STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395623	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandview Nursing and Rehabilitation	78 Woodbine Lane Danville, PA 17821

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on a review of the facility assessment, facility-provided training documentation, and staff interviews, it was determined the facility failed to ensure an effective behavioral health care and services training program was provided for employees for 12 out of 12 months reviewed (May 2025 through April 2026).Findings include: A review of the facility assessment (a mandated, comprehensive, and recurring evaluation designed to determine the necessary resources such as staffing, equipment, and services needed to care for residents competently during daily operations and emergencies) last reviewed by the facility on January 29, 2026, revealed that the facility identified that it manages the medical conditions and medication-related issues causing psychiatric symptoms and behaviors and identifies and implements interventions to help support individuals with issues such as dealing with anxiety, caring for someone with cognitive impairment, caring for individuals with depression, trauma, post-traumatic stress disorder, or other psychiatric diagnoses, or intellectual or developmental disabilities. The assessment indicated that, on average, 90 residents receive psychiatric services (treatment provided by a qualified practitioner for mental health conditions such as mood disorders, anxiety, or psychosis), and 99 residents receive psychological services (therapeutic interventions such as counseling or behavioral therapy to address emotional and mental health needs) each month. The assessment indicated staff education is a key component to assuring that residents receive quality care. The facility assessment failed to identify or include a structured or ongoing staff training program specific to behavioral health care and services, despite the identified resident population requiring these services. A review of the facility's annual staff training modules for the period of May 2025 through April 2026 failed to reveal evidence that staff received training related to behavioral health care and services, including the identification of behavioral symptoms, implementation of non-pharmacological interventions (approaches that do not involve medications, such as redirection, environmental modification, or de-escalation techniques), or appropriate response to residents with psychiatric or psychological needs. During an interview conducted on April 17, 2026, at 11:30 AM, the Director of Nursing and Nursing Home Administrator were unable to provide documentation demonstrating that staff received training in behavioral health care and services during the review period. During the same interview, both confirmed the facility provides care to residents with varying and complex behavioral health needs, including those requiring psychiatric and psychological services. The facility failed to ensure the development and implementation of a behavioral health care and services training program for staff, consistent with the needs identified in the facility assessment and the resident population served. 28 Pa. Code 201.20(a)(b)(d) Staff development. 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of Minimum Data Set (MDS) assessments, and staff interview, it was determined the facility failed to ensure the MDS assessments accurately reflected the residents' status for six of eight residents reviewed for MDS accuracy (Residents 2, 4, 6, 7, 14, and 39).Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (October 2025), which provides instructions for completing the Minimum Data Set (MDS, a federally required standardized assessment used to evaluate resident status and develop care plans), indicates the assessment must accurately reflect the resident's functional status and be completed with participation from appropriate health professionals. The RAI Manual defines the Assessment Reference Date (ARD) as the last day of the observation period used to determine the resident's status. Information collected during the assessment period associated with the ARD must include direct observation of the resident, communication with the resident, and communication with direct care staff across shifts. The RAI Manual instructs that Section GG Functional Abilities must reflect the resident's usual performance, meaning the level of assistance the resident typically requires for activities such as eating, hygiene, toileting, bathing, and mobility, based on documentation and observation of the resident's actual performance during the assessment period. A clinical record review revealed Resident 2 was admitted to the facility on [DATE], with cerebral infarction (brain damage caused by interrupted blood flow to the brain, which may affect movement and ability to perform daily activities). A review of Resident 2's Annual MDS assessment dated [DATE], revealed Section GG Functional Abilities indicated Resident 2 required partial or moderate assistance with personal hygiene (activities such as combing hair, shaving, applying makeup, and washing and drying the face and hands). However, documentation in the clinical record during the assessment period associated with the ARD indicated Resident 2 was dependent on staff for personal hygiene on five of nine documented occasions, required substantial or maximal assistance on three of nine occasions, and required partial or moderate assistance on one of nine occasions.Section GG also indicated Resident 2 required partial or moderate assistance to roll left and right in bed. However, documentation during the assessment period associated with the ARD indicated Resident 2 was dependent on staff for bed mobility on three of nine documented occasions, required substantial or maximal assistance on five of nine occasions, and required partial or moderate assistance on one of nine occasions.Section GG also indicated Resident 2 required partial or moderate assistance to roll left and right in bed. However, documentation during the assessment period associated with the ARD indicated Resident 2 was dependent on staff for bed mobility on three of nine documented occasions, required substantial or maximal assistance on five of nine occasions, and required partial or moderate assistance on one of nine occasions. A clinical record review revealed Resident 14 was admitted to the facility on [DATE], with Alzheimer's disease (a progressive brain disorder that affects memory, thinking ability, and the ability to perform daily activities). A review of Resident 14's Quarterly MDS assessment dated [DATE], revealed Section GG indicated Resident 14 required partial or moderate assistance with eating (the ability to use utensils to bring food or liquid to the mouth). However, documentation during the assessment period associated with the ARD indicated Resident 14 was dependent on staff for eating on five of six documented occasions and required substantial or maximal assistance on one of six occasions. Section GG also indicated Resident 14 required substantial or maximal assistance with personal hygiene. However, documentation during the assessment period associated with the ARD indicated Resident 14 was dependent on staff for personal hygiene on nine of nine documented occasions. Section GG indicated Resident 14 required substantial or maximal assistance with bed mobility. However, documentation during the assessment period associated with the ARD indicated Resident 14 was dependent on staff for bed mobility, rolling left and right in bed and returning to a back lying position, on nine of nine documented occasions. A (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	clinical record review revealed Resident 6 was admitted to the facility on [DATE], with dementia (a condition characterized by decline in memory and thinking skills that interferes with daily functioning). A review of Resident 6's Annual MDS assessment dated [DATE], revealed Section GG indicated Resident 6 required substantial or maximal assistance with toileting hygiene (cleansing oneself and adjusting clothing before and after toileting). However, documentation during the assessment period associated with the ARD indicated Resident 6 was dependent on staff for toileting hygiene on nine of nine documented occasions. Section GG also indicated Resident 6 required substantial or maximal assistance with showering and bathing (washing, rinsing, and drying the body). However, documentation during the assessment period associated with the ARD indicated Resident 6 was dependent on staff for bathing on two of two documented occasions.A clinical record review revealed Resident 4 was admitted to the facility on [DATE], with diagnoses including acquired absence of the left leg below the knee and right hip joint (surgical removal of the lower portion of the left leg and right hip joint). A review of Resident 4's Quarterly MDS assessment dated [DATE], revealed Section GG indicated Resident 4 required substantial or maximal assistance with showering and bathing. However, documentation during the assessment period associated with the ARD indicated Resident 4 was dependent on staff for bathing on four of four documented occasions. Section GG also indicated Resident 4 required partial or moderate assistance with personal hygiene. However, documentation during the assessment period associated with the ARD indicated Resident 4 was dependent on staff for personal hygiene on five of seven documented occasions and required substantial or maximal assistance on two of seven occasions. Section GG indicated Resident 4 required partial or moderate assistance with bed mobility. However, documentation during the assessment period associated with the ARD indicated Resident 4 was dependent on staff for bed mobility on five of eight documented occasions and required substantial or maximal assistance on three of eight occasions. A review of Resident 39's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included end-stage renal disease (the final stage of kidney decline where the kidneys are no longer able to function to meet the body's needs). A review of Resident 39's Quarterly MDS assessment dated [DATE], revealed Section GG indicated Resident 39 required substantial or maximal assistance with showering and bathing. However, documentation during the assessment period associated with the ARD indicated Resident 39 was dependent on staff for bathing on one of one documented occasion. Section GG also indicated Resident 39 required partial or moderate assistance with personal hygiene. However, documentation during the assessment period associated with the ARD indicated Resident 39 was dependent on staff for personal hygiene on four of four documented occasions. Section GG indicated Resident 39 required supervision or touching assistance to wheel 50 feet in a wheelchair and complete two turns. However, documentation during the assessment period associated with the ARD indicated Resident 39 was dependent on staff for wheelchair mobility on two of two documented occasions. Resident 39 was dependent on staff to wheel 50 feet and make two turns in a wheelchair on two of two occasions documented. Review of Resident 39's Quarterly MDS assessment dated [DATE], revealed Section J Health Conditions indicated Resident 39 had no falls within the month prior to admission and no falls within the prior two to six months. However, documentation in the clinical record indicated Resident 39 sustained a fall at the facility resulting in an acute right femoral intertrochanteric fracture (a break in the upper portion of the thigh bone near the hip joint). A clinical record review revealed that Resident 7 was most recently admitted to the facility on [DATE], with diagnoses that included diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces) and hemiplegia (paralysis on one side of the body). A review of Resident 7's admission MDS assessment dated [DATE], revealed Section GG indicated Resident 7 required partial or moderate assistance with personal hygiene. However, documentation during the assessment period associated with the ARD indicated Resident 7 was dependent on staff for personal hygiene on five of seven documented occasions and required (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	substantial or maximal assistance on two of seven occasions. During an interview on April 15, 2026, at 1:30 PM, the above findings were reviewed with the Registered Nurse Assessment Coordinator. The Registered Nurse Assessment Coordinator acknowledged the MDS assessments for Residents 2, 4, 6, 7, 14, and 39 did not accurately reflect the residents' status documented in the clinical record. The facility failed to ensure the Minimum Data Set assessments accurately reflected the status of Residents 2, 4, 6, 7, 14, and 39.Refer F94028 Pa. Code 211.5(f)(ii) Medical records. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policies, and staff interviews, it was determined the facility failed to monitor resident weights consistently and accurately to timely identify changes in nutritional status and implement nutritional interventions for 3 of 33 residents reviewed (Residents 146, 84, and 161).Findings include: A review of the facility policy titled Weight Assessment and Interventions, last reviewed by the facility on January 29, 2026, indicated each resident's weight would be monitored by the interdisciplinary team and staff would intervene for undesirable weight loss. The policy indicated any weight change of 5 percent or more since the last weight assessment would be reweighed for confirmation and, if verified, nursing would immediately notify the Registered Dietitian. The policy further indicated that 5 percent weight loss in 1 month is significant, 7.5 percent weight loss in 3 months is significant, and 10 percent weight loss in 6 months is significant for unplanned and undesired weight loss. A review of the facility policy titled Nutritional Assessment, last reviewed January 29, 2026, indicated the dietitian, in conjunction with nursing staff and healthcare practitioners, would conduct a nutritional assessment for each resident upon admission and as indicated by a change in condition that placed the resident at risk for impaired nutrition. A clinical record review revealed Resident 146 was readmitted to the facility on [DATE], with diagnoses that included dysphagia (difficulty swallowing), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and muscle wasting with atrophy (wasting or thinning of muscle mass and can be caused by disuse of muscles). A review of a readmission nutrition evaluation completed by the Registered Dietitian on December 25, 2025, at 11:23 AM, indicated the resident's height was 59 inches and weight obtained on December 22, 2025, at 1:48 PM, was 91.2 pounds. The Registered Dietitian documented that the resident's ideal body weight was 123 pounds, the resident's weight had trended downward from 96 pounds on November 26, 2025, to 91.2 pounds on December 22, 2025, and the resident was underweight. The Registered Dietitian further documented the resident met criteria for malnutrition related to a mechanically altered diet, low body mass index (BMI, a measurement using height and weight to estimate whether body weight is low, normal, or high), compromised skin, variable oral intake, and a history of protein calorie malnutrition (poor nutrition caused by inadequate intake of calories and protein, which can result in weight loss, muscle loss, and impaired healing). The Registered Dietitian documented a goal for weight stability with gradual gain and recommended Med Pass 2.0, a liquid high calorie, high protein oral supplement, 120 milliliters three times daily. The note indicated staff should monitor weight trends and the resident should consume 75 percent or greater of most meals and supplements, show no signs or symptoms of malnutrition, and maintain weight without significant changes through the next review period, with weight gains favorable. A review of the resident's five day Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 27, 2025, revealed that Resident 146 was cognitively intact with a BIMS score of 13 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13 through 15 indicates cognitively intact). The assessment coded the resident's height as 59 inches and weight as 91 pounds. Section K0300 was coded to indicate the resident had a significant weight loss of 5 percent or more in the last month or 10 percent or more in the last 6 months that was not physician prescribed. Section K0520 indicated the resident required a mechanically altered diet and did not have a therapeutic diet in place. A review of Resident 146's weight record revealed the resident weighed 91.2 pounds on December 22, 2025, at 1:48 PM, and 82.2 pounds on January 5, 2026, at 11:35 AM. This reflected a 9-pound weight loss, or 9.8 percent, in approximately 1 week. A review of a nutrition progress note completed by the Registered Dietitian on January 12, 2026, at 2:20 PM, 7 days after the January 5, 2026, weight was obtained, indicated the current weight was 82.2 pounds on (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	January 5, 2026, compared to 96.1 pounds on December 3, 2025, for a 14-pound loss, or 14.5 percent, in 1 month. The note described the weight loss as unfavorable, documented that the resident remained underweight, and indicated oral intake was mostly 50 to 75 percent of meals with oral supplementation in place. The note indicated staff would continue the current plan of care and monitor weekly weights to follow up for further nutritional interventions. Further clinical record review failed to reveal a reweight was obtained after the January 5, 2026, significant weight loss, as required by facility policy. The clinical record also failed to reveal timely identification of the significant weight loss or timely development and implementation of additional interventions to address the resident's ongoing nutritional decline. After the January 12, 2026, nutrition note, the clinical record did not include further nutrition monitoring related to the significant weight loss. During an interview on April 16, 2026, at 10:45 AM, the Nursing Home Administrator reviewed the above findings. A review of Resident 84's clinical record revealed admission to the facility on March 19, 2025, with diagnoses to include major depressive disorder, and cerebral infarction (stroke which occurs when blood flow to part of the brain is blocked or interrupted). A review of Resident 84's weight record revealed the resident weighed 105 pounds on February 4, 2026, and 94 pounds on March 1, 2026. This reflected an 11-pound weight loss, or 10.5 percent, in less than 1 month. Clinical record review failed to reveal the facility immediately reweighed Resident 84 after this significant weight loss. Clinical record review also failed to reveal documented evidence that the facility notified the Registered Dietitian, physician, or resident representative of the significant weight loss. During an interview on April 16, 2026, at 9:40 AM, the Nursing Home Administrator reviewed the above findings and was unable to provide documentation showing staff had timely notified the dietitian and physician of the resident's significant weight loss or obtained and recorded a reweigh to support an accurate assessment of the resident's nutritional status and needs. Clinical record review revealed that Resident 161 was admitted on [DATE], with diagnosis of major infection, major depression and diabetes. A review of Resident 161's quarterly Minimum Data Set assessment MDS dated [DATE], revealed that Resident 161 was moderately cognitively impaired with a BIMS score of 10; a score of 8 through 12 indicates moderate cognitive impairment. Review of Resident 161's weight record revealed that the resident weighed 133.6 lbs. on February 5, 2026, and as of March 1, 2026, weighed 126 lbs. representing a 7.6 pound weight loss in 24 days. A review of dietary notes and physician orders revealed the facility did not complete a dietary assessment and intervention until February 15, 2026, at which time the note indicated the weight loss was unfavorable and a dietary supplement was added. The clinical record failed to reveal the facility implemented timely follow-up monitoring after the identified weight loss. A review of the weight record revealed Resident 161 weighed 126.4 pounds on April 9, 2026. Clinical record review failed to reveal more aggressive monitoring, such as weekly weights, or timely reassessment before April 9, 2026, to assure reasonable measures were implemented to assure that the resident's nutritional needs and goals were being met. During an interview on April 17, 2026, at 12:30 PM, the Director of Nursing reviewed the above findings and was unable to provide documentation showing re-evaluation of dietary goals, care plan revisions, or ongoing aggressive weight monitoring by dietary services after the February 15, 2026, dietary note. These findings showed the facility failed to consistently reweigh residents after significant weight changes, failed to timely notify appropriate clinical staff, and failed to implement and monitor nutritional interventions to identify and address changes in nutritional status for Residents 146, 84, and 161. 28 Pa Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c) (d)(3)(5) Nursing services.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, Medication Administration Records (MARs), facility policy, and staff interview, it was determined the facility failed to ensure pain was managed in accordance with professional standards of practice by not consistently attempting or documenting non-pharmacological (non-medication) interventions prior to the administration of as-needed (PRN) opioid pain medications for two of 33 residents reviewed (Residents 3 and 78).Findings include: A review of the facility policy titled Pain Assessment and Management, last reviewed January 26, 2026, indicated non-pharmacological interventions may be appropriate alone or in conjunction with medications. The policy identified interventions such as environmental adjustments (for example, changing room temperature), repositioning, pressure-reducing mattresses, application of ice or heat, exercise including range of motion (movement of joints to prevent stiffness), and cognitive or behavioral approaches such as relaxation or music. The policy further indicated pharmacological interventions (medications used to treat pain, such as analgesics) may be prescribed; however, these medications may not address the underlying cause of pain and may result in adverse effects, including drowsiness, increased fall risk, and decreased appetite. A review of Resident 3's clinical record revealed the resident was admitted on [DATE], with diagnoses including peripheral vascular disease (a condition involving narrowed blood vessels that reduce blood flow) and chronic left hip pain. A review of Resident 3's clinical record revealed the resident was admitted on [DATE], with diagnoses including peripheral vascular disease (a condition involving narrowed blood vessels that reduce blood flow) and chronic left hip pain. A review of physician orders dated October 31, 2025, at 3:30 PM, revealed an order for oxycodone HCl (an opioid pain medication used to treat moderate to severe pain) five milligrams by mouth every six hours as needed for pain levels four through ten (pain scale is a standardized tool used to measure a resident's level of pain, typically ranging from zero-no pain to ten-worst possible pain, to guide treatment decisions The order directed staff to offer non-pharmacological interventions prior to medication administration, including repositioning, toileting, backrub, dimming lights, food, fluids, or other measures. A review of the MAR (Medication Administration Record, a legal document that records medications administered to a resident) revealed the opioid medication, oxycodone HCL, was administered without licensed nursing staff attempting non-pharmacological interventions prior to administering the medications as follows: MAR dated November 1, 2025, through November 30, 2025, indicated oxycodone HCL was administered eleven (11) times out of one hundred and twenty (120) opportunities. MAR dated December 1, 2025, through December 31, 2025, indicated oxycodone HCL was administered twenty-three (23) times out of one hundred and twenty-four (124) opportunities. MAR dated January 1, 2026, through January 31, 2026, indicated oxycodone HCL was administered twenty-two (22) times out of one hundred and twenty-four (124) opportunities. MAR dated February 1, 2026, through February 28, 2026, indicated oxycodone HCL was administered twenty-three (23) times out of one hundred and twelve (112) opportunities. MAR dated March 1, 2026, through March 31, 2026, indicated oxycodone HCL was administered thirty-one (31) times out of one hundred and twenty-four (124) opportunities. The facility was unable to provide consistent documented evidence that licensed nursing staff attempted non-pharmacological interventions prior to administering the PRN opioid medication, oxycodone HCL as ordered. A review of Resident 78's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included a left femur fracture (a break in the thigh bone, the longest and strongest bone in the human body, usually caused by high-impact trauma). A review of Resident 78's physician's orders revealed an order for oxycodone HCl five milligrams, give one-half tablet by mouth every four hours as needed for pain levels four through seven, with direction to attempt non-pharmacological interventions first, including repositioning, toileting, food, fluids, back rub, dim lights, or other measures. A review of Resident 78's MAR dated March 12, 2026, through March 31, (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2026, indicated oxycodone HCL was administered twenty-one (21) times out of one hundred and fourteen (114) opportunities. A review of MAR dated April 1, 2026, through survey ending on April 17, 2026, indicated oxycodone HCL was administered ten (10) times out of seventy-eight (78) opportunities. The facility was unable to provide consistent documented evidence that non-pharmacological interventions were attempted prior to administering Resident 78 a PRN opioid pain medication, oxycodone HCL. During an interview conducted on April 15, 2026, at 1:33 PM, the above findings were reviewed with the Director of Nursing, who confirmed the facility could not provide documented evidence that non-pharmacological interventions were consistently attempted prior to administering PRN opioid pain medications to Residents 3 and 78. 28 Pa Code 211.10 (c) Resident care policies. 28 Pa. Code 211.5(f) Medical records. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services.

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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. Based on observation, staff interview, manufacturer guidelines, and review of select facility policy, it was determined the facility failed to adhere to acceptable storage and labeling practices for multi-dose medications and failed to maintain proper refrigeration temperatures for medications used in resident treatment on one of two nursing units (West), involving 10 residents (Residents 2, 4, 6, 22, 39, 56, 87, 90, 93, and 123).Findings include: A review of manufacturer guidelines for injectable agents used to lower blood glucose (blood sugar), including insulin products such as glargine, lispro, Lantus, and Novolog, as well as non-insulin injectable agents such as Trulicity, indicated that these medications must be stored under controlled temperature conditions to maintain effectiveness (potency, meaning the medication's ability to produce the intended therapeutic effect). Manufacturer guidance indicated that when refrigerated, these medications are to be maintained between 36 and 46 degrees Fahrenheit and must not be frozen, as freezing or exposure to temperatures outside the recommended range may alter the medication's stability and effectiveness.A review of the facility policy titled Storage of Medications, last reviewed January 29, 2026, indicated medications are to be stored in accordance with manufacturer recommendations and under proper temperature controls. The policy indicated refrigerated medications are to be maintained between 36 and 46 degrees Fahrenheit and that refrigerator temperatures are to be recorded daily. The policy also required staff to promptly report any refrigerator malfunction for emergency repair or replacement. Observation of the [NAME] nursing unit medication room on April 15, 2026, at 9:30 AM revealed a medication refrigerator containing multiple injectable blood glucose-lowering medications. A thermometer inside the refrigerator registered 30 degrees Fahrenheit. Review of the posted temperature log revealed that staff had not documented the refrigerator temperature for April 15, 2026, as of 9:30 AM. Posted parameters for acceptable refrigerator temperatures indicated a range of 36 to 40 degrees Fahrenheit, which was inconsistent with the facility policy range of 36 to 46 degrees Fahrenheit. A review of recorded refrigerator temperatures from January 1, 2026, through April 14, 2026, revealed repeated temperatures below acceptable ranges. Specifically, temperatures of 35 degrees Fahrenheit were documented on January 2, 7, 11, 17, 20, 22, 24, 27, and 30; February 6, 18, 22, 25, and 27; March 3, 11, 16, 19, 21, and 27; and April 5, 2026. Temperatures of 34 degrees Fahrenheit were documented on January 19 and March 22, 2026. These findings indicate ongoing storage of medications outside of manufacturer-recommended temperature ranges. Observation confirmed that the following residents had injectable medications stored in the refrigerator requiring strict temperature control: Resident 2 (Lantus), Resident 4 (Novolog), Resident 6 (Glargine), Resident 22 (Lispro), Resident 39 (Lispro), Resident 56 (Trulicity), Resident 87 (Novolog), Resident 90 (Glargine), Resident 93 (Novolog), and Resident 123 (Novolog). Failure to maintain appropriate storage temperatures placed these medications at risk for reduced potency, which may impact blood glucose control. Observation of the same refrigerator on April 15, 2026, at 9:30 AM revealed an opened multi-dose vial of tuberculin (a solution used for tuberculosis screening) that was not labeled with a date of opening. Dating medications upon opening is necessary to ensure compliance with manufacturer guidelines, which commonly require multi-dose vials to be discarded after a specified period, often 28 days, due to the risk of contamination (introduction of microorganisms) and reduced effectiveness over time. During an interview on April 15, 2026, at 9:30 AM, the Director of Nursing confirmed that injectable blood glucose-lowering medications are to be stored between 36 and 46 degrees Fahrenheit and that medications are to be dated when opened. The Director of Nursing confirmed that an opened tuberculin vial should be discarded 28 days after opening. Despite repeated documentation of temperatures below acceptable ranges, there was no evidence the facility implemented or sustained corrective actions to ensure refrigerated medications were consistently maintained within (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	manufacturer-recommended temperature parameters to preserve medication potency and ensure safe administration. 28 Pa. Code 211.12 (c)(d)(3) (5) Nursing services. 28 Pa. Code 211.10(d) Resident care policies.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a clinical record review and staff interview, it was determined the facility failed to ensure that the required resident information was communicated to the receiving health care provider for three out of 33 residents reviewed (Residents 7, 39, and 108).Findings include: A review of Resident 7's clinical record revealed the resident was admitted to the facility on [DATE], and transferred to the emergency department on February 4, 2026. A review of Resident 7's clinical record revealed there was no documented evidence the facility communicated the required information to the receiving health care provider, including contact information of the physician responsible for the care of the resident, resident representative information, including contact information, advance directive information, all special instructions or precautions for ongoing care, as appropriate, comprehensive care plan goals, and all other necessary information. A review of Resident 39's clinical record revealed the resident was admitted to the facility on [DATE], and transferred to the community hospital on March 9, 2026. A review of Resident 39's clinical record revealed there was no documented evidence the facility communicated the required information to the receiving health care provider, including contact information of the physician responsible for the care of the resident, resident representative information, including contact information, advance directive information, all special instructions or precautions for ongoing care, as appropriate, comprehensive care plan goals, and all other necessary information. A review of Resident 108's clinical record revealed the resident was admitted to the facility on [DATE], and transferred to the community hospital on February 10, 2026. A review of Resident 108's clinical record revealed there was no documented evidence the facility communicated the required information to the receiving health care provider, including contact information of the physician responsible for the care of the resident, resident representative information, including contact information, advance directive information, all special instructions or precautions for ongoing care, as appropriate, comprehensive care plan goals, and all other necessary information. During an interview on April 17, 2026, at 11:30 AM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) were unable to provide documented evidence the facility communicated residents' required clinical information to receiving health care providers to ensure a safe and effective transfer of care on February 4, 2026, for Resident 7, on February 10, 2026, for Resident 108, or on March 9, 2026, for Resident 39. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12 (d)(3) Nursing services.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, observations, and staff interviews, it was determined the facility failed to ensure residents received necessary treatment and services consistent with professional standards of practice to promote healing of existing pressure injuries for two of 33 residents reviewed (Residents 7 and 75).Findings include: According to the US Department of Health and Human Services, Agency for Healthcare Research &; Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, standardized pressure ulcer risk assessment, and care planning and implementation to address the areas of risk. The American College of Physicians (ACP) is a national organization of internists, who specialize in the diagnosis, treatment, and care of adults. The largest medical-specialty organization and second-largest physician group in the United States, Clinical Practice Guidelines, indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i.e., support surfaces, repositioning, and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement, and wound cleansing; using adjunctive therapies; and considering possible surgical repair. A review of the facility policy titled Pressure Injury Prevention and Management, last reviewed by the facility on January 29, 2026, revealed the facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure injury, prevent infection, and prevent the development of additional pressure injuries. The facility defines avoidable as the resident developed a pressure injury and the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate. Clinical record review revealed Resident 7 was admitted [DATE], with diagnoses including diabetes (a chronic disease affecting the body's ability to regulate blood sugar levels) and hemiplegia (paralysis affecting one side of the body), both conditions that increase risk for impaired mobility and skin breakdown. A care plan initiated February 4, 2026, identified risk for impaired skin integrity (damage to skin tissue) related to decreased mobility. Interventions included use of a pressure reduction mattress, monitoring and measuring wounds, and providing treatments as ordered. An admission evaluation titled Skin Evaluation, dated February 12, 2026, revealed Resident 7 was at risk for alteration in skin integrity related to impaired mobility with open skin areas identified.An external wound clinic report dated March 31, 2026, documented a Stage 3 left heel pressure injury (a deep wound involving loss of skin layers and exposure of underlying tissue caused by prolonged pressure) measuring 3.5 centimeters (cm) by 1.8 cm by 0.3 cm. The wound contained yellow fibrinous slough (dead tissue that can delay healing) covering 26 to 50 percent of the wound bed and red granulation tissue (new healthy tissue indicating healing) covering 26 to 50 percent of the wound bed. The wound exhibited mild serous drainage (clear or light yellow fluid from a wound) and no odor was indicated. Recommendations included use of a low air loss mattress (a specialized medical support surface mattress designed to prevent and treat severe pressure injuries by combining pressure redistribution with moisture management; this device provides alternating air pressure in accordance with a resident's weight) Resident 7 was scheduled for a follow-up appointment in five weeks. Clinical record review from March 31, 2026, through April 17, 2026, revealed no documented evidence the facility monitored or measured the Stage 3 left heel pressure injury during this period. Clinical record review indicated Resident 7 weighed 222 pounds (lbs.) on April 9, 2026. Observation on April 17, 2026, at 9:37 AM revealed Resident 7 resting on a low air loss mattress set to 275 lbs. During the observation, the regional nurse consultant confirmed the mattress setting was not adjusted to the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's current weight. An observation on April 17, 2026, at 9:39 AM revealed Resident 7's stage 3 left heel injury measured 3.0 cm x 1.5 cm x 0.2 cm. The wound presented without odor, 20 percent slough, 80 percent granulation, and with moderate serosanguineous drainage (a thin, watery, pale pink, or light red fluid commonly seen during the early inflammatory phase of wound healing).Clinical record review revealed Resident 75 was admitted [DATE], with diagnoses including osteomyelitis of the vertebra, sacral, and sacrococcygeal region (infection of bone tissue in the lower spine and tailbone area often associated with skin breakdown and pressure injuries). Resident 75's wound care consultant report dated April 10, 2026, documented treatment for a right buttock end-of-life skin failure wound (skin breakdown occurring as body systems decline near end of life due to decreased blood flow to tissues) measuring 4 cm by 3.5 cm by 0.1 cm and a left heel end-of-life skin failure wound measuring 1 cm by 1 cm by 0 cm. Treatment recommendations included use of an air mattress. A care plan initiated November 14, 2025, For Resident 75, identified risk for impaired skin integrity related to inadequate nutrition (insufficient intake of nutrients needed to maintain skin health) and immobility (limited ability to reposition independently). Interventions included use of a pressure reduction mattress on the bed (with staff to check placement and function every shift), and chair, repositioning with two staff assistance while in bed, weekly skin audits (routine skin inspections), and treatments as ordered. A physician order dated February 19, 2026, directed staff to apply an air mattress to the resident's bed and to check the placement and function on every shift. An observation on April 13, 2026, at 11:21 AM revealed Resident 75 asleep and lying in bed on an air mattress. The air mattress pump was set for a resident that weighed 148 lbs. A clinical record review revealed that on March 31, 2026, Resident 75 weighed 97.8 lbs. Review of the air mattress manufacturer's operating instructions indicated in Step 6: Determine the patient's weight and set the control knob to that weight setting on the control unit. The mattress should be set according to the resident's current weight to ensure appropriate pressure redistribution. During an interview on April 17, 2026, at 8:45 AM the Director of Nursing confirmed Resident 75's air mattress was not set for the resident's current weight. During an interview on April 17, 2026, at 11:30 AM, the above findings were reviewed with the Director of Nursing. The Director of Nursing was unable to provide documented evidence the facility monitored or measured Resident 7's left heel pressure injury between March 31, 2026, and April 17, 2026. The Director of Nursing further confirmed low air loss mattresses should be set according to the resident's weight and manufacturer instructions. The facility failed to ensure Residents 7 and 75 received necessary treatment and services consistent with professional standards of practice to promote healing of pressure injuries, including ongoing wound monitoring and implementation of pressure redistribution interventions adjusted according to resident-specific clinical needs. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical review and resident and staff interviews, it was determined the facility failed to ensure a resident with limited mobility received appropriate equipment necessary to maintain or improve mobility with the maximum practicable independence for one of 33 residents reviewed (Resident 4).Findings include: A clinical record review revealed that Resident 4 was admitted to the facility on [DATE], with diagnoses that included acquired absence of the left leg below the knee and right hip joint (the left leg and right hip joint were removed, either partly or entirely, due to injury, illness, or surgery, rather than being born without it). Review of the care plan initiated July 17, 2025, indicated Resident 4 had a self-care deficit related to decreased mobility (reduced ability to move independently). Interventions included getting the resident out of bed to a Geri-chair (a supportive medical chair designed for individuals with mobility limitations) or personal chair as tolerated, and use of back support in the wheelchair to promote positioning and comfort. An occupational therapy Discharge summary dated [DATE], indicated recommendations for Resident 4 to utilize a high-back reclining wheelchair with elevating leg rests (adjustable supports that raise the legs to improve positioning and circulation), a foot buddy (a positioning device used to help maintain proper foot alignment and prevent slipping), and a cushion (a pressure-relieving support surface intended to reduce the risk of skin breakdown). The discharge summary indicated Resident 4 was able to maintain upright positioning in the high-back reclining wheelchair for four hours and was able to safely propel (move) the wheelchair independently within the facility. A physician's order dated January 21, 2026, directed Resident 4 to utilize a high-back reclining wheelchair with elevating leg rests, foot buddy, and cushion for appointments. A review of Resident 4's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 28, 2026, revealed that Resident 4 was cognitively intact with a BIMS score of 14 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13 through 15 indicates cognition is intact). A progress note dated April 6, 2026, at 1:00 PM indicated Resident 4 was awaiting a new wheelchair in order to get out of bed. Resident 4 reported weak abdominal muscles (reduced core strength affecting the ability to sit upright) and inability to sit upright in a standard wheelchair. The note indicated a recliner chair had been obtained but required repair as per resident. During an interview conducted April 14, 2026, at 11:30 AM, Resident 4 indicated he had not had a wheelchair he could use independently for several months. Resident 4 stated his reclining wheelchair broke in January 2026 shortly after discharge from occupational therapy services and he had been waiting for the facility to repair or replace the wheelchair so he could independently move throughout the facility. An occupational therapy note dated April 15, 2026, indicated out-of-bed seating options were discussed with Resident 4. Resident 4 indicated a desire to independently propel himself throughout the facility. The note indicated the newly ordered high-back wheelchairs were not able to recline and no available high-back wheelchair appropriately met the resident's needs at that time. During an interview conducted April 16, 2026, at 12:20 PM, Employee 1, Registered Occupational Therapist (OTR), stated she could not recall the exact date Resident 4's high-back reclining wheelchair became unusable. Employee 1, OTR, indicated an order of wheelchairs was delivered after Resident 4's wheelchair broke; however, none met Resident 4's clinical needs. Employee 1, OTR, explained Resident 4 requires a high-back reclining wheelchair to allow for pressure relief (reduction of prolonged pressure on body areas that may lead to skin breakdown) and due to limited abdominal strength affecting ability to maintain upright positioning. Employee 1, OTR, was unable to provide documented evidence the facility provided or was actively attempting to provide Resident 4 with a wheelchair that supported the resident's highest practicable level of physical well-being and (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	independence prior to surveyor inquiry. During an interview conducted on April 17, 2026, at 11:30 AM, the above findings were reviewed with the Director of Nursing (DON) and Nursing Home Administrator (NHA). The DON and NHA were unable to provide documented evidence explaining why Resident 4's identified need for a high-back reclining wheelchair had not been met since the prior wheelchair became unusable in January 2026. The facility failed to ensure Resident 4 received appropriate equipment necessary to promote mobility, maintain functional ability, and support the resident's highest practicable level of independence. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa Code 211.12(d)(3) Nursing services.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, and staff interviews, it was determined the facility failed to provide care and services in accordance with professional standards and physician orders for the management and monitoring of a Peripherally Inserted Central Catheter (PICC) line and subsequent midline catheters for one resident out of 33 residents reviewed (Resident 75).Findings include: A review of nursing standards published by Lippincott Nursing Center (Picking Up on PICC Lines, Nursing Made Incredibly Easy) indicates that appropriate PICC line care (a peripherally inserted central catheter, also called a PICC line, is a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near the heart, used for intravenous fluids, including antibiotics) includes obtaining and documenting a baseline external catheter length (the portion of the catheter visible outside the body) and ongoing comparison of that measurement to identify catheter migration (movement of the catheter inward or outward from its original position). These standards further indicate that arm circumference (measurement around the arm where the catheter is inserted) should be obtained and trended to monitor for complications such as edema (swelling caused by fluid accumulation), phlebitis (inflammation of the vein), infiltration (leakage of fluid into surrounding tissue), or deep vein thrombosis (a blood clot in a deep vein). Accepted standards of nursing practice for midline catheter care (a peripheral intravenous catheter inserted into a vein of the upper arm with the tip remaining in a peripheral vein and not extending into the central circulation) require ongoing assessment, monitoring, and documentation to ensure safe administration of intravenous therapy and early identification of complications. According to the Infusion Nurses Society Infusion Therapy Standards of Practice (2021), vascular access devices, including midline catheters, must be routinely assessed for patency (the catheter remains open and able to infuse fluids), proper function, and signs of complications. These assessments include evaluation of the insertion site and surrounding tissue for erythema (redness), edema (swelling caused by fluid accumulation), warmth, pain, drainage, or induration (hardening of tissue), which may indicate phlebitis (inflammation of the vein), infiltration (leakage of fluid into surrounding tissue), or infection. Nursing standards further require that clinicians monitor the affected extremity for changes in arm circumference when clinically indicated, as increases may suggest edema or the development of a deep vein thrombosis (a blood clot in a deep vein). Ongoing comparison to baseline or prior assessments is necessary to identify clinically significant changes. A review of clinical records revealed Resident 75 was initially admitted to the facility on [DATE], with diagnoses including osteomyelitis of the vertebra, sacral, and sacrococcygeal region (a serious infection and inflammation of the tailbone area, often originating from adjacent pressure ulcers). A review of the resident's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 20, 2026, revealed that Resident 75 was severely cognitively impaired with a BIMS score of 6 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 0 through 7 indicates severe cognitive impairment). A review of the hospital Discharge summary dated [DATE], indicated the resident underwent placement of a PICC line (a peripherally inserted central catheter, also called a PICC line, is a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near the heart, used for intravenous fluids, including antibiotics) for administration of intravenous antibiotics related to sacral osteomyelitis. A review of the facility's readmission evaluation dated March 19, 2026, indicated the presence of a PICC line in the upper left arm; however, there was no documentation of the external catheter length or arm circumference at the time of readmission. A review of physician orders dated March 20, 2026, included a directive for nursing staff to measure the resident's arm circumference (measurement around the upper part of arm, performed to monitor for potential complications like blood clots or (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	swelling) on admission and every 72 hours thereafter, to measure the PICC line external length (portion of the catheter remaining outside the body. It is crucial for detecting migration of the PICC line (movement of the tip of the catheter from its intended, documented position) on admission and every 7 days, and to document all measurements in the progress note. Nursing documentation dated March 23, 2026, at 5:10 PM indicated the resident removed (pulled out) the PICC line. On March 24, 2026, at 3:33 PM a new midline catheter (soft plastic tube inserted into a peripheral upper arm vein with the tip resting near the armpit) was inserted in the left upper arm by an outside consultant. The procedure note documented an external catheter length of 0 cm and a mid-arm circumference of 25 cm at the time of the insertion. Nursing documentation dated March 24, 2026, at 6:59 PM indicated the resident pulled out the newly inserted catheter again. On March 27, 2026, another midline catheter was inserted in the right upper arm. The procedure note documented an external catheter length of 0 cm and a mid-arm circumference of 21 cm at the time of the insertion. A physician's order dated March 26, 2026, directed nursing staff to measure and document the midline external catheter length on admission and weekly thereafter (every Thursday on day shift). A physician's order dated March 26, 2026, directed nursing staff to monitor the midline site every shift for infection, line fracture, breakage, dislodgement, pain, or swelling. Staff were to document the findings in the progress notes. The physician's order from March 20, 2026, for staff to measure the arm circumference every 72 hours and document the measurement in the progress note, remained in effect. A comprehensive review of the Nursing admission Evaluation dated March 19, 2026, the Medication Administration Record and Treatment Administration Record for March and April 2026, and nursing progress notes from March 19 through April 17, 2026, revealed no documented evidence that nursing staff consistently completed or recorded the required measurements for PICC line external length, midline catheter length, or arm circumference on admission, every 72 hours, or weekly as ordered. During an interview on April 17, 2026, at 10:45 AM the Director of Nursing confirmed that there was no documentation to support that nursing staff consistently followed physician orders for monitoring and documenting catheter length and arm circumference for Resident 75. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observations, clinical record review, and resident and staff interviews, it was determined the facility failed to provide food and beverages in accordance with residents' documented allergies, intolerances, and stated food preferences for two residents of 33 residents reviewed (Residents 188 and 167).Findings include: A review of Resident 188's lunch meal ticket (a menu-based document that provides essential information about a resident's meal such as diet order, preferences, food allergies, dislikes, dining location, supplements, and adaptive equipment if required, and helps staff accurately prepare and serve meals to residents based on their individual needs and preferences) indicated the resident had an allergy to lactose, and a dislike to pineapple and raw tomatoes. Observation of Resident 188's lunch meal on April 15, at 1:18 PM revealed the resident was served a side salad containing raw tomatoes and a cup of white whole milk. At that time, the resident stated she is allergic to raw tomatoes, pineapple, and milk. During an interview on April 15, 2025, at 1:25 PM, in the presence of Resident 188, Employee 4 (Regional Dietary Director) and Employee 5 (Regional Dietary Manager) confirmed the resident was served raw tomatoes despite the meal ticket identifying tomatoes as a dislike. Observation of the drink cart on the resident's unit on April 15, 2026, at 1:33 PM revealed no lactose-free milk available. During an interview at the time of the observation, Employee 3 (nurse aide) stated that drink carts are delivered from the kitchen and do not include lactose-free milk. Observation of the kitchen walk-in refrigerator on April 15, 2026, at 1:37 PM in the presence of Employee 5 revealed an unopened 1/2 gallon of lactose-free white milk on the shelf. Employee 5 stated that nursing staff must request or obtain lactose-free milk from the kitchen, as it is not provided on the unit drink carts. Clinical record review revealed a Certified Registered Nurse Practitioner (CRNP) progress note dated April 7, 2026, documented the resident had dietary allergies to chocolate (tongue blisters), raw tomatoes (nausea, vomiting, and rash), pineapple (swollen tongue), and was lactose intolerant (diarrhea). Review of the resident's allergy list in the medical record included pineapple and lactose but failed to include raw tomatoes, despite documentation in the CRNP's note identifying this allergy. A review of Resident 167's lunch meal ticket indicated documented dislikes of tomatoes and cucumbers. Observation of the resident's lunch meal on April 15, 2026, at 1:37 PM revealed the resident was served a side salad containing tomatoes and cucumbers. At that time, the resident stated he frequently receives foods identified on his dislike list. During an interview on April 16, 2026, at 9:35 AM with the Nursing Home Administrator and Director of Nursing confirmed the facility failed to ensure accurate transcription of dietary allergies in the medical record and failed to ensure residents received meals consistent with their documented allergies, intolerances, and preferences. 28 Pa. Code 211.6(a) Dietary services. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 201.18(b)(1)(3) Management.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395623	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandview Nursing and Rehabilitation	78 Woodbine Lane Danville, PA 17821

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined the facility failed to provide required adaptive dining equipment to maintain the resident's ability to eat independently for one resident out of 33 residents reviewed (Resident 188).Findings include: A review of the clinical record revealed Resident 188 was admitted to the facility on [DATE], with diagnosis to include muscle weakness and need for assistance with personal care. Review of the resident's comprehensive care plan, dated April 3, 2026, identified activities of daily living deficits related to weakness, dizziness, vertigo (type of dizziness) and impaired ambulation. Interventions included the use of weighted utensils (adaptive eating tools designed with extra weight to help stabilize hands, reduce tremors, and decrease spills during meals), and a two-handled cup for all meals to support safe and effective eating. Review of physician orders dated April 3, 2026, confirmed the resident was to receive weighted utensils and a two- handled cup with all meals. Observation of the resident's lunch meal ticket (a menu-based document that provides essential information about a resident ' s meal such as diet order, preferences, food allergies, dislikes, dining location, supplements, and adaptive equipment if required, and helps staff accurately prepare and serve meals to residents based on their individual needs and preferences) indicated the resident was to be provided with weighted utensils and a two-handled cup. However, an observation of Resident 188's lunch meal on April 15, 2026, at 1:18 PM, revealed the resident was not provided with the physician-ordered weighted utensils. During an interview on April 15, 2025, at 1:25 PM Employee 4 (Regional Dietary Director) confirmed the facility failed to provide the required adaptive dining equipment as ordered by the physician.28 Pa. Code 211.12 (d)(3)(5) Nursing services.

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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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on clinical record review, staff interviews, and review of facility job descriptions, it was determined the facility failed to ensure staff responsible for participation in the Minimum Data Set (MDS, a federally mandated standardized assessment used to evaluate a resident's condition and guide care planning) assessment process were adequately trained and competent to perform assigned duties in accordance with federal requirements and professional standards of practice which resulted in inaccurate resident assessments for six out of eight residents reviewed (Residents 2, 4, 6, 7, 14, and 39). Findings include: A review of the facility job description titled MDS Coordinator Registered Nurse (RN) revealed the position is responsible for conducting and coordinating the development and completion of the resident assessment process in accordance with the requirements of federal and state regulations as well as company policy and procedure. Duties and responsibilities of the position include developing and monitoring a system to verify that all interdisciplinary team members have completed, dated, and signed the assessments according to the federal regulations. According to the Pennsylvania Nurse Practice Act, a Licensed Practical Nurse (LPN) may participate in the nursing process by contributing to data collection and observation of the resident; however, the comprehensive nursing assessment (a systematic evaluation requiring clinical judgment to determine a resident's condition and care needs) is the responsibility of a Registered Nurse (RN). The MDS assessment process requires the synthesis and evaluation of clinical information, which involves professional nursing judgment. The Minimum Data Set assessments (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) are completed with information collected by an interdisciplinary team. Each entry is signed by the person who completed the section to verify the information accurately reflects the resident assessment. The RNAC (Registered Nurse Assessment Coordinator) is required by Federal regulation to sign and date and thereby certify the assessment is completed. An RNAC is defined as an individual licensed as a registered nurse by the State Board of Nursing and employed by a nursing facility and is responsible for coordinating and certifying completion of the resident assessment instrument .A review of resident MDS assessments completed by the facility revealed inaccuracies in six out of eight residents reviewed (Residents 2, 4, 6, 7, 14, and 39). Fourteen out of fifteen identified errors were in Section GG Functional Abilities (a component of the MDS that documents a resident's ability to perform activities of daily living, such as bathing, personal hygiene, and mobility, based on the level of assistance required). The facility failed to accurately document the level of care and assistance required by residents during the assessment look-back period (a defined timeframe in which staff observations and documentation are used to determine the resident's functional status). During an interview conducted on April 15, 2026, at 1:30 PM, the above findings were reviewed with the Registered Nurse Assessment Coordinator (RNAC). The RNAC confirmed the MDS assessments for Residents 2, 4, 6, 7, 14, and 39 were not accurate. During an interview conducted on April 15, 2026, at 1:40 PM, the identified errors were reviewed with Employee 2, a Licensed Practical Nurse (LPN) assigned to assist in the MDS assessment process. Employee 2 indicated it was her responsibility to collect data and observations from resident clinical records for RNAC review and submission. Employee 2 confirmed the MDS assessments for Residents 2, 4, 6, 7, 14, and 39 contained errors and that the data entered did not accurately reflect the residents' status. Employee 2 was unable to explain why the information documented in the clinical record, including documentation from the look-back period reflecting the level of assistance required for activities of daily living, did not match the information submitted in the MDS assessments. Employee 2 further indicated she had not received sufficient training to perform her assigned duties related to the MDS process. During an interview conducted on April 16, 2026, at 9:25 AM, the RNAC indicated that Employee 2 had been identified as requiring additional training to perform duties associated with the MDS assessment (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	coordination process. During an interview conducted on April 17, 2026, at 11:30 AM, the above findings were reviewed with the Director of Nursing (DON) and Nursing Home Administrator (NHA). The DON and NHA were unable to provide documented evidence that Employee 2 received training in facility policies and procedures related to completion of the MDS assessment process. The facility failed to ensure that staff assigned to assist with the MDS process were appropriately trained and competent to perform their assigned role within their scope of practice, including accurate data collection and reporting to support RN assessment and completion of the MDS. Refer F641 28 Pa. Code 201.20(b)(d) Staff development. 28 Pa Code 211.12(c)(d)(1)(2)(3)(5) Nursing services.