STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395572	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Manor	900 Manchester Road Fairview, PA 16415

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of clinical records, and staff interviews it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider upon transfer to the hospital, for five of six residents reviewed (Residents R7, R9, R10, R48, and R54).Findings include: Resident R7's clinical record revealed an admission date of 12/2/23, with diagnoses that included heart failure, atrial fibrillation (irregular heartbeat), and diabetes (a health condition that is caused by the body's inability to produce enough insulin). Resident R7's clinical record revealed progress notes revealed notes dated 8/21/25, and 10/26/25, indicating transfers to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. Resident R9's clinical record revealed an admission date of 5/23/25, with diagnoses that included Anemia (a reduction in red blood cells resulting in symptoms such as fatigue and weakness), Gastroesophageal reflux disease (GERD - happens when stomach acid flows back up into the esophagus and causes heartburn), and High Blood Pressure. Resident R9's clinical record revealed a progress note dated 12/13/25, indicating a transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. Resident R10's clinical record revealed an admission date of 12/3/25, with diagnoses that included Encephalopathy (a group of conditions that cause problems with the brain that can appear as confusion, memory loss, and personality changes), Respiratory Failure (a condition where you don't get enough oxygen or you get too much carbon dioxide in your body), and Sepsis (a reaction to an infection that causes extensive inflammation throughout the body, potentially leading to tissue damage, organ failure, and even death). Resident R10's clinical record revealed a progress note dated 10/29/25, indicating a transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. Resident R48's clinical record revealed an admission date of 1/10/24, with diagnoses that included quadriplegia (paralyzed in both arms and both legs), hyperlipidemia (high cholesterol), and atrial (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fibrillation. Resident R48's clinical record revealed progress notes dated 10/2/25, and 3/3/26, indicating transfers to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. Resident R54's clinical record revealed an admission date of 2/16/26, with diagnoses that included diabetes, congestive heart failure, and gastro esophageal reflux disease. Resident R54's clinical record revealed a progress note dated 4/7/26, indicating transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. During an interview on 4/10/26, at 10:10 a.m. the Director of Nursing confirmed that Residents R7, R9, R10, R48, and R54's clinical records lacked evidence that the necessary clinical information was provided to the receiving healthcare provider upon transfer and when the transfers occurred and that clinical information should have been provided to the receiving healthcare provider upon transfer. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(c.3)(2) Resident rights

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on review of clinical records and staff interview, it was determined that the facility failed to provide a written summary of the baseline care plan and order summary to the resident and/or representative for three of 25 residents reviewed (Residents R12, R9, and R10).Findings include: Resident R12's clinical record revealed an admission date of 7/31/25, with diagnoses that include malignant neoplasm of lower lobe, left bronchus or lung (lung cancer), and major depressive disorder (a serious mood disorder that causes feelings of sadness, loss of interest in daily activities, emotional and physical problems that impact daily life). Resident R12's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R12 and/or his/her representative. During an interview on 4/9/26, at 2:09 p.m. the Nursing Home Administrator (NHA) and Director of Nursing confirmed that the clinical record for Resident R12 lacked evidence that a written summary of the baseline care plans, and order summaries were provided to the resident and/or their representative upon admission to the facility. Resident R9's clinical record revealed an admission date of 5/23/25, with diagnoses that include Anemia (a reduction in red blood cells resulting in symptoms such as fatigue and weakness), Gastroesophageal reflux disease (GERD - happens when stomach acid flows back up into the esophagus and causes heartburn), and High Blood Pressure. Resident R9's clinical record lacked evidence that a copy of the baseline care plan including physician orders with medications, dietary orders, therapy services, were provided to Resident R9 and/or their representative. Resident R10's clinical record revealed an admission date of 12/3/25, with diagnoses that include Encephalopathy (a group of conditions that cause problems with the brain that can appear as confusion, memory loss, and personality changes), Respiratory Failure (a condition where you don't get enough oxygen or you get too much carbon dioxide in your body), and Sepsis (a reaction to an infection that causes extensive inflammation throughout the body, potentially leading to tissue damage, organ failure, and even death). Resident R10's clinical record lacked evidence that a copy of the baseline care plan including physician orders with medications, dietary orders, therapy services, were provided to Resident R10 and/or their representative. During an interview on 4/10/26, at 9:30 a.m. the NHA confirmed there was no evidence that a copy of the baseline care plan including physician orders with medications, dietary orders, therapy services, were provided to Residents R9 and R10 and/or their representatives. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services 28 Pa. Code 201.18 (b)(1) Management

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. Based on review of facility policies and clinical records, and resident and staff interviews, it was determined that the facility failed to ensure that the resident and/or resident representative was offered the opportunity to participate in the development, review, and/or revision of their person-centered care plan for two of 25 residents reviewed (Residents R14, and R60).Findings include: A facility policy dated 12/2/25, entitled Care Plan Policy revealed Residents will have the opportunity to discuss their goals for care including their preferences for advance care planning and Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse and a STNA [state tested nurse aide] with the responsibility for the resident, a member of the food and nutrition staff, and other appropriate staff and disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's representative. A facility policy dated 12/2/25, entitled Resident Rights Policy revealed The right to participate in the development and implementation of his or her person-centered plan of are, including but not limited to: The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care and The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. Resident R14's clinical record revealed an admission date of 3/9/25, with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), gastroesophageal reflux disease GERD - happens when stomach acid flows back up into the esophagus and causes heartburn), and High Blood Pressure. During an interview on 4/07/26, at 1:10 p.m. Resident R14 revealed he/she did not recall when he/she was last invited to or attended a care plan meeting. Resident R14's clinical record revealed the following MDS (Minimum Data Set - federally mandated standardized assessment conducted at specific intervals to plan resident care needs) assessment with the following Assessment Reference Date (ARD - a look back period of time for the MDS assessment): quarterly MDS with ARD 5/8/25, quarterly MDS with ARD 8/8/25, quarterly MDS with ARD 11/8/25, quarterly MDS with ARD 2/8/26, annual MDS with ARD 2/17/26. Resident R14's clinical record revealed that a care plan meeting was held with resident and resident representative on 10/2/25, which was prior to the MDS ARD of 11/8/25. Further review of Resident R14's clinical record lacked any evidence that the resident and/or resident representative was invited to or attended a care plan meeting in conjunction with the 5/8/25, 8/8/25, and 2/8/26, quarterly MDS's and the 2/17/26 annual MDS. Resident R60's clinical record revealed an admission date of 2/29/24, with diagnoses that included Hemiparesis (partial weakness on one side of the body) and Hemiplegia (complete paralysis or loss of ability to move one side of the body) related to Cerebral Infarction (occurs when the blood flow to a part of the brain is interrupted preventing oxygen and nutrients from reaching brain cells causing them to die), Diabetes - a health condition caused by the body's inability to produce enough insulin, and High Blood Pressure. During an interview on 4/07/26, at 12:44 p.m. Resident R60 revealed he/she did not recall when he/she was last invited to or attended a care plan meeting. Resident R60's clinical record revealed the following MDS assessments with the following ARD: quarterly MDS with ARD 6/4/25, quarterly MDS with ARD 7/16/25, quarterly MDS with ARD 10/11/25, quarterly MDS with ARD 1/11/26, and annual MDS with ARD 3/5/26. Resident R60's clinical record lacked any evidence that the resident and/or resident representative was invited to or attended a care plan meeting in conjunction with the 6/4/25, 7/16/5, 10/11/25, or 1/11/26 quarterly MDS's and the 13/5/26 annual MDS. During an interview on 4/9/26, at 2:33 p.m. Social Worker stated they have not consistently had care plan meetings. When asked if the care plan meetings are scheduled in conjunction with the MDS schedule, he/she stated no, but they should be. The Social (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Worker confirmed that the clinical records lacked evidence of Resident R14, and R60 and/or their representatives being routinely invited to attend care plan meetings. 28 Pa. Code 201.29(a) Resident rights

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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. Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to develop comprehensive person-centered care plan for a resident requiring intravenous (IV) therapy that included measurable objectives and timetables to meet a resident's needs for one of 25 residents reviewed (Resident R4).Findings include: Review of facility policy entitled, Care Plan Policy dated 12/2/25, indicated The Manor will develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs. Review of Resident R4's clinical record revealed an admission date of 3/1/26, with diagnoses that included Cerebral infraction (also known as a stroke it occurs when blood flow to part of the brain is blocked), malignant carcinoid tumor of the small intestine (cancer in the digestive tract), and hypertension (high blood pressure). Review of Resident R4's physician's orders revealed an order to change dressing system and measure PICC (peripheral inserted central catheter) every seven days, and PRN (as needed) dated 3/2/26, and another order for sodium chloride flush intravenous solution 10 cc (cubic centimeters) every day dated 3/2/26. Review of Resident R4's person centered plans of care lacked evidence that a plan of care for intravenous therapy was developed. During an interview on 4/10/26, at 10:38 a.m. the Director of Nursing (DON) confirmed that a plan of care for intravenous therapy was not developed for Resident R4. The DON also confirmed that an intravenous therapy plan of care should have been developed. 28 Pa. Code 201.14 (a) Responsibility of Licensee 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services

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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 facility policy, clinical records, facility documents, and staff interview, it was determined that the facility failed to review and revise comprehensive care plans to reflect an elopement (an at-risk individual leaving a supervised care setting without staff knowledge) for one of 25 residents reviewed (Resident R53).Findings include:Review of facility policy entitled Care Plan Policy dated 12/2/25, revealed Periodically reviewed and revised by a team of qualified persons after each assessment.Resident R53's clinical record revealed an admission date of 1/16/25, with diagnoses that included diabetes (a health condition that caused by the body's inability to produce enough insulin), dementia (brain changes that cause a decline in mental ability that interferes with daily life due to memory loss, thinking/language difficulties, and personality changes), and hypertension (high blood pressure) .Review of facility documents revealed Resident R53 had an elopement on 5/13/25. Review of Resident R53's care plan for elopement created on 1/17/25, revealed Resident R53 was an elopement risk, and the care plan was never revised to reflect he/she had an elopement on 5/13/25. During an interview on 4/9/26 at 1:55 p.m. the Nursing Home Administrator confirmed that Resident R53's elopement care plan was not reviewed/revised following his/her elopement and that care plans should be reviewed and revised as necessary. 28 Pa. Code 211.5(f) Medical records 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on review of facility policies, clinical records, facility documents, and staff interview, it was determined that the facility failed to implement sufficient monitoring and supervision to prevent elopement (an at-risk individual leaving a supervised care setting without staff knowledge) and failed to adequately implement search procedures related to an elopement for one of 25 residents reviewed (Resident R53). Findings include: Review of the facility policy entitled, Accidents and Incidents Policy, dated 12/2/25, states, The Manor will ensure that the resident's environment remains free of accident hazards and each resident receives adequate supervision and assistive devices to reduce accidents. Review of facility policy entitled Missing Resident Policy dated 12/2/25, states It shall be the policy of our organization that all necessary steps are taken to locate any resident that is missing from a Community.Building and Grounds Search: Upon discovery that a resident is missing an announcement of code brown or other approved statement will be made. A building and grounds search will be conducted simultaneously by staff assigned by the Person In Charge (PIC).Check Sign-Out Sheet. The resident sign-out sheet will be checked to see if the person is out of the Community.Internal Community Search. Staff are to check all areas of Community as assigned per PIC. Areas to be searched include the following: resident rooms, lobbies, hallways, dining areas, closets, bathrooms, public rooms, lounges, therapy rooms, basements and employee break areas. (Note: this list may not be all inclusive)External Community Search. Staff will check external areas assigned per the PIC to include: patios, grounds, parking lots, vehicles, outside structures, storage buildings and dumpsters.DocumentationClinical Record-Information recorded in the clinical record should include facts only.The time the resident was noted missing.A description of procedures taken to locate resident.Resolution including the resident condition.Time family and physician were notified.Care plan change to prevent future occurrence . Resident R53's clinical record revealed an admission date of 1/16/25, with diagnoses that included diabetes (a health condition that caused by the body's inability to produce enough insulin), dementia (brain changes that cause a decline in mental ability that interferes with daily life due to memory loss, thinking/language difficulties, and personality changes), and hypertension (high blood pressure). An elopement care plan created on 1/17/25, indicated an intervention for a secure care (a device that sets off an alarm if an induvial is exit seeking or has exited the building) on Resident R53 at all times was added on 3/19/25. Review of information dated 5/15/25, submitted by the facility, revealed the following information: Staff indicated they did hear the secure care alarm and did not see Resident R53 outside or near the door inside. He/she was last seen 20 minutes prior related to medication administration.His/her secure device was tested and functioning. It is believed that Resident R53 left with a small group of visitors. Review of the two written statements obtained related to the elopement revealed the following information: Employee Licensed Practical Nurse (LPN) E1indicated around supper time the Registered Nurse Supervisor received a call asking if one of the facility's residents might be going up to the road in a wheelchair. Both headed to the parking lot where a car was pulling in and Resident R53 was being pushed back to the facility. Resident R53 indicated he/she was heading to the mall. LPN Employee E1 brought Resident R53 back to his/her hall and notified the staff working on his/her hall. LPN Employee E2 indicated he/she was the hall nurse on two units, so he/she was going back and forth between the two units. At dinnertime he/she was passing medications when LPN Employee E1 advised that Resident R53 was outside. LPN Employee E1 indicated the charge nurse received a call from someone driving that one of the residents was outside in the parking lot, so the two of them ran out right away to get him/her. LPN Employee E2 had personally encountered Resident R53 20 minutes prior related to administering medications. During an interview on 4/9/26 at 1:55 p.m. the Nursing Home Administrator confirmed that the facility failed to properly supervise Resident R53 and failed to respond appropriately related to the secure device alarm, by completing a head count and going (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	outside of the facility and looking thoroughly. 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.12 (d) (5) Nursing Services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on review of facility policy and clinical records, observation, and staff interview, it was determined that the facility failed to promote cleanliness and help prevent the spread of infection regarding respiratory care equipment for one of one residents reviewed for respiratory care (Resident R60). Findings include: A facility policy dated 12/2/25, entitled Oxygen Concentrators - Care and Maintenance of Oxygen Concentrators revealed If there are external cabinet filters present, these are to be cleaned weekly by washing the filters with warm water. Allow the filter to dry thoroughly before replacing. Some concentrators have these filers on the sides or on the back of the unit. Resident R60's clinical record revealed an admission date of 2/29/24, with diagnoses that included Hemiparesis (partial weakness on one side of the body) and Hemiplegia (complete paralysis or loss of ability to move one side of the body) related to Cerebral Infarction (occurs when the blood flow to a part of the brain is interrupted preventing oxygen and nutrients from reaching brain cells causing them to die), Diabetes - a health condition caused by the body's inability to produce enough insulin, and High Blood Pressure. Resident R60's clinical record revealed a physician's order dated 3/31/25, for oxygen at 0 - 4 liters per minute (lpm) via nasal cannula (a thin tube with two prongs that fit in a resident's nostrils to deliver oxygen) or mask to maintain oxygen saturations levels at or greater than 90%. Further review revealed a physician's order dated 10/7/25, to clean oxygen concentrator filter weekly every night shift every Tuesday. Observation on 4/7/26, at 12:44 p.m. revealed Resident R60 sitting in his/her wheelchair with oxygen in place and the oxygen concentrator liter flow set on 2 lpm via nasal cannula. Further observation of the concentrator filter on both sides of the oxygen concentrator revealed a large amount of gray fluffy substance covering the entire filter. During an interview on 4/7/26, at 12:50 p.m. Licensed Practical Nurse Employee E3 confirmed that Resident R60's oxygen concentrators filters contained a large amount of a gray fluffy substance and should be cleaned. 28 Pa. Code 211.10(c) Resident care policies 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 facility policy, manufacturer's guidelines, observations, and staff interviews, it was determined that the facility failed to ensure medications were properly dated when opened in one of five medication rooms reviewed and one of five medication carts reviewed (Main Medication Room and D-Wing Medication Cart). Findings include: Review of a facility policy entitled Vials and Ampules of Injectable Medications dated 12/2/25, indicated that, .The date opened is recorded by the first person to use each multidose vial.multi-dose vials expire 28 days after initial use, unless otherwise indicated by the manufacturer. Manufacturer's recommendations for Tubersol PPD (solution used for tuberculosis testing upon admission and for employment), indicated that vials which are entered and in use for 30 days should be discarded. Manufacturer's guidelines for Lantus insulin (a long-acting insulin used to manage blood sugar levels in people with diabetes), indicated that after opened, vials and pre-filled pens should be discarded after 28 days. Observation on 4/7/26, at 1:10 p.m. of the Main Medication Room refrigerator revealed an opened vial of Tubersol without an open date, therefore staff were unable to determine the expiration date. At that time, the Director of Nursing confirmed that the open vial of Tubersol lacked an open date. Observation on 4/7/26, at 2:04 p.m. of the D-Wing Medication Cart revealed an open injector pen of Lantus insulin without an open date, therefore staff were unable to determine the expiration date. At that time, Licensed Practical Nurse Employee E3 confirmed that the open injector pen of Lantus lacked an open date. 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on review of facility policies, clinical records, facility documents, and staff interview, it was determined that the facility failed to maintain complete and accurate clinical records for two of 25 residents reviewed (Residents R4 and R53).Findings include: Review of facility policy entitled Documentation Policy dated 12/2/25, revealed The Manor will provide a complete account of the resident's care, treatment, response to the care, signs, symptoms, etc., as well as the progress of the resident's care, (i.e., nursing progress notes, episodic charting, and plan of care.) Appropriate information to assist the physician in ordering medications, treatments, and diet. The purpose of the clinical record is to provide ongoing, individualized information regarding the status of the resident. Review of facility policy entitled Accidents and Incidents Policy dated 12/2/25, states, Documentation in the clinical record will reflect the same information and/or incident report.Follow up documentation will be made in the clinical record each shift for seventy-two hours including, but not limited to: vital signs, reaction to incident and physical findings. Review of facility policy entitled Missing Resident Policy dated 12/2/25 states, DocumentationClinical Record-Information recorded in the clinical record should include facts only.The time the resident was noted missing.A description of procedures taken to locate resident.Resolution including the resident condition.Time family and physician were notified.Care plan change to prevent future occurrence. Review of Resident R4's clinical record revealed an admission date of 3/1/26, with diagnoses that include Cerebral infraction (also known as a stroke it occurs when blood flow to part of the brain is blocked), malignant carcinoid tumor of the small intestine (cancer in the digestive tract), and hypertension (high blood pressure). Review of Resident R4's physician orders revealed an order to change dressing system and measure PICC (peripheral inserted central catheter) every seven days, and PRN (as needed) dated 3/2/26, and another order for sodium chloride flush intravenous solution 10 cc (cubic centimeters) every day dated 3/2/26. Review of Resident R4's progress notes revealed a note on 4/2/26, indicating that Resident R4 had a right chest tunneled central venous catheter (CVC, an intravenous catheter that is placed in the neck, chest, or groin and is surgically inserted). Resident R53's clinical record revealed an admission date of 1/16/25, with diagnoses that included diabetes (a health condition that caused by the body's inability to produce enough insulin), dementia (brain changes that cause a decline in mental ability that interferes with daily life due to memory loss, thinking/language difficulties, and personality changes), and hypertension (high blood pressure). Review of information dated 5/15/25, submitted by the facility, revealed Resident R53 had an elopement (an at-risk individual leaving a supervised care setting without staff knowledge) on 5/13/25. There was no documentation in Resident R53's clinical record related to his/her elopement. During an interview on 4/9/26 at 1:55 p.m. the Nursing Home Administrator confirmed that the facility failed to have complete documentation related to the elopement in R53's clinical record. During an interview on 4/10/26, at 10:38 a.m. the Director of Nursing confirmed that Resident R4's clinical records did not have accurate documentation regarding a CVC. 28 Pa. Code 211.5(f)(i)(ii)(iii)(iv)(ix) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services