STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395585	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitions Healthcare North Huntingdon	8850 Barnes Lake Road North Huntingdon, PA 15642

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, observations, and staff interviews, it was determined that the facility failed to make sure that medical supplies and medications were properly stored and/or disposed of in one of two medication rooms (A/B Nursing Unit Medication Room). Findings include: Review the facility policy Storage of Medications dated 4/1/26, indicated that outdated, contaminated, or deteriorated items will be removed from stock and disposed of accordingly. During an observation of the A/B nursing unit medication room on 4/28/26, at approximately 12:32 p.m. the following was observed:(5) Medline foley catheter 20 french with an expiration date of 9/28/25.(10) Medline foley catheter 22 french with an expiration date of 12/28/25.(5) Amsino foley catheter 20 french with an expiration date of 9/3/25.(6) BD MaxPlus needleless connector with an expiration date of 8/17/25.(1) Osang Health Care covid-19 antigen self test with an expiration date of 12/12/23.(1) BBL CultureSwab collection and transport system with an expiration date of 10/10/25.(6) BBL CultureSwab collection and transport system with an expiration date of 12/27/25.(4) McKeeson IV catheter 26-gauge needles with an expiration date of 10/20/25.(2) Medline Suresite IV auto safety IV catheter 22-gaugle needles with an expiration date of 2/28/26.(2) Covideien monoject 25-gauge needles with an expiration date of 1/31/26.(1) Medline Suresite IV auto safety IV catheter 20-gaugle needles with an expiration date of 2/28/26.(1) Medline safety syringe 25-gauge needle with an expiration date of 3/4/26.(6) Wolf-pak IV start kit with CHG prevanties pad with an expiration date of 11/30/25.(8) Caresite extension set with caresite luer access device 8-inch with an expiration date of 2/28/26.(1) Medline sterile 0.09% normal saline 100 mL with an expiration date of 3/1/26.(1) [NAME] medical drainage bag 600 mL with an expiration date of 1/5/26.(1) Amsino Amsure foley insertion tray with an expiration date of 10/31/26. During an interview on 4/28/26, at approximately 2:30 p.m. the Nursing Home Administrator confirmed that the facility failed to make sure that medical supplies and medications were properly stored and/or disposed of in one of two medication rooms. 28 Pa. Code: 201.14 (a) Responsibility of licensee.28 Pa. Code: 201.18 (b)(1)(e)(1) Management.28 Pa. Code: 211.9 (a)(1) Pharmacy services.28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interview it was determined the facility failed to make certain a resident had an updated, person-centered care plan individualized to each specific resident's needs for three of eight residents (Resident R12, R23, R99).Findings include: Review of the facility policy Care Plan-Comprehensive dated 4/1/26, previously dated 4/1/25, indicated each resident will have a comprehensive care plan developed that is individualized, includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident, and reflect the resident's cultural references, values, and practices. Review of Resident R12's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R12's clinical record Minimum Data Set (MDS-a periodic assessment of resident's needs) dated 2/2/26, indicated diagnoses of stroke (blood flow to the brain is blocked or a vessel bursts causing rapid brain cell death), high blood pressure, cirrhosis(liver scarring resulting in long term damage, often leading to liver failure), diabetes(high blood sugar due to insufficient insulin production), Post-Traumatic Stress Disorder (PTSD- a mental health condition triggered by experiencing or witnessing terrifying events, causing long-lasting flashbacks, nightmares, severe anxiety, and avoidance of behaviors). Review of Resident R12's care plan, dated 4/10/26, indicated resident has altered mood, behaviors related to depression, history. of PTSD, anxiety, verbal behaviors, inappropriate comments towards women, and racial slurs. Resident is to be assessed and monitored for trigger of mood/behaviors, triggers loss of independence and feelings of helplessness. Review of Resident R12's Physician orders dated 7/28/21, consult and follow-up as needed with psychology service. Review of Resident R23's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R23's clinical record MDS dated [DATE], indicated diagnoses of traumatic brain dysfunction (disruption in normal brain function, caused by an external force-resulting in physical, cognitive, and emotional dysfunction), aphasia (language disorder caused by brain damage-difficult to speak, write and understanding language), seizure disorder (neurological condition with recurring, unprovoked surges of abnormal electrical activity in the brain). Review of Resident R23's Physician orders dated 2/27/26, indicated enteral feeding every four hours and check tube, check placement every shift, cleanse the area around stoma every shift, change syringe and tubing every day, elevate the head of bed during feedings and when giving medications, administer Isosource 1.5 feeding three times a day, 250ml bolus feed. Review of Resident R23's care plan, dated 4/9/26, indicated no plan of care for a gastrostomy tube (g-tube that is inserted through the abdomen into the stomach for feeding) or tube feedings. Review of Resident R99's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R99's MDS dated [DATE], indicated diagnoses of high blood pressure, neurogenic bladder (nerve damage from disease or injury interrupts signals between nervous system and bladder leading to incontinence, urinary retention or frequent infections), spina bifida (neural tube defect where the spine and spinal cord do not for properly in the womb, can lead to physical disabilities, leg weakness, bowel/bladder issues and hydrocephalus (fluid on the brain)). Review of Resident R99's Physician orders dated 3/28/26, indicated to flush foley catheter with 30ml of sterile water as needed for blockage and provide foley care every shift. On 4/17/26, order for Indwelling Foley catheter size 18 French with 10ml balloon, connected to drain bag. Review of Resident R99's care plan, dated 4/28/26, indicated no plan of care for indwelling foley catheter. During an interview on 4/29/26, at approximately 10:00 a.m. with Director of Nursing (DON) and Nursing Home Administrator (NHA), the DON reviewed Resident R12, R23 and R99's care plans. The DON and NHA asked for clarification for R12's triggers and it was explained that there was no documentation to state what triggers caused his PTSD to be exacerbated, it was just documented to watch behaviors thus being deficient in plan of care. The DON (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	then reviewed Resident R23's care plan and stated it should have been updated to reflect current physician orders for tube feedings and care and also reviewed Resident R99's care plan and stated it should have been updated to reflect current physician orders to reflect an indwelling catheter placement and care. The facility failed to make certain that residents had an updated, person-centered care plan individualized to each specific resident's needs for three of eight residents (Resident R12, R23, R99). 28 Pa. Code 201.24 (e)(1)(5) Admissions Policy.28 Pa. Code 211.12(d)(1)(3)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, observations, and staff interviews, it was determined that the facility failed to provide appropriate respiratory care and maintain oxygen equipment for two of eight sampled residents (Residents R53, and R133).Findings include: Review of the facility policy Oxygen Concentrators reviewed on 4/1/26, with a prior review date of 4/1/25. The policy indicates The facility will include cleaning of humidifiers and filters to maintain optimal function and infection procedures. Procedure change cannula weekly (11-7) and as needed. Filters (11-7) clean weekly and as needed. Review of the facility policy CPAP/BIPAP reviewed on 4/1/26 with a prior review date of 4/1/25. Verify physician's order and oxygen source if ordered. Connect one end of the oxygen tubing to the oxygen enrichment adapter and the other end to the oxygen source. Cleaning the system weekly. Review of Resident R53's admission record indicated he was admitted on [DATE]. Review of Resident R53's Minimum Data Set (MDS- a periodic assessment of care needs) dated 2/2/26, indicated the diagnoses of coronary artery disease (CAD arteries become narrowed or blocked by buildup of plaque reducing blood flow to the heart), heart failure (the heart is unable to pump enough blood to meet the body's need for blood and oxygen), and hypertension (high blood pressure). Review of Resident R53's current physician orders dated 4/10/26, indicated resident BiPAP (machine that makes you inhale and exhale more easily) setting to bleed in 2 liters per minute of oxygen. Resident is on 5 liters per minute of oxygen. Change oxygen tubing and set-up weekly every night shift, every Sunday label tubing with date when changed and as needed. Review of Resident R53 clinical record on 4/27/26 revealed, resident did not have orders for oxygen concentrator maintenance related to filters, humidifier bottle, tubing on (orders were placed on 4/29/26 after facility notification). Interview and observations on 4/27/26, at approximately 10:30 with Registered Nurse (RN) Employee E1, Resident R53, was observed, with oxygen tubing connected to their oxygen concentrator that had a label and date of 4/6/26. Review of Resident R133's admission record indicated he was originally admitted on [DATE]. Review of Resident R133's MDS dated [DATE], indicated the diagnoses of respiratory failure (lungs cannot provide enough oxygen or remove enough carbon dioxide), chronic obstructive pulmonary disease (COPD progressive lung disease limiting airflow to the lungs), and anxiety disorder (intense, excessive, and persistent feelings of worry, fear, and uneasiness). Review of Resident R133's current physician orders dated 4/19/26, indicated resident is on 2 liters per minute of oxygen. Oxygen equipment, change tubing/nasal cannula/mask/humidifier bottle and clean filter weekly (when in use). Review of Resident R133 vital sign documentation dated 4/17/26 indicates resident was on oxygen at 2 liters per minute via nasal cannula. Interview and observations on 4/27/26, at approximately 10:40 a.m., with Licensed Practical Nurse (LPN) Employee E2, Resident R133, was observed, with oxygen tubing connected to their oxygen concentrator, the tubing had not been labeled or dated. Resident stated the tubing had not been changed. During an interview on 4/27/26, at 11:00 a.m. the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to provide appropriate respiratory care and maintain oxygen equipment. 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 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 policy, clinical records, and staff interviews it was determined that the facility failed to make certain consistent dialysis communication was maintained for one of five residents reviewed (Residents R56).Findings include: Review of the facility policy Hemodialysis, Home Hemodialysis dated 4/1/26 with a prior review date of 4/1/25. The policy indicates Each resident is provided with a dialysis communication binder, so the facility and dialysis center can communicate. Daily dialysis treatments sheets are utilized for each treatment session. Review of the clinical record indicated Resident R56 was admitted to the facility on [DATE]. Review of Resident R56's Minimum Data Set (MDS-a periodic assessment of care needs) dated 3/3/26, indicated diagnoses of hypertension (high blood pressure), diabetes (body does not use insulin effectively), and end stage renal disease (kidneys fail to filter waste and balance fluids). Review of Resident R56's physician order dated 3/18/25, indicated dialysis: Monday, Wednesday, and Friday at [dialysis center]. Chair time scheduled for 10:30 a.m. Review of Resident R56's current care plan indicated dialysis three times a week, treatments as scheduled: Monday, Wednesday, and Friday at [dialysis center]. Resident R56's dialysis communication forms from 3/27/26 through 4/27/26 revealed incomplete communication on the following dates: Dialysis Center nurse did not complete vital signs or weight pre or post treatment and dialysis nurse did not sign the dialysis communication forms:3/27/26, 3/30/26, 4/3/26, 4/6/26, 4/8/26, 4/10/26, 4/22/26, 4/24/26 Dialysis Center nurse did not complete vital signs or weight post treatment and dialysis nurse did not sign the dialysis communication forms:4/1/16 Dialysis Center nurse did not sign the dialysis communication forms:4/15/26, 4/17/26, 4/20/26, 4/27/26 During an interview on 4/29/26, at 10:00 a.m. the Nursing Home Administrator and Director of Nursing confirmed the facility failed to make certain consistent dialysis communication was maintained. 28 Pa. Code: 211.5(f) Clinical records28 Pa. Code: 211.12(d)(2)(3) Nursing services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on review of policies and clinical records, as well as observations, it was determined that the facility failed to ensure that proper infection control practices were followed while providing medications to three of 32 residents reviewed (Resident R26, R31, and R119).Findings include: The facility policy Administration Procedure for All Medications reviewed on 4/1/26, previously reviewed on 4/1/25, indicated medications will be administered in a safe and effective manner. In Section IV step three states to clean hands using antimicrobial soap and water or facility approved hand sanitizer before a med pass, before handling medications and before contact with a resident. In step four it states to use a barrier (e.g. clean disposable tray or plastic cup) to carry medication containers into the resident's room and to separate the supplies and the over the bed table or other surface on which the supplies are placed, when medications are administered. The facility policy Handwashing/Hand Hygiene reviewed on 4/1/26, previously reviewed 4/1/25, indicated effective hand hygiene reduces the incidence of healthcare associated infections. In the section of Procedure step seven states to use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: (c) Before preparing or handling medications. During an observation during medication administration on April 28, 2026, at approximately 8:30 a.m. revealed Licensed Practical Nurse (LPN) Employee E2 prepared to administer medications to Resident R26 and obtained Lopressor from medication blister pack (30-day supply in individual blister bubbles). The nurse touched the medication to place it on the pill splitter to give half the dose of the medication, proceeded to cut the pill in half and then dropped the medication on top of the medication cart, picked it up with her bare hands and placed it into the cup of medications. She then administered the medication to Resident R26. During an interview with LPN Employee E2 on April 28, 2026, at 8:32 a.m. confirmed that she should not have touched the medications and should have obtained a new tablet after the medication dropped onto the cart. During an observation during medication administration on April 28, 2026, at approximately 8:45 a.m. revealed LPN Employee E4 prepared to administer medications to Resident R31 and obtained Claritin, Senna/Docusate, Folic Acid, B12 from stock medications (medications used for multiple residents). The nurse touched the tablets with bare hands and placed the tablets into the cup for medications. LPN Employee E4 obtained Lyrica, Norco, Amiodarone, Bumetanide, Eliquis, Fluoxetine, Vistaril, Potassium Chloride, Spironolactone and Symproic, via blister pack by popping the pills directly into his hands before putting them into the medication cup. Once all medications were dispensed, he picked the medications up by his bare hands again and placed them in a small pouch (used to crush medications) and proceeded to crush the medications and then emptied the crushed medications into chocolate pudding to administer to the resident. During an observation during medication administration on April 28, 2026, at approximately 8:55 a.m. LPN Employee E4 touched the tablets with his bare hands and placed the medications into the cup to be administered. LPN Employee E4 prepared to administer medication to Resident R119 and obtained Iron from the stock medications and then proceeded to pop from blister packs Amlodopine, Wellbutrin, Duloxetine, Metformin, Eliquis and Famotidine into his hand and placed them in the medication cup to be administered. During an interview with LPN Employee E4 on April 28, 2026, at 9:00 a.m. confirmed that he should not pop or pour the medications into his hands and if he does, he should wear gloves. During an interview with the Director of Nursing on April 28, 2026, at 1:30 p.m. confirmed staff were not to touch resident's medications with their bare hands. 28. Pa. Code 201.14(a) Responsibility of licensee.28. Pa. Code 211.10(d) Resident Care policies.28. Pa. Code 211.12(d)(1)(5) Nursing Services.