7/26, at 9:25 p.m. indicated, CNA (nurse aide) reported to this nurse that resident had a small amount of blood in his stool. Further review of Resident R1's progress notes failed to reveal notification of Resident R1's resident representative / responsible party. Review of a progress note dated 3/5/26, at 2:30 a.m. indicated, This resident observed fully body tremors while resident was in bed x2, resident's speech was slurred, RN (registered nurse) made aware, notified MD (doctor of medicine) via communication paper. Further review of Resident R1's progress notes failed to reveal notification of Resident R1's resident representative / responsible party. Review of a progress note dated 3/15/26, at 4:31 a.m. indicated, Resident had a large brown emesis beginning of the shift, at around 0410 (4:10 a.m.) x2 more brown emesis, projectile, given Zofran (medication to treat nausea/vomiting). Further review of Resident R1's progress notes failed to reveal notification of Resident R1's resident representative / responsible party. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of dysphagia (difficulty swallowing) and Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior). Review of Section C: Cognitive Patterns indicated that Resident R2 had severe cognitive impairment. Review of a progress note dated 2/9/26, at 12:27 p.m. indicated, Resident was vomiting this AM. Medications were held. MD made aware and RN notified. Further review of Resident R2's progress notes failed to reveal notification of Resident R2's resident representative / responsible party. Review of weight change progress notes revealed:12/17/25: Five-pound loss since 11/17/25. 02/09/26: 7.7% loss. Weight loss continues and decline noted in po intake at this time. Recommend change to Enhanced diet.03/06/26: 10.4% loss. Weight loss over 6 months noted. Resident continues on enhanced diet with excellent po intakes (92%). Ice cream with am and pm snack (100% acceptance). Recommend enhanced pudding with meals. Further review of Resident R2's progress notes failed to reveal notification of Resident R2's (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident representative / responsible party of continued weight loss. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Section C: Cognitive Patterns indicated that Resident R3 had severe cognitive impairment. Review of a progress note dated 12/17/25, at 10:31 a.m. indicated Resident R3 had episodes of diarrhea. Further review of Resident R3's progress notes failed to reveal notification of Resident R3's resident representative / responsible party. Review of a progress note dated 12/17/25, at 9:57 p.m. indicated that Resident R3 had excoriation to the sacrum and groin. Further review of Resident R3's progress notes failed to reveal notification of Resident R3's resident representative / responsible party. Review of a progress note dated 12/22/25, at 1:50 p.m. indicated, Resident's stool was yellow, stringy, and has mucus with a strong odor. At 5:52 p.m. a progress note indicated a new order for liver profile lab work the next morning. Further review of Resident R3's progress notes failed to reveal notification of Resident R3's resident representative / responsible party. Review of a progress note dated 1/9/26, at 10:34 p.m. indicated that Resident R3 had continued loose stools. Further review of Resident R3's progress notes failed to reveal notification of Resident R3's resident representative / responsible party. During an interview on 3/15/26, at approximately 1:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to notify the resident representative / responsible party of changes in condition or care for three of seven residents. 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 201.29(d) Resident rights. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.