STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395607	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shippenville Nursing and Rehab	21158 Paint Boulevard Shippenville, PA 16254

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to implement an intervention in a comprehensive person-centered care plan for a resident requiring suctioning (a procedure to remove unwanted fluid from a person) for one of 19 residents reviewed. (Residents R12). Findings include: Review of facility policy entitled, Comprehensive Care Plan dated 1/22/26, indicated It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident. and Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions. Review of Resident R12's clinical record revealed an admission date of 1/8/18, with diagnoses that included multiple sclerosis (a disease where the body's immune system attacks the nerves which can cause vision problems, muscle weakness, numbness, feeling tired, difficulty thinking and bowel and bladder dysfunction), chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), and dysphagia (difficulty swallowing). Review of Resident R12's physician's orders revealed an order for suction every four hours if cannot clear secretions. Review of Resident R12's plan of care revealed a plan of care for respiratory impairment dated 2/6/23, with an intervention of, may suction as directed for increased secretions. Change canister post suction. Observations on 6/9/26, at 1:45 p.m. and again at 2:13 p.m. revealed a suction machine (a medical device designed to remove unwanted fluids from a patient's body) sitting on Resident R12's bedside stand. The collection container (a container where the unwanted fluids are collected) was three quarters of the way full of cloudy liquid which appeared to be secretions. During an interview on 6/11/26, at 1:36 p.m. the Director of Nursing (DON) confirmed that Resident R12's respiratory impairment plan of care intervention to change canister post suction was not implemented. The DON also confirmed that care plan interventions should be implemented. 28 Pa. Code 201.14 (a) Responsibility of Licensee 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to promote cleanliness and help prevent the spread of infection regarding respiratory care equipment for one of 19 residents reviewed (Resident R12).Findings include: Review of facility policy entitled Suctioning the Upper Airway dated 1/22/26, indicated Empty and rinse collection container if necessary or as indicated by facility protocol. Review of Resident R12's clinical record revealed an admission date of 1/8/18, with diagnoses that include multiple sclerosis (a disease where the body's immune system attacks the nerves which can cause vision problems, muscle weakness, numbness, feeling tired, difficulty thinking and bowel and bladder dysfunction), chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), and dysphagia (difficulty swallowing). Review of Resident R12's physician's orders revealed an order for suction every four hours if cannot clear secretions. Review of Resident R12's plan of care revealed a plan of care for respiratory impairment dated 2/6/23, with an intervention of, may suction as directed for increased secretions. Change canister post suction. Review of Resident R12's treatment record revealed the last time that Resident R12's suction machine (a medical device designed to remove unwanted fluids from a patient's body) was documented as used was 4/1/26. Review of Resident R12's progress notes revealed the last note indicating that Resident R12's suction machine was used was dated 4/2/26. Observations on 6/9/26, at 1:45 p.m. and again at 2:13 p.m. revealed a suction machine sitting on Resident R12's bedside stand. The collection container (a container where the unwanted fluids are collected) was three quarters of the way full of cloudy liquid which appeared to be secretions. During an interview on 6/9/26, at 2:56 p.m. the Director of Nursing (DON) confirmed that Resident R12's suction machine collection container needed emptied. The DON also confirmed that the collection container should be emptied after every use. 28 Pa. Code 211.10(c) 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. Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to ensure medications were administered according to physician's orders for residents receiving dialysis (method of mechanically cleaning the blood) for one of two residents reviewed for dialysis (Resident R27). Findings include: Review of the facility policy Hemodialysis, dated 1/22/26, indicated that the licensed nurse will communicate to the dialysis facility and attending physician medication administration or withholding of certain medications prior to the dialysis treatment and document such orders. Review of Resident R27's clinical record revealed an admission date of 4/09/26, with diagnoses that included heart disease, heart failure, acquired absence of right & left leg below the knee, type II diabetes (the body does not make enough insulin to control blood sugar), and end stage renal disease with dependance on renal dialysis, which required being away from the facility on Monday, Wednesday, and Friday each week for dialysis treatments. Review of physician's orders dated 4/09/26, indicated that Resident R27 was to have Calcium Carbonate Antacid (a medication used to treat indigestion and heartburn), 500 milligrams (mg) three times daily with meals and Novolog insulin per sliding scale blood sugar monitoring (a medication used to treat high blood sugar levels with blood sugar checks), before meals and at bedtime. Review of May and June 2026, Medication Administration Records (MARs) revealed that Resident R27 did not receive the following medications as ordered with reason given as: Not in Facility or Absent from Home Calcium Carbonate noon and Novolog insulin 11:30 a.m. doses on 5/4/26, 5/6/26, 5/8/26, 5/11/26, 5/13/26, 5/18/26, 5/20/26, 5/25/26, 5/27/26, 6/1/26, 6/3/26, 6/5/26, 6/8/26, and 6/10/26. There was no documentation until 6/11/26, that the physician was notified of a need to hold or alter the time of administration for the above listed medications for Resident R27 on dialysis days. During an interview on 6/11/26, at 1:30 p.m. the Assistant Director of Nursing confirmed that the above medications for Resident R27 were not administered on dialysis days as ordered by the physician. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of facility policies, observations and staff interviews, it was determined that the facility failed to appropriately discard outdated medications for one of three medication carts reviewed (B wing medication cart) and one of two medication rooms reviewed (200/300 medication room) and failed to prevent the opportunity for potential unauthorized access of medications on one of three medication carts observed (C wing medication cart). Findings include: Review of facility policy entitled Labeling of Medications and Biologicals dated 1/22/26, indicated Labels for multi-use vials must include: The date the vial was initially opened or accessed.All opened or accessed vials should be discarded within 28 days. Review of facility policy entitled Medication Storage date 1/22/26, indicated During a medication pass, medications must be under the direct observation of the person administering medications, or locked in the medication storage area/cart. Review of manufacturer's guidelines revealed that an open pen of Lantus Insulin must be used within 28 days after opening or be discarded, even if the vial still contains insulin. Review of manufacturer's guidelines revealed that an open vial of Tubersol (an injectable solution used for tuberculosis testing upon admission and employment) should be discarded within 30 days after opening. Observation of drug storage on 6/9/26, at 12:51 p.m. of the B-wing medication cart revealed an open pen of Lantus insulin lacking an open date. Observations in the 200/300 wing medication room revealed in the refrigerator an open vial of Tubersol with an open date of 4/1/26. During an interview on 6/9/26, at the time of observations LPN Employee E2 confirmed that the open Lantus insulin pen lacked an open date, and staff were unable to determine the discard date and the vial of Tubersol had an open date of 4/1/26. He/she also confirmed that the Lantus insulin pen and vial of Tubersol should have been discarded. Observations on 6/9/26, between 1:00 p.m. and 1:05 p.m. revealed LPN Employee E3 unlocked C wing medication cart parked in the hall against the wall with the drawers facing into the hallway. He/she then proceeded to walk down the hall and around the corner without securely locking C wing medication cart and was unable to view the medication cart. During an interview on 6/9/26, at 1:06 p.m. LPN Employee E3 confirmed that he/she left the C wing medication cart unlocked which was out of their view. He/she also confirmed that the medication cart should be locked when out of view. 28. Pa. Code 201.18(b)(1) Management 28. Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1) 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 facility policy, observations, and staff interviews, it was determined that the facility failed to prevent the potential for cross-contamination during completion of a wound dressing change for one of 19 residents reviewed (Resident R29).Findings include: Review of facility policy entitled Wound Care dated 1/22/26, indicated Steps in the procedure. Put on exam glove. Loosen tape and remove dressing. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. Put on gloves. Observations on 6/11/26, at 11:01 a.m. revealed Registered Nurse (RN) Employee E1 completing a wound dressing change in Resident R29's room. During the dressing change RN Employee E1 removed a soiled dressing from Resident R29's coccyx. He/she then proceeded to clean the wound without washing his/her hands and changing his/her gloves after removing the soiled dressing. During an interview on 6/11/26, at 11:15 RN Employee E1 confirmed that he/she did not wash their hands or change gloves after removing the soiled dressing. RN Employee E1 also confirmed that he/she should have washed their hands and applied clean gloves before cleaning the wound. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services