STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395589	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Carmel Senior Living Community	2616 Locust Gap Highway MT Carmel, PA 17851

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, it was determined that the facility failed to store food items in a safe and sanitary manner and maintain equipment in a sanitary condition, in the main kitchen of the facility.Findings include: Initial tour of the facility's main kitchen with Employee 1, dietary staff, on June 14, 2026, at 9:20 AM revealed the following: A walk-in cooler contained the following: a bowl of pudding and two large, flat trays of a prepared food item open to the ambient air with no protection from the contamination, a container of buttered noodles with no dates on it, six cardboard boxes of food items (some of the boxes contained yogurt, a box with pork printed on the side, and cucumbers) that were stored directly on the floor of the cooler. A second walk-in cooler contained the following: a clear juice pitcher with a red liquid that was marked as prepared 6-10 with a broken base and cracks near the top perimeter, a carton of thickener, and a container of plant-based milk alternative. These items were sitting on a tray in a spilled liquid. Further observation of the cooler revealed the following: a second tray holding two boxes of a coffee item that were wrapped in plastic that were sitting in a liquid, a four ounce carton of milk and a single-serve butter packet were on the floor, the bottom shelf of a storage shelf contained a protective sheet that spanned the shelf that had a red colored liquid spilled on it in multiple areas, and nine cartons of milk stored in a black storage container that had an excessive amount of liquid in the bottom of the container. The floor behind the ice machine contained discarded straw wrappers, debris, and a plastic cup lid. There was a significant accumulation of a brown/tan colored debris on top of the dish machine. The washroom for the food carts had debris in the drain, debris on the floor, a significant accumulation of grime on the floor, and marring to one wall with a golf-ball sized hole. This was also observed on June 16, 2026, at 9:12 AM and 11:48 AM. There was an accumulation of dried stains on a plastic cover over the mixer. There was a build-up of grime and debris on the floor under the cook's food prep table. The bottom shelf of the table that held the spices and a container of olive oil had a build-up of a greasy and oily substance on the shelf. The dry goods storage room contained the following: There was a box of straws on the floor in the corner. There was a rolled-up paper towel, a piece of a sugar wafer, a plastic spoon, a packaged soft-baked cookie, and a packet of sweetener on the floor. There were several boxes being stored on the floor that included: a box of tartar sauce, a box of cocoa drink mix, a box of snack crackers, a package of soda cans, a package of apple juice, and a box of single-serve creamy French dressing packets. The box of French dressing packets was open, and a packet of dressing was next to it on the floor and four additional packets were found on top of an adjacent box. Employee 1 reported that the boxes are usually put away on Friday and it was unclear why they were not. The room that leads to the walk-in freezer had an accumulation of dried-up leaves on the perimeter of the floor. Some of the leaves were stuck in cobwebs. Two ceiling vents in this room at the entrance to the main kitchen contained an extensive build-up of dust. There were plastic lids and what appeared to be food debris on the floor of the walk-in freezer. The findings were reviewed with Employee 1 on June 14, 2026, at 10:00 AM. Observation of the facility's main kitchen on June 16, 2026, at 9:12 AM revealed serving ware that included adaptive food plates and regular plates in a storage container under the steam table. Employee 6, dietary staff, indicated these items were clean. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	There was debris on two of the plates and a significant accumulation of debris on the liner in the bottom of the container. Further observation revealed a four-section container that held various adaptive silverware had an accumulation of debris in the bottom of two of the sections. An observation of the main dining room on June 16, 2026, at 9:29 AM revealed a small griddle that was covered with a red fabric cover. There was an accumulation of dried food debris on top of the griddle. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on June 16, 2026, at 2:48 PM. 483.60(i) Food prepare, distribute, and serve -sanitary/safetyPreviously cited 7/18/25 28 Pa. Code 201.14(a) Responsibility of licensee

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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 clinical record review and staff interview, it was determined that the facility failed to provide written notice of transfer and written notice of the facility bed-hold policy to residents' responsible parties at the time of transfer for four of six residents reviewed for hospitalization concerns (Residents 11, 12, 15, and 113).Findings include: Clinical record review for Resident 11 revealed they were sent to the hospital on April 10, April 13, and May 9, of 2026. Further review revealed no evidence that the facility notified the resident representative of these transfers to the hospital in writing, or that a bed-hold notice had been provided. Clinical record review for Resident 12 revealed that they were sent to the hospital on March 4 and March 31, of 2026. Further review revealed no evidence that the facility notified the resident representative of the resident's March 31, 2026, hospital transfer in writing, and no bed-hold notice had been provided for either of these hospitalizations. Clinical record review for Resident 113 revealed that they were sent to the hospital on May 20, 2026. Further review revealed no evidence that the facility notified the resident representative of this transfer to the hospital in writing, or that a bed-hold notice had been provided. The above information was reviewed with the Nursing Home Administrator (NHA) on June 16, 2026. The NHA also confirmed that no bed-hold transfer notices had been provided. Interview with Resident 15 on June 15, 2026, at 10:47 AM revealed that he was recently hospitalized due to chest pain. Clinical record review for Resident 15 revealed nursing documentation dated May 16, 2026, at 7:20 AM that staff found him on the floor. Resident 15's wife requested that the facility send him to the hospital for evaluation. Nursing documentation dated May 21, 2026, at 2:12 PM revealed that Resident 15 returned to the facility from the hospital. Nursing documentation dated May 28, 2026, at 11:20 PM revealed that Resident 15 rang his call bell to complain of chest pain. Nursing documentation dated May 28, 2026, at 11:45 PM revealed that Resident 15 left the facility with 911 emergency personnel for his transfer to the hospital. Nursing documentation dated May 31, 2026, at 2:50 PM revealed that Resident 15 returned to the facility from the hospital. Review of Notification of Transfer forms dated May 16, 2026, and May 29, 2026, noted that there was verbal communication with Resident 15's wife regarding his transfer to the hospital (handwritten note by staff on the line designated for, Signature of Resident or Resident Representative). The forms errantly noted the email address for the Pennsylvania Long-Term Care Ombudsman as AGING@pa.gov instead of the correct email address of LTC-Ombudsman@pa.gov. Resident 15's medical record did not contain evidence that the facility provided written notice to Resident 15 and his resident representative (wife) that specified the facility policies regarding bed-hold periods that permitted Resident 15 to return to the nursing facility. Interview with the Nursing Home Administrator and the Director of Nursing on June 17, 2026, at 9:50 AM confirmed that the facility had no evidence that written notification was provided to Resident 15's responsible party related to the facility's bed hold policies and required notification of transfer information. S483.15(s)(2)(iii)(3)-(6)(8)(d)(1)(2) discharge processPreviously cited 7/18/25 28 Pa. Code 201.14(a) Responsibility of license 28 Pa. Code 201.29(a) Resident rights

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 clinical record review and resident and staff interview, it was determined that the facility failed to invite residents to their care plan meetings for three of three residents reviewed for care planning concerns (Residents 20, 36, and 78). Findings include: Interview with Resident 78 on June 15, 2026, at 8:50 AM revealed that the resident has not gotten an invitation to care plan meetings. Clinical record review for Resident 78 revealed that the resident's most recent comprehensive assessment dated [DATE], noted that staff assessed the resident as having a BIMS (Brief Interview for Mental Status) of 15 which indicated no cognitive impairment. Clinical record review for Resident 78 revealed no evidence that the resident or the resident representative was invited to a care plan meeting. The above information for Resident 78 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on June 15, 2026, at 2:30 PM. The facility provided no further documentation to indicate that Resident 78 or their resident representative was invited to a care plan meeting. A follow-up interview with the Nursing Home Administrator and Director of Nursing on June 17, 2026, at 1:24 PM revealed that the facility could provide no documentation to indicate that Resident 78 or their representative was invited to a care plan meeting. Interview with Resident 36 on June 15, 2026, at 9:32 AM revealed that she had no knowledge of care plan meetings. Clinical record review for Resident 36 revealed clinical record profile information that included her son as her resident representative. Resident 36's clinical record revealed that the facility completed an annual MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated August 22, 2025, and quarterly MDS assessments dated November 21, 2025, February 19, 2026, and May 20, 2026. The surveyor requested evidence of Resident 36 and/or her son/responsible party's involvement in care planning during an interview with the Nursing Home Administrator and Director of Nursing on June 15, 2026, at 2:15 PM. Interview with the Nursing Home Administrator on June 16, 2026, at 12:00 PM confirmed that the facility could not provide evidence that Resident 36 or her family were invited to participate in her care plan meetings since the facility's last standard survey (ending July 18, 2025). During an interview with Resident 20 on June 14, 2026, at 1:31 PM, they stated that they have never received an invitation to their care plan meetings, nor do they recall ever attending a care plan meeting. Clinical record review for Resident 20 revealed they were admitted on [DATE]. No evidence could be found in the clinical record to indicate that the resident was invited to or attended any of their care plan meetings. Interview with the Nursing Home Administrator on June 16, 2026, at 12:00 PM confirmed that the facility could not provide evidence that Resident 20 was invited to or attended their care plan meetings. 483.21(b)(2)(i)-(iii) Care Plan Timing and RevisionPreviously cited deficiency 7/18/25 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure that care and services were provided in a manner that enhanced resident dignity for one of three residents sampled (Resident 4). Findings include: Observation of Resident 4 on June 15, 2026, at 10:41 am revealed that there was a large dried, brown stain, measuring eight inches, and roughly round, noted on their hospital gown to the right side of their abdomen over their colostomy (an opening in the abdomen created during a surgical procedure that connects to the colon allowing stool to pass from the body without going through the anus). Concurrent interview with the resident revealed that they had received colostomy care over night and that their colostomy bag (a medical bag that is secured over the colostomy site to hold stool) be changed. Clinical record review of Resident 4's Kardex (documentation system used by staff to organize and reference key resident information essential for resident care) revealed that had last received colostomy care on June 15, 2026, at 4:12 AM. Above findings for Resident 4 reviewed during an interview with the Nursing Home Administrator and Director of Nursing on June 16, 2026, at 2:15 PM. 28 Pa. Code 201.18(b)(1) Management

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to ensure that the facility determined a resident's ability to self-administer medications for one of one resident reviewed (Resident 20).Findings include: Observation of Resident 20 on June 14, 2026, at 10:53 AM revealed the resident was sitting in a reclining chair. An adjacent bedside table a had a container of Nystatin topical powder (an antifungal medication used to treat fungal or yeast infections of the skin) on it. A concurrent interview revealed the resident utilized the medication to treat reddened areas to her groin and under her left breast. Resident 20 stated she cannot apply it because she can't reach under her left breast very well. Clinical record review following the above observation and interview revealed no current physician's order for Nystatin. Further clinical record review for Resident 20 revealed no physician's order that the resident may self-administer the medication, or that the facility determined the resident was able to safely self-administer the medication. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on June 16, 2026, at 2:15 PM. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9 (a)(1)(b) Pharmacy services 28 Pa. Code 211.12(d)(1) Nursing services

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation and resident and staff interview it was determined that the facility failed to ensure call bell accessibility for one of 32 residents reviewed (Resident 7).Findings include: Observation of Resident 7 on June 15, 2026, at 11:45 AM revealed she was out of bed in her chair on the left side of her bed. There was no call bell device visible within reach of Resident 7. An adaptive call bell was noted hanging from the top of Resident 7's mattress on the right side of her bed. Interview with Employee 3 (licensed practical nurse) on June 15, 2026, at 10:56 AM confirmed the above finding. Employee 3 relocated the adaptive call bell within reach of Resident 7. Observation of Resident 7 on June 16, 2026, at 10:55 AM revealed her to be in her bed. The adaptive call bell was clipped above her head, above her pillow, on the right side of her bed. Resident 7 stated that she could not find her call bell. Resident 7 stated that she could not raise her left arm above her head due to range of motion limitations and she was unable to reach high enough to feel for the call bell. Interview with Employee 2 (nurse aide) on June 16, 2026, at 10:56 AM confirmed the location of the Resident 7's call bell (out of Resident 7's reach). Employee 2 repositioned the call bell to make it accessible for Resident 7. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on family and staff interview and clinical record review, it was determined that the facility failed to support resident choice regarding providers of health care services for one of 32 residents reviewed (Resident 66).Findings include: Interview with Resident 66's daughter on June 15, 2026, at 12:05 PM revealed that she and her sisters stipulated to the facility that her mother was not to have any male caregivers. During an investigation related to missing pillows, she became aware that her mother received care from a male caregiver. Resident 66's daughter stated that she and her sisters have submitted grievances related to her mother's care. Review of Grievance/Concern Forms provided by the facility upon the surveyor's request which were dated May 8, 2026, and May 20, 2026, revealed no reference to male staff providing care to Resident 66. Interview with the Nursing Home Administrator and the Director of Nursing on June 16, 2026, at 2:15 PM indicated that the facility was aware of Resident 66's family report that male staff provided her care, however, the facility determined that a male staff member did not provide personal care to Resident 66, he only made Resident 66's bed. The interview indicated that the facility updated Resident 66's plan of care to include that male staff were not to be in Resident 66's room after her daughter voiced the concern regarding the male staff in her room. The facility could not produce a grievance form related to the male staff concern during the onsite survey. Clinical record review of Resident 66's bedside Kardex (electronic list of care need instructions available to nurse aide staff) active since May 10, 2026, revealed no male nurse aides were to provide Resident 66 care. Review of Resident 66's Documentation Survey Report (electronic documentation completed by nurse aide staff to attest to the provision of care) dated May 2026 revealed several entries completed by Employee 4 (male nurse aide) and Employee 5 (male nurse aide) to attest to the provision of care needs such as upper and lower body dressing, personal hygiene, toilet transfers, toileting hygiene, incontinence care, and preventative skin care with a barrier cream to Resident 66's buttocks and sacrum (tailbone, lower portion of the spine). The report also indicated that Employees 4 and 5 attested to a review of Resident 66's Kardex and that the Kardex was followed for care. Dates of care provided by male nurse aide staff included May 3, 7, 13, 16, 21, 25, and 29, 2026. Review of Resident 66's Documentation Survey Report dated June 2026 revealed that either Employee 4 or Employee 5 documented that Resident 66's Kardex was reviewed and that the Kardex was followed for care; however, that personal care was provided on June 2 and 14, 2026. The surveyor reviewed the above concerns that Resident 66's plan of care incorporated her preference for only female nurse aides, but male nurse aides documented provision of care during an interview with the Nursing Home Administrator and the Director of Nursing on June 17, 2026, at 9:50 AM. 28 Pa. Code 201.18(b)(2) Management 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interview, it was determined that the facility failed to provide a clean, comfortable, homelike environment on two of four nursing units ([NAME] Nursing Unit and Marble Nursing Unit; Residents 4 and 12), and provide a safe and clean environment in the common area between the two nurse stations. Findings include: Observation of the drinking water fountain in the common area located between the two nurse stations on June 16, 2026, at 9:34 AM revealed the fountain has a plastic cover over it. The cover has duct tape across it to secure it. The cover is observed to be ripped in several areas and has dried stains on it. There is paper debris visible in the basin of the fountain. A follow-up observation of the drinking water fountain with the Director of Nursing on June 16, 2026, at 12:51 PM revealed the same observation as above. There is debris visible in the basin of the fountain that included a plastic cup and what appeared to be used lollipop sticks. Observation of Resident 4's room on June 15, 2026, at 1040: AM revealed two house flies flying around the resident. Family visiting Resident 4's roommate stated that there are always flies flying around Resident 4. A follow-up observation on June 16, 2026, at 11:23 AM, revealed a fly in Resident 4's the room on the ceiling. The resident pointed up to the ceiling and indicated that she did not like all the flies. Observation of Resident 12's room on June 15, 2026, at 11:08 AM revealed that on the windowsill were two five-pound bags of sugar, and sugar granules were noted on windowsill. The floor felt very sticky underfoot and a large amount of orange crumbs were scattered on the floor at the foot of the bed, the floor beside the bed, and in front of the resident's dresser. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on June 17, 2026, at 10:19 AM. 28 Pa. Code 201.18(b)(3)(e)(2.1) Management

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to ensure a resident's medication regimen was free from potentially unnecessary medication for one of five residents reviewed for medication regimen review (Resident 36).Findings include: The facility policy entitled, Psychotropic Medication Use, last reviewed without changes on May 20, 2026, noted that psychotropic medication management is an interdisciplinary process and includes determining adequate indications for use, adequate monitoring for efficacy and adverse consequences, and determining appropriateness of gradual dose reduction. When determining whether to initiate, modify, or discontinue medication therapy, the interdisciplinary team conducts and documents an evaluation of the resident that includes the resident's: physical, behavioral, mental, and psychosocial status; expressions or indications of distress; changes in functional status; and resident complaints, behaviors, and symptoms. Circumstances that warrant an evaluation of the resident's underlying medical condition and medications include an irregularity identified during the drug regimen review. Psychotropic medication may be considered appropriate when: a resident's behavioral symptoms present a danger to the resident or others; a resident is exhibiting indications of distress that are significant to the resident; non-pharmacological approaches have been attempted but did not relieve the medical symptom which are presenting a danger or significant distress; and/or a gradual dose reduction was attempted, but clinical symptoms returned. The clinical rationale for the use of psychotropic medication is documented in the medical record. Documentation must include that behavioral interventions were attempted but not successful, and these interventions were deemed clinically contraindicated. Alternatively, documentation from a physician must describe that alternative treatments are clinically contraindicated and the rationale for this conclusion. Clinical record review for Resident 36 revealed that her medication regimen included the use of Lorazepam (an antianxiety psychotropic medication) 0.5 mg (milligrams) daily for an anxiety disorder since July 8, 2024. Resident 36's medication regimen also included the use of Duloxetine (an antidepressant psychotropic medication) 20 mg daily since October 26, 2024. Review of a plan of care initiated by the facility March 24, 2026, to address Resident 36's use of an anti-anxiety medication revealed interventions that included to observe for and record occurrences of target behavior symptoms (e.g., pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, etc.) and document per facility protocol. Review of a plan of care initiated by the facility March 24, 2026, to address Resident 36's use of an antidepressant medication revealed interventions that included to observe for and document/report to the physician ongoing signs and symptoms of depression unaltered by an antidepressant medication such as, sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, negative mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance. Review of Resident 36's MAR/TAR (Medication Administration Record/Treatment Administration Record, electronic documentation completed by licensed staff) revealed that the facility identified one target behavior, restlessness, to monitor for psychotropic medication use since May 2, 2025. Resident 36's clinical record indicated that her dose of the antianxiety and antidepressant medications remained the same since 2024. A Note to Attending Physician/Prescriber from the facility's consultant pharmacist dated January 8, 2026, requested that the physician consider an attempted dose reduction or trial discontinuation of the Duloxetine and/or Lorazepam medication as, CMS guidelines require periodic review of psychoactive medications. Please consider an attempted dose reduction or trial discontinuation, as you deem appropriate. If gradual dose reduction is clinically contraindicated at this time, please document the clinical rationale below. This (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	must address the reason(s) why an attempted GDR would likely impair the resident's function or cause psychiatric instability, by exacerbating an underlying medical or psychiatric disorder. The physician's response dated January 13, 2026, noted the only clinical rationale as, medically stable. There was no supporting rationale to disagree with the recommendation such as ongoing distressing target behaviors or a failed GDR in the past. Interview with the Director of Nursing and the Nursing Home Administrator on June 17, 2026, at 9:50 AM confirmed that the facility had no evidence of target behavior monitoring for the use of antianxiety and antidepressant medications for Resident 36 as stipulated in her plan of care. The interview confirmed that the facility had no additional information to support Resident 36's physician's response to the consultant pharmacist recommendation in January 2026. 483.10(e)(1), 483.12(a)(2), 483.45(c)(3)(d)(e) Right to be Free From Chemical RestraintsPreviously cited deficiency 7/18/25 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
	395589	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Carmel Senior Living Community	2616 Locust Gap Highway MT Carmel, PA 17851

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on clinical record review and staff interview it was determined that the facility failed to ensure each resident was appropriately screened through the PASRR process prior to, and during, admission to the facility for two of three residents reviewed for PASRR concerns (Residents 15 and 9). Findings include: The PASRR (Preadmission Screening and Resident Review) official website at https://www.dhs.pa.gov/providers/Providers/Pages/PASRR-Process.aspx, noted that the PASRR requires that all applicants to a Medicaid-certified nursing facility be evaluated for serious mental illness (SMI), intellectual disability (ID) and/or other related condition (ORC). PASRR can advance person-centered care planning by assuring that psychological, psychiatric, and functional needs are considered along with personal goals and preferences in planning long term care. In brief, the PASRR process requires that all applicants to Medicaid-certified Nursing Facilities be given a preliminary assessment to determine whether they might have SMI, ID, or ORC before admission. This is called a PASRR Level I screen. The PASRR Level I form is to be used as a worksheet. You are to make any additions or corrective changes directly on the PASRR Level I form itself. Date and initial/sign to indicate that a change has been made to the form. Nursing Facilities are responsible for making sure the form is filled out correctly at the time of admission. Clinical record review for Resident 15 revealed that the facility admitted him on April 29, 2026. Clinical record review of the PASRR Level I form available for Resident 15 during the onsite survey revealed that staff documented the form as completed on April 29, 2025, (a year earlier than his admission to the facility). Section III-A, question one, listed no mental health diagnoses for Resident 15. Review of Resident 15's diagnoses list upon his admission to the facility noted the following diagnoses dated April 27, 2026: Post-traumatic stress disorder (PTSD, a mental health condition that is caused by an extremely stressful or terrifying event and symptoms cause significant distress or problems with daily functioning)Anxiety Disorder, unspecified (excessive worry about various aspects of life interfering with daily activities and well-being)Major depressive disorder, recurrent (persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems) Review of an admission MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated May 9, 2026, noted that staff included Resident 15's diagnoses of anxiety disorder, depression, and PTSD, in the assessment. Review of Resident 15's medication regimen noted the following antidepressant psychotropic medications for the following diagnoses: Mirtazapine 15 mg (milligrams) at bedtime related to major depressive disorder, recurrent Sertraline 100 mg daily for depression related to major depressive disorder, recurrent The surveyor requested current Resident 15's PASRR assessments for Resident 15 during an interview with the Nursing Home Administrator and the Director of Nursing on June 15, 2026, at 2:15 PM. Interview with the Nursing Home Administrator and the Director of Nursing on June 16, 2026, at 2:15 PM confirmed that the above referenced PASRR assessment was the only version available for Resident 15 for his admission to the facility. The facility failed to ensure that Resident 15's PASRR form was completed correctly at the time of his admission to the facility. Clinical record review for Resident 9 revealed the resident had a PASRR completed on admission dated June 14, 2024, which indicated the resident had a diagnosis of dementia (a decline in memory, thinking and reasoning), and no other diagnosis to be captured on the PASRR. Further clinical record review for Resident 9 revealed a diagnosis of depression was added to the resident's list of diagnoses on October 25, 2024. There was no evidence that Resident 9's PASRR was updated to reflect that additional depression diagnosis. The above information was reviewed with the Nursing Home Administrator and Director of Nursing on June 16, 2026, at 2:20 PM. The facility provided an updated PASRR for Resident 9 which indicated the resident's diagnosis of unspecified psychosis not due to a substance or known physiological condition, depression, was added to the PASRR by social services on June 16, 2026, after it was brought to the facility's attention by the surveyor as noted above. 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 211.5 (f)(v) Medical Records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing 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 review, observation, and family and staff interview, it was determined that the facility failed to ensure a dependent resident received assistance with activities of daily living for two of three residents reviewed for activities of daily living concerns (Resident 63 and 66). Findings include: Interview with Resident 66's daughter on June 15, 2026, at 12:05 PM revealed that family visited Resident 66 on Mother's Day (May 10, 2026) and found that no staff assisted her mother to eat lunch and that she appeared in a group activity disheveled and undignified. Resident 66's daughter stated that her mother was dependent on staff to feed her. Review of a plan of care initiated by the facility on May 10, 2023, to address Resident 66's ADL (activities of daily living) Self Care Performance Deficit revealed interventions that included: Bath/Shower schedule: Mondays and Thursdays evening shift (3:00 PM to 11:00 PM or 2:00 PM to 10:00 PM); Resident 66 preferred showersBathing: The resident required assistance of one staff for bathing/showerDenture care every morning and at hour of sleepEating: Resident 66 was dependent for feeding Review of a quarterly MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) assessment dated [DATE], assessed Resident 66 as dependent on the assistance of staff for eating, oral hygiene, showering/bathing, dressing, personal hygiene, toileting, bed mobility, and transfers. Review of Documentation Survey Report documentation (electronic documentation completed by nurse aide staff to attest to the completion of activities of daily living care) dated May 2026 revealed no documentation regarding the amount Resident 66 ate for the lunch meal on May 10, 2026 (Mother's Day). Further review of the Documentation Survey Report dated May 2026 revealed the following omissions of staff documentation related to Resident 66's activities of daily living: Amount eaten for breakfast or lunch on May 1, 4, 11, 20, and 23, 2026Oral hygiene day shift May 1, 4, 11, 14, 20, 23, and 27, 2026Personal hygiene evening shift May 2, 3, 5, 6, 8, 9, 11, 28, and 29, 2026Shower May 11 or 28, 2026 (Monday and Thursday respectively) Observation of Resident 66 on June 16, 2026, at 3:45 PM revealed her in her wheelchair, in the hallway. Resident 66's hair did not appear combed. Review of Documentation Survey Report documentation dated June 2026 revealed that no staff initialed to attest to providing Resident 66 with oral or personal hygiene care for day shift on June 16, 2026. Further review of the Documentation Survey Report dated June 2026 revealed the following omissions of staff documentation related to Resident 66's activities of daily living: Oral and personal hygiene day shift on June 1, 8, 12, and 16, 2026Transferred out of bed for all meals, meal amount eaten, and consumption of nutritious supplement shake with all meals for breakfast or lunch on June 1, 8, or 12, 2026Amount eaten for the dinner meal on June 4 and 13, 2026 The surveyor reviewed the above concerns related to Resident 66's ADL care during an interview with the Nursing Home Administrator and the Director of Nursing on June 17, 2026, at 9:50 AM. During an interview with Resident 63 on June 14, 2026, at 2:20 PM, they stated that they often do not get their showers because they require two staff for care. Resident 63 stated that they did not get a shower last Tuesday (June 9, 2026). Clinical record review for Resident 63 reveals a Kardex (documentation system used by staff to organize and reference key resident information essential for resident care) which indicated the resident was not available for a shower on June 9, 2026. Further review revealed that the resident returned from a medical appointment at 6:10 PM. Further record review revealed that Resident 63 had an MDS assessment dated [DATE], that indicated the resident is dependent for showering/bathing. During an interview with the Nursing Home Administrator and the Director of Nursing on June 16, 2026, at 2:15 PM, they confirmed that showers are still being conducted after the resident's appointment return time. The above information was reviewed with the Nursing Home Administrator and the Director of Nursing on June 17, 2026, at 10:27 AM 483.24(a)(2) ADL Care Provided for Dependent ResidentsPreviously cited deficiency 7/18/25 28 Pa. Code 211.12(d)(1)(5) 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 observation, clinical record review, and resident and staff interview, it was determined that the facility failed to provide the highest practicable care related to alteration in skin integrity for one of two residents reviewed for skin concerns (Resident 16) and ordered medication parameters for one of one resident reviewed (Resident 78).Findings include: Interview with Resident 16 on June 14, 2026, at 3:19 PM revealed that she had broken skin under her stomach and under her breasts that is red. Resident 16 stated that staff do not apply treatment to the area every day. Observation of Resident 16 on June 16, 2026, at 10:51 AM with Employee 8 (registered nurse) revealed that the skin under Resident 16's bilateral breasts and bilateral inguinal areas (groin) was reddened with white substance over the areas. Interview with Employee 8 on the date and time of the observation confirmed that staff applied a treatment of a white substance under her breasts and in her inguinal areas. Resident 16 stated that not all staff had her lay down to best apply the treatment to her bilateral inguinal areas. Clinical record review for Resident 16 revealed nursing documentation dated May 29, 2026, at 8:00 PM that Resident 16's right abdominal fold was excoriated with a foul odor. The documentation indicated that the nurse obtained a new physician's order for Nystatin (antifungal medication) powder twice daily for seven days for a fungal rash (yeast skin infection). A physician's order dated June 5, 2026, instructed staff to apply Nystatin powder to Resident 16's right abdominal fold two times a day for a fungal rash for seven days. Resident 16's clinical record did not contain an order to treat the reddened areas of her left abdominal fold (groin) or under her bilateral breasts. Nursing documentation by Employee 8 dated June 16, 2026, at 11:02 AM (following the above observation of Resident 16's skin) noted that Resident 16 had redness, fungal rash, under her bilateral breasts and groin. Employee 8 obtained a new order for Nystatin powder twice a day for fourteen days. Review of Resident 16's TAR (Treatment Administration Record, electronic documentation completed by licensed staff to attest to the completion of treatments) dated June 2026 revealed no documentation of treatments to the skin under her bilateral breasts or left groin (despite the observation of a white substance under both breasts and left groin area as documented above and confirmed by Resident 16). The TAR indicated that staff failed to document the completion of the treatment to Resident 16's right abdominal fold on June 9 and 11, 2026, at 6:00 AM. Staff documented a code of 16 on June 2 and 4, 2026, day shift, which indicates to refer to nursing documentation; however, there was no nursing documentation that addressed the treatments for those dates and times. The surveyor reviewed the above concerns related to the treatments of Resident 16's skin alteration during an interview with the Nursing Home Administrator and the Director of Nursing on June 16, 2026, at 2:15 PM. Clinical record review for Resident 78 revealed a current physician order dated July 3, 2024, at 8:00 AM for Metoprolol Succinate (a medication that is used to treat high blood pressure and/or heart rate) ER (extended release) oral tablet 24-hour 50 milligrams; give 50 milligrams by mouth one time a day related to essential hypertension (high blood pressure). The order noted to hold for systolic blood pressure (the top number of a blood pressure reading where the heart contracts) less than 100 or heart rate less than 60. Review of Resident 78's June 2026 MAR (Medication Administration Record) and June 2026 blood pressure and pulse revealed no documentation to indicate that staff were measuring the blood pressure and heart rate prior to each administration of the medication as ordered. The above information for Resident 78 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on June 15, 2026, at 2:30 PM. The facility provided no further documentation to indicate that staff were monitoring Resident 78's blood pressure and heart rate prior to administration of the Metoprolol. During a follow-up meeting with the Nursing Home Administrator and Director of Nursing on June 17, 2026, at 10:19 AM, the Director of Nursing reported that these parameters for Resident 78 were from the pharmacy and were previously discontinued a while ago. However, the facility provided no further documentation from the physician to indicate that monitoring the blood pressure and pulse rate with the metoprolol administration were no longer necessary and the order (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was current and active since 2024 upon surveyor review. 483.25 Quality of CarePreviously cited deficiency 7/18/25 28 Pa. Code 211.5(f)(i)-(iv)(viii)(ix) Medical records 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 clinical record review and staff interview it was determined that the facility failed to implement a fall prevention intervention for one of five residents reviewed for fall concerns (Resident 15).Findings include: Clinical record review for Resident 15 revealed admission nursing documentation dated April 29, 2026, at 4:51 PM that Resident 15 was hospitalized after falling from a standing position and sustaining left frontal and parietal bone (frontal and parietal bones form the front and top lateral portions of the skull) fractures, multicompartmental intercranial hemorrhage (bleeding that extends into more than one anatomical compartment of the brain), and left inferior and superior pubic rami fractures (fractures of the front of the pelvic bone). A plan of care initiated by the facility upon Resident 15's admission, dated April 29, 2026, to address his risk for falls, revealed interventions that included to be sure the resident's call light was within reach and encourage Resident 15 to use it for assistance as needed. Provide a prompt response to all requests for assistance. Nursing documentation dated April 30, 2026, at 6:49 AM revealed that Resident 15 was, falling/crawling out of bed (attempts) during this shift, bed alarm was placed under resident. RN (registered nurse) aware and order put in by RN. Nursing documentation dated May 3, 2026, at 12:29 PM revealed that staff observed Resident 15 on the floor; and the call light was not activated. Resident 15 stated that he was trying to sit on the side of the bed and slid out. He was incontinent of urine at the time of the fall. A bed alarm that was in place did not activate (no sound) and Resident 15's call light was not in reach. Staff obtained a physician's order to have Resident 15 evaluated at the emergency room. A head and neck CT (noninvasive imaging test that uses X-rays to create detailed cross-sectional images of the head and neck, including the brain, skull, sinuses, and neck structures) radiology report dated May 4, 2026, at 12:08 AM noted no new intracranial blood products, no evidence of active bleeding within the brain, and no acute vascular findings within the head or neck. Review of the facility's investigation of Resident 15's fall on May 3, 2026, confirmed that two staff statements indicated that Resident 15's call bell was not in reach and that no alarm activated. The surveyor reviewed the above concerns related to Resident 15's fall during an interview with the Nursing Home Administrator and the Director of Nursing on June 17, 2026, at 9:50 AM. 483.25(d)(1)(2) Free of Accident Hazards/Supervision/DevicesPreviously cited deficiency 7/18/25 28 Pa. Code 211.12(d)(1)(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 observation and staff interview it was determined that the facility failed to ensure the application of supplemental oxygen per the physician's order for one of one resident reviewed for oxygen concerns (Resident 35).Findings include: Observation of Resident 35 on June 15, 2026, at 10:12 AM revealed supplemental oxygen in use via a room concentrator (machine that draws in room air and condenses the oxygen saturation of the room air to administer supplemental oxygen at 90 percent or higher through a nasal cannula (NC, a flexible tubing with prongs at one end that insert into the nares) set at less than one liter per minute. Clinical record review for Resident 35 revealed an active physician's order for staff to administer supplemental oxygen at two liters per minute via nasal cannula continuously every shift. Observation of Resident 35 on June 16, 2026, at 10:34 AM revealed his supplemental oxygen again set at approximately one liter per minute. Interview with Employee 8 (registered nurse) on June 16, 2026, at 10:36 AM confirmed that Resident 35's active physician order for supplemental oxygen is for two liters per minute. Observation of Resident 35 with Employee 8 on the date and time of the interview confirmed the supplemental oxygen setting at approximately one liter per minute. Employee 8 attempted to adjust the liter flow on the room concentrator; however, she determined that the machine liter flow gauge was malfunctioning which did not allow her to set the liter flow at the appropriate setting of two liters per minute. Employee 8 obtained a new room oxygen concentrator at that time. The surveyor reviewed the above concerns related to Resident 35's supplemental oxygen administration during an interview with the Nursing Home Administrator and the Director of Nursing on June 16, 2026, at 2:15 PM. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement an individualized person-centered care plan to address dementia and cognitive loss displayed by one of one resident reviewed (Resident 11).Findings include: Clinical record review for Resident 11 revealed the facility admitted her on April 3, 2026, with a diagnosis including Dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life). A review of Resident 11's current care plan (an outline of an individual's health needs, specific care requirements, and the actions necessary to achieve desired health outcomes) entitled, Impaired cognitive function/dementia or impaired thought processes related to dementia revealed general basic interventions such as cueing and reorienting, reporting changes to the physician, provide activities that accommodate needs. There was no indication that the facility had implemented an individualized person-centered care plan to address the residents' specific dementia and cognitive loss needs. The findings were reviewed with the Nursing Home Administrator and Director of Nursing on June 17, 2026, at 12:10 PM. 483.40(b)(3) Dementia Treatment and ServicesPreviously cited 07/18/25 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to ensure that the resident's attending physician addressed and responded appropriately to consultant pharmacy recommendations for two of five residents reviewed (Residents 12 and 36). Findings include: The facility policy entitled, Consultant Pharmacist Reports, Medication Regimen Review (Monthly Report) last reviewed without changes on May 20, 2026, revealed that the consultant pharmacist performs a comprehensive medication regimen review (MRR) at least monthly. Findings and recommendations are reported to the Director of Nursing, the attending physician, the medical director, and if appropriate the administrator. The findings are faxed or emailed within 72 hours to the Director of Nursing or designee and documented and stored with the other consultant pharmacist recommendations in the resident's chart. The consultant pharmacist's evaluation includes, but is not limited to, reviewing the following: A written diagnosis, indication, or documented objective findings support each medication orderDocumentation by physician, nurse, and/or consultants indicating progress toward or maintenance of goals of therapyLaboratory results, diagnostic studies, or other medication therapy measurements are obtained by staff/physician and acted uponThe duration of therapy is indicated and is appropriate for the residentMedical condition and response to drug therapy are evaluated to assure the appropriateness of the medication regimen Recommendations are acted upon and documented by the facility staff and/or the prescriber. Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreement. The Director of Nursing or designated licensed nurse address and document recommendations that do not require a physician intervention (e.g., monitor blood pressure). The facility policy entitled, Consultant Pharmacist Reports, Documentation and Communication of Consultant Pharmacist Recommendations, last reviewed without changes on May 20, 2026, revealed that the consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist observations and recommendations regarding residents' medication therapy are communicated to those with authority and/or responsibility to implement the recommendations, and responded to in an appropriate and timely fashion. A record of the consultant pharmacist's observations and recommendations is made available in an easily retrievable form to nurses, physicians, and the care planning team. The timing of these recommendations should enable a response prior to the next medication regimen review. Clinical record review for Resident 36 revealed a Note to Attending Physician/Prescriber from the facility's consultant pharmacist dated January 8, 2026, that requested that the physician consider an attempted dose reduction or trial discontinuation of Duloxetine (antidepressant medication) and/or Lorazepam (antianxiety medication) medications as, CMS guidelines require periodic review of psychoactive medications. Please consider an attempted dose reduction (GDR) or trial discontinuation, as you deem appropriate. If gradual dose reduction is clinically contraindicated at this time, please document the clinical rationale below. This must address the reason(s) why an attempted GDR would likely impair the resident's function or cause psychiatric instability, by exacerbating an underlying medical or psychiatric disorder. The physician's response dated January 13, 2026, noted the only clinical rationale as, medically stable. There was no supporting rationale to disagree with the recommendation such as indicating progress toward or maintenance of goals of therapy, ongoing distressing target behaviors, or a failed GDR in the past. Electronic documentation by the facility's consultant pharmacist dated April 6, 2026, for Resident 36 noted, Recommendations made, review Clinical Pharmacy Report. Record review for Resident 36 did not reveal any Clinical Pharmacy Report for the resident provided to the facility, or attending physician, that indicated the recommendations made as indicated above for the April 6, 2026, review of Resident 36's medications. The surveyor requested evidence of the consultant pharmacist's findings for Resident 36 on April 6, 2026, during an interview with the Nursing Home Administrator and (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Director of Nursing on June 17, 2026, at 9:50 AM. Interview with Employee 9 (assistant director of nursing) on June 17, 2026, at 12:01 PM revealed that the consultant pharmacist review on April 6, 2026, for Resident 36 requested that a periodic lipid panel (a blood test that measures cholesterol and triglyceride levels to assess risk of heart disease and other cardiovascular conditions) be done to monitor the medication Atorvastatin (medication used to lower cholesterol and reduce the risk of heart disease, heart attack, and stroke). The facility did not have this recommendation on a Note to Attending Physician/Prescriber. The interview confirmed that nursing staff would not write a physician's order to obtain routine laboratory testing; thus, it would need to be an action by the physician. Clinical record review for Resident 12 revealed a consulting pharmacist report dated October 6, 2025, requesting a gradual dose reduction or a documented rationale for declining the resident's Tizanidine (a muscle relaxer medication to treat muscle spasticity) 4 mg (milligram) three times a day, Pregabalin (a medication that can be used to treat nerve pain) 75mg daily every eight hours, and Oxycodone 10 mg (medication to treat severe pain) every four hours as needed. Resident 12's physician indicated agreement to stop or decrease Resident 12's Tizanidine and Pregabalin orders, while declining the recommendation to stop the Oxycodone on October 10, 2025, indicating that the oxycodone should continue for pain management. Further clinical record review revealed no evidence that any order was written to decrease or stop the Tizanidine or Pregabalin orders as the physician indicated on October 10, 2025. The surveyor requested any information indicating an additional information regarding Resident 12's medications noted above on June 17, 2026, at 9:30 AM, but no further information was provided. Above findings were reviewed during an interview with the Director of Nursing on June 17, 2026, at 12:50 PM, and it was confirmed that no further documentation was available. 28 Pa. Code 211.9 (d)(k) Pharmacy services 28 Pa. Code 211.12(d)(3)(5) Nursing services

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, review of facility documents, and resident and staff interview, it was determined that the facility failed to provide palatable food items and menu items as indicated for one of eight residents reviewed (Resident 73).Findings include: Interview with Resident 73 on June 14, 2026, at 1:43 PM, revealed that lunch had just been served. On the resident's bed was a plate of food with breaded chicken, noodles, and mixed vegetables. The resident indicated that the chicken and noodles were gross and that the chicken was dry and hard. Concurrent observation of the chicken revealed it was difficult to cut, and although the breading on the chicken felt very damp, the chicken was very dry to the touch, and the noodles were mushy and over cooked. The resident continued to indicate that they did not receive the meal that was listed on their provided menu because they were on a liberal renal diet (a flexible diet designed for patients with kidney disease), and that this happened all the time. Upon review of a facility menu the resident had in their room, the food items the resident received was noted to be for a regular diet. Concurrent record review for Resident 73 revealed the resident had an active physician's order for a liberalized renal diet. Interview with Employee 7, dietary manager, on June 16, 2026, at 10:00 AM revealed that the menus are delivered to the residents by her or by the resident council president, and no alternate diets are printed and distributed, nor are they displayed anywhere. Resident 73 was not aware of the foods she was to be receiving as her menu only reflected a regular diet. Above findings were reviewed during an interview with the Nursing Home Administrator and the Director of Nursing on June 16, 2026, at 2:15 PM. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management

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	395589	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Carmel Senior Living Community	2616 Locust Gap Highway MT Carmel, PA 17851

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on review of the facility meal schedule, observation, and resident and staff interview, it was determined that the facility failed to ensure that meals were served at regularly scheduled times in accordance with resident needs on one of four nursing units (Oak Nursing Unit; Residents 6, 30, and 78).Findings include: Review of the facility's Resident Council meeting minutes dated June 2, 2026, at 1:58 PM revealed that the residents indicated concerns related to meal trays arriving late. Review of facility grievances revealed the following grievances related to late meals: grievance dated February 5, May 2, and May 3, 2026, for Resident 30. Interview with Resident 78 on June 15, 2026, at 8:47 AM revealed that meals are frequently late. A follow-up interview with Resident 78 on June 16, 2026, at 1:05 PM revealed that meals can be up to 40 minutes late on some days. An interview with Resident 6 on June 15, 2026, at 9:50 AM revealed concerns related to lunch being served late. Observation of the Oak Nursing Unit on June 14, 2026, at 11:53 AM revealed a posted sign in the hallway that indicated, Meal Service Times. Each nursing unit was listed with an associated serving time for breakfast, lunch, and dinner. Oak Nursing Unit's posted lunch time was listed as 12:30 PM. The facility also provided a document titled, Meal Service Times, that noted Oak Nursing Unit meal service time as 12:30 PM. Observation on the Oak Nursing Unit on June 14, 2026, revealed that lunch trays arrived on the unit late at 1:16 PM via the meal delivery cart and staff started passing the food trays. An interview with Employee 7, dietary manager, on June 16, 2026, at 12:28 PM revealed that Employee 7 was aware of the late lunch meal on June 14, 2026. Employee 7 indicated that the food preparation that was to be completed the day prior to the meal was not completed by staff. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on June 16, 2026, at 2:30 PM. The Nursing Home Administrator confirmed there have been ongoing issues with late meal trays. 28 Pa. Code 201.14(a) Responsibility of licensee

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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 clinical record review and staff interview, it was determined that the facility failed to ensure complete and accurate clinical documentation for 1 of 24 residents reviewed (Resident 30).Findings include: Clinical record review for Resident 30 revealed a current physician order dated August 18, 2025, for bilateral floor mats when in bed. A quarterly Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated May 26, 2026, revealed that facility staff assessed Resident 30 as having a BIMS (Brief Interview for Mental Status) of 00, which indicated severe cognitive impairment. The current task list (located in the electronic health record where staff document specific care related events for a resident) for Resident 30 revealed a safety device - bilateral floor mats when in bed with a frequency of every shift. A review of the task documentation for Resident 30 for April 2026, May 2026, and June 2026, revealed the following dates where there was no documentation (left blank) to indicate that staff had addressed the floor mats: April 10, 2026; evening shiftApril 11, 2026; day shiftApril 12, 2026; day shiftApril 16, 2026; evening shiftApril 19, 2026; evening shiftApril 20, 2026; evening shiftApril 23, 2026; evening and night shiftsApril 25, 2026; day shiftApril 26, 2026; evening shiftApril 27, 2026; evening shift May 8, 2026; day shiftMay 9, 2026; evening shiftMay 10, 2026; day shiftMay 31, 2026; night shift The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on June 16, 2026, at 2:30 PM; and June 17, 2026, at 10:19 AM. The facility reported that the missing documentation was a documentation issue with staff. 28 Pa. Code 211.5(f) Medical records

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on a review of select facility policies and procedures, clinical record review, and staff and resident interview, it was determined that the facility failed to ensure that contracted hospice services met professional standards of practice and timeliness of services for one of one resident reviewed for hospice concerns (Resident 15). Findings include: Review of the facility's current contract with the hospice services provider revealed hospice shall furnish to the facility at the time of the patient's admission, a copy of the patient's plan of care, medical history, advance directive, DNR (do not resuscitate) status, and request for service signed by the patient or authorized representative of the patient and shall specify the general inpatient care or respite care services to be provided by the facility. Hospice shall promptly communicate orally or in writing any changes in the plan of care to the facility. The patient care coordinator/designee shall coordinate the general inpatient care or respite care provided to the patient by reviewing the plan of care and updating the plan of care as necessary during the patient's inpatient stay. The patient care coordinator/designee shall make a notation on the patient's chart each time the plan of care is reviewed. The patient care coordinator will be responsible for scheduling weekly interdisciplinary team meetings which shall include the inpatient staff caring for hospice patients as mutually determined by hospice and facility personnel. Interview with Resident 15 on June 15, 2026, at 10:58 AM revealed that he had received hospice services for a couple weeks and staff have come almost daily to check on him and determine if he has any needs. Nursing documentation dated June 3, 2026, at 9:55 AM revealed that the Director of Nursing obtained a physician's order for referral to a contracted hospice provider. Nursing documentation dated June 8, 2026, at 12:07 PM revealed that the facility's contracted hospice provider staff visited Resident 15 and that Resident 15's admission to hospice services was effective June 8, 2026. Resident 15's clinical record contained no documentation that related to the June 8, 2026, visit by the contracted hospice provider staff. Review of a Hospice and Facility Coordinated Plan of Care available in a binder maintained at the nurses' station for Resident 15 revealed that the provider did not include the following: the date, hospice diagnosis, funeral home information, diet, durable medical equipment used, medical supplies, code status (e.g., resuscitate or do not resuscitate), or the frequency of visits of a social worker or chaplain. The plan of care indicated that a nurse and a hospice aide would visit twice a week. The surveyor requested documentation completed by the contracted hospice provider since Resident 15's admission to their services during an interview with the Director of Nursing and the Nursing Home Administrator on June 15, 2026, at 2:15 PM. An email provided by the facility dated June 15, 2026, at 4:19 PM (following the surveyor's questioning) from the facility's contracted hospice provider noted Resident 15's admission note documentation. Interview with the Nursing Home Administrator and the Director of Nursing on June 17, 2026, at 9:50 AM confirmed that the facility had no documentation by providers from the contracted hospice provider since Resident 15's admission to their services more than a week prior. The interview indicated that the contracted hospice provider reported to her that they would supply documentation of their visits monthly. The facility had no documentation before the surveyor's questioning. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and staff interview, it was determined that the facility failed to properly contain and dispose of garbage at the facility's outside dumpsters. Findings include: Observation of the facility's main dumpsters located outside on facility property on June 14, 2026, at 10:06 AM revealed the following: There were four observed dumpsters. Each of the dumpsters had at least one of the hinged lids open. One dumpster had multiple birds observed sitting on the dumpster top rail. There were multiple birds on the garbage bags inside the dumpster that flew away upon approaching. The ground surrounding the dumpsters had various items discarded that included: a plastic energy shot bottle, a medical glove, two sugar packets, a discarded milk pint container, a plastic two-section tray, and a plastic white single serve pudding container. A second observation on June 16, 2026, at 9:25 AM revealed the ground surrounding the dumpsters had the following discarded items: a medical glove, small paper products, a plastic two-section tray, a sweetener packet, a plastic white single serve pudding cup, a battery, and a plastic energy shot bottle. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on June 16, 2026, at 2:48 PM. 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, review of posted daily nurse staffing data, and staff interview, it was determined that the facility failed to post and retain posted nursing staffing information for the past 18 months for one of four nursing units (Marble).Findings include: A review of nurse staff postings provided by the facility for May 1, 2026, through June 14, 2026, revealed there was no evidence of a nurse staff posting for May 19, 2026. Upon further review of facility nurse staff postings from October 2025, with Employee 10 (scheduler), on June 16, 2026, at 10:50 AM, there was no evidence of daily staff postings for October 2, 10, 12, 15, 16, 17, 23, and 26, 2025. Observation of the Marble nursing unit with Employee 10, on June 17, 2026, at 9:30 AM, revealed no evidence of nurse staff postings on the unit. Employee 10 concurrently confirmed there was no posting on the Marble unit and there was no evidence of the missing postings of the above noted dates. 28 Pa. Code 201.14(a) Responsibility of licensee