STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395638	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Village at Sewickley	1000 Masonic Drive Sewickley, PA 15143

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on review of the facility's water management plan, facility documentation, and staff interviews, it was determined that the facility failed to implement control measures in the cooling tower and closed loop systems as the water management plan indicated to prevent the growth of Legionella bacteria, and the facility failed to conduct remedial control measures timely and appropriately for eight of ten months (November 2025 to March 2026).Findings Include: Review of the facility's Water Management Plan dated 3/15/25, revealed for this water management plan to be most effective, it must be fully implemented. The persons responsible for verifying implementation of control measure are listed within each control measure. Cooling tower systems (CTs) present the potential for Legionella growth and exposure and are identified as a significant risk and control location. If Legionella is found positive in cooling towers immediate measures are taken to reduce risk and comply with laws. Then samples must be rested in 30-60 days. It was indicated retesting 3-7 days after hyperchlorination or super-heated flush can indicate the procedure was effective only short-term-retesting less than 30 days after a disinfection procedure will not indicate longer term Legionella control. Review of the facility's water management plan control measure for the cooling towers indicated the following:- To perform remedial (while in operation) or emergency (full shutdown) disinfection if indicated by test results or other conditions. It was indicated to record disinfectant levels and hold times. Repeat procedure of not performed per specs or if follow-up test results are unsatisfactory.-To treat cooling water to continuously control Legionella. For monitoring record each chemical, check and record pH, temperature, conductivity, biocidal indicators, either continuously by automated measuring equipment or manually at least three times each week with no more than two days between each measurement. Check total aerobic heterotrophic bacteria plate count (HPC) weekly. Correct any non-compliance with chemical applications. Regarding HPC and Legionella results: HPC 10,000-1000,000 cfu/ml or Legionella 10-100 cfu/ml; within 24 hours, dose with a different biocide, increase concentrations of the existing biocide(s), or take other action to immediately reduce Legionella levels. Within 48 hours, perform full system decontamination. Communication regarding the implementation of the corrective actions must be initiated by the verification person listed for this control measure, or the person he or she appoints. Record corrective actions and maintain the records. A further review failed to list a verification person. Review of the technical service report dated 10/22/25, revealed the test on Star Point Closed loop showed adequate level of CHEMWAY 918 corrosion protection but it's at the minimum. There was no CHEMWAY 918 on site. Review of facility provided documentation, failed to include evidence the cooling tower and closed loop systems were serviced for November 2025. Review of the technical service report dated 12/5/25, indicated when CHEMWAY 918 arrives onsite, please add 5 gallons of 918 to the system and change filter bag. Review of facility provided documentation, failed to include evidence the cooling tower and closed loop systems were serviced on January 2026. Review of the technical service report dated 2/16/26, revealed the test on the star point closed loop showed low level of CHEMWAY 918 corrosion inhibitor in the system. No corrosion inhibitor was added in December based on chemical inventory. Please add 5 gallons of 918 to the system and change the filter bag. It was indicated a test of the central closed loop showed a drop in corrosion inhibitor in the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395638	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Village at Sewickley	1000 Masonic Drive Sewickley, PA 15143

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	system. It was indicated to add 5 gallons of CHEMWAY 918 corrosion inhibitor to the system. Change filter bag. Review of the facility's lab report collected 2/18/26, and completed on 3/2/26, indicated the facility's cooling tower was positive for legionella pneumophilla, with a concentration of 35.0 CFU/milliliters(ml). Review of the facility's lab report collected 3/10/26, and completed on 3/17/26, indicated legionella was not detected in the facility's cooling tower. The facility retested the water 20 days after positive result was obtained. The facility failed to wait 30 days to retest to ensure long term Legionella control as the water management plan indicated. During an interview on 6/16/26, at 11:20 a.m. Safety Committee Officer, Employee E4 stated the facility's cooling tower maintenance is taken care of by an outside contractor. Safety Committee, Employee E5 was asked to provide evidence of disinfection after the facility's cooling tower tested positive for Legionella on 2/18/26. 3/2/26. During an interview on 6/16/26, at 1:10 p.m. Safety Committee Officer, Employee E4 indicated if the facility's cooling tower tests positive it gets cleaned by the outside contracted company, the disincentive is boosted, and the water is retested. It was indicated the contracted company that services the cooling towers conducts service bi-monthly during winter months. It was confirmed there is no evidence the facility's cooling towers were monitored for November 2025 and January 2026. Safety Committee Officer, Employee E4 confirmed the facility is unable to provide evidence the cooling tower was dosed with a different biocide, the existing biocide concentrations were increased, or other actions were taken within 24 hours to immediately reduce Legionella levels after positive results on 3/2/26. The facility also failed to provide evidence a full system decontamination was completed within 48 hours, as the facility's water management plan indicated. During an interview on 6/16/26, at 1:26 p.m. information was disseminated to the Nursing Home Administrator that the facility failed to implement control measure in the cooling tower as the water management plan indicated to prevent the growth of Legionella bacteria, and the facility failed to conduct remedial control measures timely and appropriately. 28 Pa. Code 201.14(a) Responsibility of Licensee.28 Pa. Code 201.18(b)(1) Management.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395638	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Village at Sewickley	1000 Masonic Drive Sewickley, PA 15143

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility documents, clinical record review, and staff interview, it was determined that the facility failed to ensure resident rights to make informed decisions and choices about important aspects of residents' health, safety and welfare by making certain residents understand the Notice of Medicare Non-Coverage (NOMNC) and the Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) of non-coverage forms and failed to ensure the agreement is explained to the resident and his or her representative in a form and manner that he or she understands for one of three residents (Resident R67).Findings include: Review of facility policy Informing the Resident of Medicare A/Skilled Managed Care Denial, dated 8/28/25, indicated the facility has established procedures to ensure that notices of Medicare non-coverage are issued timely and in adherence with the guidelines set forth by CMS. The resident's Medicare/Skilled Managed Care eligibility will be reviewed at the time of admission and as the technical requirements or the level of care changes. The appropriate Courtesy Letter or Notice of Medicare Non-Coverage, (NOMNC), will be selected as needed. The resident's capacity status will be determined. The Courtesy Letter may be completed and presented to the resident or authorized representative. A NOMNC form will be presented for signature at least two days prior to the discontinuation of services. If the services that are being discontinued are for a Medicare A stay and the resident in not being discharged from the facility, SNF ABN of Non-Coverage will also be issued along with the NOMNC. If the resident in not capable of understanding the form contents, the resident's authorized representative should sign. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019 indicated that a Brief Interview for Mental Status (BIMS), is a screening test that aides in detecting cognitive impairment. A BIMS total score of 8-12: suggests moderate cognitive impairment. Review of Resident R67's admission record indicated the resident was admitted to the facility on [DATE]. Review of Resident R67's Minimum Data Set (MDS-periodic assessment of care needs) dated 6/2/26, indicated diagnoses hypokalemia (low potassium in blood), rhabdomyolysis (destruction or degeneration of muscle tissue), and mild cognitive impairment. Review of Section C: Cognitive Patterns indicated Resident R67 had a BIMS score of 9, moderate cognitive impairment. Review of Resident R67's demographic information available in the electronic medical record indicated that Resident R67's friend was designated as the power of attorney. Review of the NOMNC and SNF ABN forms dated 6/12/26, revealed that both forms were signed by Resident R67. During an interview on 6/16/26, at 1:30 p.m. the Nursing Home Administrator (NHA) stated that Resident R67's should not be signing their own paper work due to lower BIMS and confirmed that the facility failed to ensure resident rights to make informed decisions and choices by making certain residents understand the NOMNC and SNF-ABN forms and failed to ensure the agreement is explained to the resident and/or her representative in a form and manner that she understands for Resident R67. 28 Pa. Code 201.14(a) Responsibility of Licensee.28 Pa. Code 201.18(b)(2) Management.28 Pa. Code 201.24 (b) admission Policy.28 Pa. Code 201.29(a) Resident Rights.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395638	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Village at Sewickley	1000 Masonic Drive Sewickley, PA 15143

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policy, documentation provided by the facility, and staff interviews, it was determined the facility failed to implement abuse prevention and investigation procedures for one of four residents reviewed (Resident R79) following an allegation of possible misappropriation of medication and medical neglect as defined as the facility policy. Findings include: A review of the facility policy titled Abuse Prevention, last reviewed 8/28/25, revealed it is the policy of the facility to assure residents the right to freedom from abuse. This is assured by implementing a system of prevention, screening, identification. When an allegation is made (detection), the facility will investigate, report, and respond immediately to the allegation. Willful, as used in the definition of abuse, means the individual must have acted deliberately, not that the individual must of intended to inflict injury or harm. Medical neglect is defined as failure to provide care for existing medical problems such as not taking action on medical problems, prescribed treatments or therapies, not calling a physician when necessary regarding change of status, failure to monitor for adverse drug reactions. Misappropriation resident property is defined as the deliberate misplacement, exploitation, or wrongful use of a resident's belongings or funds without the resident's consent resulting in monetary, personal, or other benefit, gain, profit for the perpetrator. For identification of incidents of abuse procedures are in place to assure adequate review of all incidents and accidents. The facility will ensure procedures are in place that are geared to protect residents from abuse (and further abuse), the reporting staff members from retaliation, and the alleged perpetrator to allow for due process. If staff to resident abuse is suspected an investigation will begin immediately and the facility will ensure the resident is protected form any further potential abuse. A clinical record review revealed Resident R79 was admitted to the facility on [DATE], with diagnoses that include muscle weakness, high blood pressure, and thyroid disorder. A review of Resident R79's Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated 5/24/26, revealed the diagnoses were current. Section C-Cognitive Patterns revealed the residents Brief Interview for Mental Status (BIMS) score was a 15, cognitively intact. Review of the facility documents dated 3/22/26, at 11:00 a.m. revealed Resident R79 reported to the unit nurse that she would like the cough syrup medication she got the night before from the male nurse for her cough. It was revealed the resident's active and discontinued orders failed to reveal an order for cough syrup. The RN Supervisor was notified. It was indicated last night the male nurse left her room and returned with a red liquid in a small cup stating this was cough medication and it helped her cough. Resident said it made her sleep and less coughing. She reported the male nurse told her that she could get the medication over the counter. Review of facility documents dated 3/27/26, completed by Human Resource (HR) Director Employee E13 revealed on 3/22/26, Licensed Practical Nurse (LPN) Employee E5 was caring for Resident R79 who had a cough. Resident R79 asked LPN Employee E5 for more of the cough syrup she was given the night before and stated she had great sleep when she was given the cough syrup. When LPN Employee E5 looked up Resident R79's orders, no cough syrup was ordered. Resident R79 indicated a male nurse gave her the cough syrup the night before. LPN Employee E13 reported the incident to RN Supervisor Employee E6. On 3/23/26, the Director of Nursing (DON) returned to work and began investigating. The DON spoke with RN Employee E16 who worked evening on 3/21/26 and asked who would give the resident cough syrup without getting an order for it, and RN Employee E16 response was it helped. When asked where it came from, RN Employee E16 stated there's means. It was indicated the DON said this isn't over, and RN Employee E16 responded Guess references better get in order. Then on 3/25/26, two days later, the Assistant Director of Nursing (ADON) and HR Director Employee E13 called RN Employee E16 and explained due to nature of the situation he will be placed on a fact-finding leave and that he is not to report to work until he hears from us. It was indicated RN Employee E16 was the only nurse on duty (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395638	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Village at Sewickley	1000 Masonic Drive Sewickley, PA 15143

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the evening on 3/21/26. On 3/26/26, a total of five days later Social Worker Employee E17 met with Resident R79 to ask her what occurred with the cough syrup and asked her to identify the nurse that provided it. Social Worker Employee E17 provided a written report that stated she positively identified RN Employee E16 as the nurse who gave her cough medication for the first time. Before Social Worker Employee E17 showed her the pictures, I asked if she could describe the nurse who administered the cough medication and she stated a tall, bald, male nurse. I showed her the picture and she confirmed it was RN Employee E16. On 3/30/26, two additional statements were given to HR Director Employee E13, a total of eight days since facility was made aware of incident. RN Supervisor Employee E7 and RN Employee E18 reported they were in the care base when RN Employee E16 stated to them that he had seen an incident report regarding R79's cough syrup administration and he stated he administered the cough syrup. On 3/31/26, it was indicated the facility completed their investigation, a total of 10 days since the facility was made aware and the facility was ending his employment. It was indicated that the DON had to report the incident to the Department of Health. The DON stated it may be viewed as a medication error or possibly misappropriation of another resident's medication and that there may be outside entities that would need to contact RN Employee E16. Review of information submitted to the State Agency on 3/31/26, by the Director of Nursing on 3/22/26, revealed at approximately 11:00 a.m. alert and oriented Resident R79 reported to unit nurse that she would like the cough medication she got the night before from the male nurse. Licensed staff checked resident's active & discontinued orders and was unable to find cough medications on list. Resident reported that last night a male nurse left her room and returned with a red liquid in small cup stating this was cough medication and this helped her. Date confirmed was 3/21 before bed. Employee that provided medication to resident without an active MD order is RN Employee E16. It was indicated RN Employee E16 was suspended pending investigation. Review of RN Employee E16's timesheets revealed he continued to work the following times after incident was reported.-3/22/26, from 12:28 p.m. to 3/23/26, at 5:26 a.m.-3/23/26, from 2:40 p.m. to 3/24/26, at 6:54 a.m.-3/24/26, from 2:41 p.m. to 3/24/26, at 11:01 p.m. Review of the facility's deployment sheets dated 3/22/26, 3/23/26, and 3/24/26, revealed RN Employee E16 continued to work and was not suspended timely pending investigation. During an interview on 6/17/26, at 11:53 a.m. the Nursing Home Administrator (NHA) was asked when staff are expected to start an investigation if an incident was reported and replied immediately. During an interview on 6/17/26, at 12:59 p.m. RN, Supervisor Employee E7 stated she was made aware on 3/22/26, of incident regarding RN Employee E16 administering Resident R79 cough medicine without an order. RN Employee E7 confirmed he continued to work while investigation was pending. During an interview on 6/17/26, at 1:26 p.m. the NHA and DON indicated if an incident occurs on weekend shift, it is expected staff to investigate right away. The DON stated staff and residents are asked questions and it is documented in the facility's internal tracking. During an interview on 6/17/26, at 1:30 p.m. the NHA and DON indicated the facility was made aware on 3/22/26, regarding the allegation Resident R79 was provided cough medication she was not ordered. The DON stated when she returned to work on Monday, 3/23/26, she began investigating, then the ADON stepped in. Information was disseminated to the NHA and DON that the facility failed to implement abuse prevention and investigation procedures and ensure the investigation was started immediately and ensure RN Employee E16 was suspended timely pending an investigation for one of four residents reviewed (Resident 79) following a possible misappropriation of medication and medical neglect as defined as the facility's policy. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. 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
	395638	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Village at Sewickley	1000 Masonic Drive Sewickley, PA 15143

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, facility documents, facility submitted documentation, and staff interviews, it was determined that the facility failed to report allegations of possible misappropriation of medication and medical abuse as defined by the facility policy for one of three sampled resident records (Resident R79).Findings include: A review of the facility policy titled Abuse Prevention, last reviewed 8/28/25, revealed it is the policy of the facility to assure residents the right to freedom from abuse. This is assured by implementing a system of prevention, screening, identification. When an allegation is made (detection), the facility will investigate, report, and respond immediately to the allegation. Willful, as used in the definition of abuse, means the individual must have acted deliberately, not that the individual must of intended to inflict injury or harm. Medical neglect is defined as failure to provide care for existing medical problems such as not taking action on medical problems, prescribed treatments or therapies, not calling a physician when necessary regarding change of status, failure to monitor for adverse drug reactions. Misappropriation resident property is defined as the deliberate misplacement, exploitation, or wrongful use of a resident's belongings or funds without the resident's consent resulting in monetary, personal, or other benefit, gain, profit for the perpetrator. For identification of incidents of abuse procedures are in place to assure adequate review of all incidents and accidents. The facility will ensure procedures are in place that are geared to protect residents from abuse (and further abuse), the reporting staff members from retaliation, and the alleged perpetrator to allow for due process. If staff to resident abuse is suspected the following will occur:-The immediate supervisor and/or Nurse Manager will be notified.-The facility will ensure that the resident is protected from any further potential abuse.-Nursing staff will complete procedure.-The supervisor will report the suspected abuse immediately to the Department Director or Director of Nursing and the Health Care Services Administrator.-The Director of Nursing or Administrator will instruct the shift coordinator or manager how to:Notify the Protective Services Unit at the Office of Aging by phone. If the office is closed, have them page the person on-call. A written report will follow within 48 hours by the Director of Nursing or Administrator.Notify the Department of Health via Electronic Reporting System (ERS)-The investigation will begin immediately by interviewing the resident who is suspected of being abused and any witnesses. All interviews are conducted in a private setting, free from intimidating factors.-Once the investigation is concluded and it is determined whether the suspected abuse is or is not substantiated the following will occur.The Social Worker will notify the family or representative of the results of the investigation. The Director of Nursing or Administrator will provide an electronic report, PB22 (attachment AA), to the Department of Health within five (5) days from initial reporting. A review of the facility policy titled Occurrence Prevention, Documentation, and Reporting, last reviewed 8/28/25, indicated employees are expected to identify the potential for adverse events and report them to their supervisors. Licensed staff are responsible for entering all incidents that occur on their shift/neighborhood/unit on a daily basis. No hand-written incident reports are to be utilized. Statements from staff/individuals involved in resident care/situation prior to or during incident and those involved with incident reports will be obtained. The DON/Nurse Manager/designees will review all incident reports. The attached Witness Statement Form may be utilized to collect additional information regarding incidents from those identified as witnesses. The DON will electronically sign incident reports once reviewed/completed and ensure all reports as closed/locked. The DON/Nursing Manager/designees will identify reportable incidents and will gather necessary information to give to DON or their designees to submit the report according to DOH requirements. A clinical record review revealed Resident 79 was admitted to the facility on [DATE], with diagnoses that include muscle weakness, high blood pressure, and thyroid disorder. A review of Resident R79's Minimum Data Set assessment (MDS, a federally mandated standardized (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395638	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Village at Sewickley	1000 Masonic Drive Sewickley, PA 15143

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment process conducted periodically to plan resident care) dated 5/24/26, revealed the diagnoses were current. Section C-Cognitive Patterns revealed the residents Brief Interview for Mental Status (BIMS) score was a 15, cognitively intact. Review of the facility's incident report dated 3/22/26, at 11:00 a.m. revealed Resident R79 reported to the unit nurse that she would like the cough syrup medication she got the night before form the male nurse for her cough. It was revealed the resident's active and discontinued orders failed to reveal an order for cough syrup. The RN Supervisor was notified. It was indicated last night the male nurse left her room and returned with a red liquid in a small cup stating this was cough medication and it helped her cough. Resident said it made her sleep and less coughing. She reported the male nurse told her that she could get the medication over the counter. Review of facility submitted documentation did not include the incident involving Resident R79 on 3/22/26, or 3/23/26. The facility failed to report reportable incidents within 24 hours. Review of information submitted to the State Agency on 3/31/26, by the Director of Nursing revealed on 3/22/26, a total of 10 days after facility was aware of incident revealed at approximately 11:00 a.m. alert and oriented Resident R79 reported to unit nurse that she would like the cough medication she got the night before from the male nurse. Licensed staff checked resident's active & discontinued orders and was unable to find cough medications on list. Resident reported that last night a male nurse left her room and returned with a red liquid in small cup stating this was cough medication and this helped her. Date confirmed was 3/21 before bed. Employee that provided medication to resident without an active MD order is RN Employee E16. During an interview on 6/17/26, at 12:14 p.m. RN Supervisor Employee E10 stated RN Supervisor Employee E6 and RN, Supervisor Employee E7 work weekends and can report incidents to the State Agency. RN Supervisor, Employee E10 stated when I was DON events should be reported to the state the same day the facility became aware. During an interview on 6/17/26, at 12:59 p.m. RN Supervisor Employee E7 stated she was made aware on 3/22/26, of incident regarding RN Employee E16 administering Resident R79 cough medicine without an order. It was indicated by the time she came in, RN Supervisor Employee E6 took care of it. RN Supervisor Employee E7 confirmed she has access to report events to the State Agency, however she usually does not until she receives guidance from DON. During an interview on 6/17/26, at 1:26 p.m. the NHA and DON indicated if an incident occurs on weekend shift, it is expected staff to be investigated right away. It was indicated the NHA and DON can submit reports to the State Agency from home. It was indicated Adult Protective Services (APS) and law enforcement is notified at times if needed misappropriation within 24 hours. During an interview on 6/17/26, at 1:30 p.m. the NHA and DON indicated the facility was made aware on 3/22/26, regarding the allegation Resident R79 was provided cough medication she was not ordered. The DON stated when she returned to work on Monday, 3/23/26, and began investigating. The NHA and DON confirmed the incident was not reported to the State field office until 3/31/26, a total of nine days after facility was aware. The DON and NHA confirmed APS was not notified. Information was disseminated to the DON and NHA that the facility failed to ensure all alleged violations involving abuse, neglect, including misappropriation of resident property are reported immediately, but no later than 24 hours, to the State field office and adult protective services. The facility failed to report the results of all investigation to the state field office within five working days of the incident. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 201.18 (b) (1) (e) (1) Management. 28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395638	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Village at Sewickley	1000 Masonic Drive Sewickley, PA 15143

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, facility policy, clinical records, and staff and resident interviews, it was determined that the facility failed to conduct a thorough investigation of an allegation of abuse for one of three residents (Resident R79).Findings include: A review of the facility policy titled Abuse Prevention, last reviewed 8/28/25, revealed it is the policy of the facility to assure residents the right to freedom from abuse. Medical neglect is defined as failure to provide care for existing medical problems such as not taking action on medical problems, prescribed treatments or therapies, not calling a physician when necessary regarding change of status, failure to monitor for adverse drug reactions. The investigation will begin immediately by interviewing the resident who is suspected of being abused and any witnesses. All interviews are conducted in a private setting, free from intimidating factors. A review of the facility policy titled Occurrence Prevention, Documentation, and Reporting, last reviewed 8/28/25, indicated employees are expected to identify the potential for adverse events and report them to their supervisors. Managers should follow up with all identified potential events to recommend and implement corrective action. Every resident incident should be investigated. Investigation should begin at the time of the incident to identify and assess possible root causes. Incidences and accidents, including medications errors should be tracked and trended at least monthly and reviewed. The DON/Nurse Manager/designees will review all incident reports. The attached Witness Statement Form may be utilized to collect additional information regarding incidents from those identified as witnesses. The DON will electronically sign incident reports once reviewed/completed and ensure all reports as closed/locked. A clinical record review revealed Resident 79 was admitted to the facility on [DATE], with diagnoses that include muscle weakness, high blood pressure, and thyroid disorder. A review of Resident R79's Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated 5/24/26, revealed the diagnoses were current. Section C-Cognitive Patterns revealed the residents Brief Interview for Mental Status (BIMS) score was a 15, cognitively intact. Review of the facility's incident report dated 3/22/26, at 11:00 a.m. revealed Resident R79 reported to the unit nurse that she would like the cough syrup medication she got the night before form the male nurse for her cough. It was revealed the resident's active and discontinued orders failed to reveal an order for cough syrup. The RN Supervisor was notified. It was indicated last night the male nurse left her room and returned with a red liquid in a small cup stating this was cough medication and it helped her cough. Resident said it made her sleep and less coughing. She reported the male nurse told her that she could get the medication over the counter. Review of facility investigation dated 3/27/26, completed by Human Resource (HR) Director Employee E13 revealed on 3/22/26, Licensed Practical Nurse (LPN) Employee E5 was caring for Resident R79 who had a cough. Resident R79 asked LPN Employee E5 for more of the cough syrup she was given the night before and stated she had great sleep when she was given the cough syrup. When LPN Employee E5 looked up Resident R79's orders, no cough syrup was ordered. Resident R79 indicated a male nurse gave her the cough syrup the night before. LPN Employee E13 reported to RN Supervisor Employee E6. On 3/23/26, the Director of Nursing (DON) returned to work and began investigating. The DON spoke with RN Employee E16 who worked evening on 3/21/26 and asked who would give the resident cough syrup without getting an order for it and RN, Employee E16 response was it helped. When asked where it came from, RN Employee E16 stated there's means. It was indicated the DON said this isn't over, and RN Employee E16 responded Guess references better get in order. No written statements were obtained from RN Employee E16 on 3/23/26. It was indicated RN Employee E16 was the only nurse on duty the evening on 3/21/26. On 3/26/26, a total of five days later Social Worker Employee E17 met with Resident R79 to ask her what occurred with the cough syrup and asked her to identify the nurse that provided it. Social Worker Employee E17 provided a written report that stated she positively identified RN (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395638	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Village at Sewickley	1000 Masonic Drive Sewickley, PA 15143

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employee E16 as the nurse who gave her cough medication for the first time. The facility failed to obtain a written witness statement from Resident R79. Review of the facility's assignment sheet for 3/21/26, revealed Registered Nurse, Employee E16 was the floor nurse for Resident R79 for the evening shift from 3 p.m. to 11 p.m. Nurse Aide Employee E11 and NA Employee E12 were assigned as the nurse aides. RN Employee E6 was the RN Supervisor. Review of information submitted to the State Agency on 3/31/26, by the Director of Nursing revealed on 3/22/26, revealed at approximately 11:00 a.m. alert and oriented Resident R79 reported to unit nurse that she would like the cough medication she got the night before from the male nurse. Licensed staff checked resident's active & discontinued orders and was unable to find cough medications on list. Manager was notified of resident's cough and report. Resident reported that last night a male nurse left her room and returned with a red liquid in small cup stating this was cough medication and this helped her. Date confirmed was 3/21 before bed. She states the male nurse told her that she could get the medication over the counter. Employee that provided medication to resident without an active MD order was RN Employee E16. Review of the facility's investigation on 6/17/26, failed to include written witness statements from Nurse Aide Employee E11 and NA Employee E12 who were assigned as the nurse aides on the unit. Registered Nurse Employee E6 was the RN Supervisor. A further review of the facility's investigation revealed the facility did not receive a signed witness statement from alleged perpetrator, RN Employee E16 on 3/22/26. On 3/25/26, a total of three days after facility was made aware of allegation, RN Employee E16 was asked three questions via email related to Resident R79 receiving cough syrup on 3/21/26. RN, Employee E16 responded on 3/25/26, I do not recall. No further statements were obtained from the alleged perpetrator of what occurred during his shift on 3/21/26. Resident R79 failed to have a signed witness statement. No further residents were interviewed if they received medication they were not ordered from the alleged perpetrator. During an interview on 6/17/26, at 11:53 a.m. the Nursing Home Administrator (NHA) was asked when staff are expected to start an investigation if an incident was reported and replied immediately. During an interview on 6/17/26, at 12:14 p.m. RN Supervisor Employee E10 stated if an incident occurs witness statements should be obtained before they leave, if an incident involves a medication occurs then the Director of Nursing and ADON are notified. During an interview on 6/17/26, at 12:59 p.m. RN Supervisor Employee E7 stated she was made aware on 3/22/26, of incident regarding RN Employee E16 administering Resident R79 cough medicine without an order. RN Supervisor Employee E7 stated witness statements should be obtain the same shift incident occurs, It was indicated it gets tricky if a day later. During an interview on 6/17/26, at 1:26 p.m. the NHA and DON indicated if an incident occurs on weekend shift, it is expected staff to investigate right away. The DON stated staff and residents are asked questions and it is documented in the facility's internal tracking. When asked if signed witness statements are obtained, it was indicated only as needed. The NHA stated if the facility's nursing supervisors have a one on one conversation with someone, it would be expected and trusted what they documented is accurate. During an interview on 6/17/26, at 1:30 p.m. the Director of Nursing and Nursing Home Administrator confirmed that the facility failed to conduct a thorough investigation, and obtain all witness statements for one of three residents (Resident R79). 28 Pa Code: 201.29 (a)(c) Resident Rights. 28 Pa Code: 211.12 (c)(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
	395638	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Village at Sewickley	1000 Masonic Drive Sewickley, PA 15143

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility provided documents, clinical record review, and staff interviews, it was determined that the facility failed to develop a comprehensive care plan that included specific and individualized interventions to address the care needs of a resident with mental health needs for one of three residents (Resident R20) and with a pacemaker transmitter for one of four residents (Resident R23). Findings include: Review of facility policy Comprehensive Care Plans dated 8/28/25, indicated Each care plan includes measurable objectives and time frames to meet resident's medical, nursing, mental and psychosocial needs are identified in the comprehensive assessment. Each residents comprehensive care plan describes: The services and care that are to be furnished to attain the resident's highest practicable physical, mental and psychosocial well-being. Review of facility policy Comprehensive Care Planning dated 8/28/25, indicated a comprehensive care plan will be developed and implemented by the interdisciplinary team within 21 days of their admission to the facility/ The interdisciplinary [NAME] will consult with the resident and/or representative during the comprehensive care plan development process and throughout the resident's stay to ensure it's reflective of their goals of care. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. Interventions are individualized to address the resident's problem areas and care needs. Review of the clinical record indicated that Resident R20 was admitted to the facility on [DATE]. Review of Resident R20's Minimum Data Set (minimum data set - a periodic assessment of resident needs) dated 3/27/26,indicated diagnosis of Parkinson's disease (movement disorder of the nervous system that worsens over time) and dementia (a group of symptoms affecting memory, thinking, and social abilities) and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest). Review of Resident R20's clinical record PASSAR (Pennsylvania Preadmission Screening Resident Review - a screening tool used to determine mental health needs indicated: admission Dx (diagnosis) of Moderate MDD, Insomnia, Depression w/Agitation, Agitation, Amnesia, Hallucinations, Inappropriate Sexual Behaviors. Signed Social Worker Employee E20, dated 3/20/26. Review of the comprehensive care plans on 6/17/26, failed to include a care plan for Inappropriate Sexual Behaviors. During an interview on 6/17/26, at 1:54 p.m. Social Worker Employee E20 confirmed that Resident R20 did not have a comprehensive care plan for inappropriate sexual behaviors. During an interview on 6/17/26, at 1:55 p.m. Social Worker Employee E20 confirmed that the facility failed to develop a person-centered comprehensive care plan to meet Resident R20's care needs for his diagnosis of inappropriate sexual behaviors. Review of the clinical record indicated Resident R23 was admitted to the facility 11/19/25, with (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395638	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Village at Sewickley	1000 Masonic Drive Sewickley, PA 15143

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnoses of heart failure, high blood pressure, and presence of cardiac pacemaker. Review of Resident R23's care plan dated 11/20/25, revealed the resident had a pacemaker. The facility failed to include interventions to address the resident's transmitter for their pacemaker. Review of Resident R23's MDS dated [DATE], indicated diagnoses were current. During an interview on 6/15/26, at 9:42 a.m. Resident R23 confirmed she had a pacemaker. Resident R23's transmitter for their pacemaker was located next to the bed on the nightstand. Resident R23 stated it's for my pacemaker, as long as it's plugged in right and the green light is on its working properly. During an interview on 6/16/26, at 2:00 p.m. Registered Nurse (RN) Supervisor, Employee E6 stated the cardiologist managers the resident's pacemaker and transmitter, and it must be always plugged in. RN Supervisor Employee E6 confirmed Resident R23's care plan failed to include contact information for the resident's cardiologist and interventions related to the resident's pacemaker transmitter. During an interview on 6/16/26, at 2:00 p.m. Registered Nurse Assessment Coordinator (RNAC), Employee E3 confirmed the facility failed include interventions related to Resident R23's transmitter and contact information for the resident's cardiologist. During an interview on 6/16/26, at 2:36 p.m., the Nursing Home Administrator (NHA) confirmed that the facility failed to develop a comprehensive care plan that included specific and individualized interventions to address the care needs of residents with a pacemaker transmitter for one of four residents (Resident R23). 28 Pa. Code 211.10(c)(d) Resident care policies. 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
	395638	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Village at Sewickley	1000 Masonic Drive Sewickley, PA 15143

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records and staff interview, it was determined that the facility failed to follow a physician order for bowel protocol for two of six residents (Resident R39, R75). Findings include: Review of facility policy Bowel Protocol dated 8/28/25, indicated resident's bowel movements are documented by clinical team members in the point-of-care system within the resident's electronic health record. For independently toileted cognitively impaired residents the nurse aide should document no bowel movement if it is not visualized by a staff member during a shift. The LPN/RN should initiate the bowel protocol if ordered for the specific resident. Document the effectiveness/ineffectiveness of treatment. A review of the clinical record indicated Resident R39 was admitted to the facility on [DATE], with diagnoses that included chronic kidney disease, anemia and diabetes mellitus. A review of Resident R39's a MDS annual assessment (minimum data assessment)- periodic assessment of resident care needs) dated 4/6/26, indicated the diagnosis remained current. A review of Resident R39's physician orders dated 6/4/26 indicated Dulcolax Oral Tablet Delayed Release 5 MG (Bisacodyl) Give 5 mg by mouth as needed for no BM After 9 shifts with no BM and normal abdominal exam and Prune or Apricot Juice, 8 ounces PO as needed for after 6 shifts with no BM. Repeat in AM if no results. A review of resident's Documentation Survey Report for May and June revealed resident did not have bowel movement 5/30/26, 5/31/26, 6/1/26, nine shifts. Review of Resident R39's May & June MAR indicate that Dulcolax and prune/apricot juice was not given during that time. During an interview on 6/17/26, at 2:30 p.m. the Director of Nursing confirmed the facility failed to follow physician orders for Resident R39's as required. Review of the clinical record indicated Resident R75 was admitted to the facility on [DATE], with diagnoses that included dementia (loss of cognitive functioning such as thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), polyneuropathy (a nerve disease caused by damage to many nerves), and constipation. Review of Resident R75's care plan dated 6/13/26, indicated to monitor and observe for constipation. Review of Resident R75's physician order dated 6/13/25, indicated to give eight ounces of prune or apricot juice as needed after six shifts with no bowel movement. Repeat in morning if no results. Review of Resident R75's physician order dated 6/13/25, indicated to administer 5 milligram (mg) Dulcolax Oral Tablet Delayed Release 5 MG (Bisacodyl), one tablet by mouth as needed for no bowel movement after nine shifts and normal abdominal exam. If Abnormal hold and call provider. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395638	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Village at Sewickley	1000 Masonic Drive Sewickley, PA 15143

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/15/26, at 10:25 a.m. Resident R75 stated she has a history of constipation and hasn't had a bowel movement for a while. Resident R75 stated it's been more than three days, a good week. Resident R75 indicated she has no abdomen pain or bloating but has a constant feeling that she needs to go. Review of Resident R75's clinical record on 6/13/26, 6/14/26, and 6/15/26, revealed the resident had no bowel movement in a total of nine shifts. During an interview on 6/16/26, at 2:07 p.m. Registered Nurse (RN) Supervisor Employee E10 confirmed prune juice/apricot juice and 5 mg of Dulcolax was not administered to the resident as ordered. It was indicated staff should ask resident if they had bowel movement and document in clinical record. RN Supervisor confirmed upon admission it was documented it was unknown when the resident's last bowel movement was. During an interview on 6/16/26, at 2:16 p.m. Nurse Aide Employee E15 confirmed Resident R75 had not had a bowel movement this shift. During an interview on 6/16/26, at 2:17 p.m. Resident R75 stated she had not moved her bowels and still is constipated. Resident R75 confirmed she had not received any prune or apricot juice. Review of Resident R75's Medication Administration Record (MAR) for June revealed no prune juice or apricot juice and 5 mg of Dulcolax was administered to the resident. During an interview on 6/16/26, at approximately 3:00 p.m. Director of Nursing and Nursing Home Administrator confirmed the facility failed to follow a physician order for bowel protocol for one of three residents (Resident R75). 28 Pa. Code 211.12(d)(1)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395638	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Village at Sewickley	1000 Masonic Drive Sewickley, PA 15143

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff and resident interviews it was determined that the facility failed to meet residents pain needs for one of six residents reviewed (Resident R1). Findings Include: Review of the facility policy Pain Assessment Management Record Procedure dated 8/28/25, indicated the facility is committed to the promotion of the resident comfort through the assessment and effective management of resident pain. Review of the clinical record revealed Resident R1 was admitted to the facility on [DATE], with diagnoses of multiple rib fractures, pneumonia and pain. Review of Resident R1's care plan dated 5/26/26, revealed the resident was experience pain or the resident was at risk for pain and discomfort. Interventions included to administer pain medications as ordered, observe for side effects and effectiveness. Complete pain assessment, and observe for pain each shift. Review of Resident R1's physician order dated 5/23/26, indicated to administer Tramadol HCl Tablet 50 MGGive 0.5 tablet by mouth every 6 hours as needed for Pain - Moderate related to multiple fractures and Acetaminophen Oral Tablet 325 MG, Give 2 tablet by mouth every 6 hours for rib pain. Review of Resident R1's clinical record dated 5/26/26 indicated barely slept this shift. Complaining about rib/back/right side pain. Scheduled pain medication administered, PRN medication administered, All interventions ineffective. Resident continues to complain and wants MD to Do something about it. Review of Resident R1's clinical record dated 5/26/26 dietary note indicated during the visit on this date, resident reported that the pain is hindering his appetite. Review of Resident R1's clinical record dated 5/27/26 resident continues to have severe pain and discomfort in his right side on his ribs. Review of Resident R1's clinical record revealed the physician wasn't notified until 5/28/26 that Resident R1 was having increased pain and his pain medication needed evaluated. During an interview on 6/16/26, at 1:30 p.m. the Nursing Home Administrator confirmed the facility failed to meet residents pain needs for one of six residents reviewed (Resident R1). 28 Pa. Code 211. 10(c) Resident care policies28 Pa. Code 211.12(d)(1) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395638	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Village at Sewickley	1000 Masonic Drive Sewickley, PA 15143

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 for a resident with a diagnosis of dementia for one of three residents (Resident R20).Findings include: Review of facility policy Comprehensive Care Plans dated 8/28/25, indicated Each care plan includes measurable objectives and time frames to meet resident's medical, nursing, mental and psychosocial needs are identified in the comprehensive assessment. Each residents comprehensive care plan describes: The services and care that are to be furnished to attain the resident's highest practicable physical, mental and psychosocial well-being. Review of the clinical record indicated that Resident R20 was admitted to the facility on [DATE]. Review of Resident R20's Minimum Data Set, dated [DATE], (MDS - a periodic assessment of resident needs) indicated diagnosis of Parkinson's disease (movement disorder of the nervous system that worsens over time) and dementia (a group of symptoms affecting memory, thinking, and social abilities) and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest). Review of Resident R20's clinical record care plan's failed to include a care plan for dementia. During an interview on 6/18/26, at 9:43 a.m. Registered Nurse Assessment Coordinator (RNAC) Employee E21 confirmed that Resident R20 has a diagnosis of dementia and a care plan for dementia was not included in the comprehensive care plans. During an interview on 6/18/26, at 9:44 a.m. RNAC Employee E21 confirmed that the facility failed to develop and implement an individualized person - centered care plan to address dementia for a resident with a diagnosis of dementia for one of three residents (Resident R20). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10 (c)(d) Resident care policies

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395638	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Village at Sewickley	1000 Masonic Drive Sewickley, PA 15143

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to properly store medical supplies in one of two medication storage rooms (Redwood Medication Room).Findings: Review of facility Storage of Medications policy dated [DATE], indicated medications and biologicals are stored safely, securely, and properly. During a medication storage room review on [DATE], at 10:35 a.m. the following supplies were observed and expired: (1) Universal Catheter Tray - expired [DATE](1) IV Start Kit - expired [DATE] During an interview on [DATE], at 10:44 a.m. Licensed Practical Nurse Employee E1 confirmed the above expired supplies and that the facility failed to properly store medical supplies in one of two medication storage rooms (Redwood Medication Room). 28 Pa Code: 211.9 (a)(1) Pharmacy services. 28 Pa code: 211.12 (d) (1) (5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395638	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Village at Sewickley	1000 Masonic Drive Sewickley, PA 15143

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of resident clinical records, facility policy, and staff interview, it was determined the facility failed to ensure the coordination of hospice services with facility services to meet the needs of each resident for end-of-life care for one of two residents (Resident R44). Findings include: During a review of the facility policy End of Life Care dated 8/28/26, indicated that end-of-life care is approached in a comprehensive way with respect and dignity for the residents and their loved ones. The interdisciplinary delivery of services provided by a hospice organization. Review of the clinical record revealed that Resident R44 was admitted to the facility on [DATE]. Review of Resident R44's quarterly MDS dated [DATE], indicated diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels), Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior), and arthritis. Review of physician order dated 3/13/26, indicated Resident R44 was admitted under hospice services and failed to include a diagnosis for hospice care. Review of Resident R44's current comprehensive care plan failed to indicate a plan of care by the facility that displayed the coordination of hospice services by failing to include contact information for the hospice agency and how to access the hospice's 24 hour on-call system and failed to include a diagnosis for hospice care. During an interview on 6/16/26, at 2:29 p.m. the Registered Nurse Assessment Coordinator (RNAC) Employee E3 confirmed that the facility failed to include contact information for the hospice agency and how to access the hospice's 24 hour on-call system, failed to include a diagnosis for hospice care, and failed to ensure the coordination of hospice services with facility services to meet the needs of Resident R44. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.12(d)(3) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395638	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Village at Sewickley	1000 Masonic Drive Sewickley, PA 15143

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 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on review of job description, facility documents and staff interviews, it was determined that the facility failed to provide Infection Control training to one of five direct care facility staff reviewed (Nurse Aide (NA) Employee E19). Findings include: Review of the facility Nursing Assistant - HC Position Description indicated the position will perform various resident care activities and related non-professional nursing services while ensuring the care of our residents is provided in a safe, caring, timely, and appropriate manner by maintaining the appropriate competencies and skills through continued education that encompasses all of these areas. Essential Functions/Professional competencies: maintain compliance with yearly education requirements according to facility policies and DOH (Department of Health) regulations. Maintains competencies and skills through continued education, including in-service education, programs, floor conferences and nursing staff meetings. During an interview on 6/18/26, at 10:10 a.m. the Nursing Home Administrator (NHA) stated that education is distributed electronically to be completed within calendar year running January through December. Review of facility education documents for the year 2025 revealed the following concerns: Review of Nurse Aide (NA) Employee E19's facility provided information did not include training on Infection Control. During an interview on 6/18/26, at 11:05 a.m. the NHA confirmed that the facility failed to provide Infection Control training to one of five direct care facility staff reviewed (Employee E19). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a)(d) Staff development.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395638	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Village at Sewickley	1000 Masonic Drive Sewickley, PA 15143

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of job description, facility documents and staff interviews, it was determined that the facility failed to ensure that all nurse aide staff received a minimum of twelve hours of in-service education training each year for one out of two Nurse Aide (NA) Employees (Employee E19).Findings include: Review of the facility Nursing Assistant - HC Position Description indicated the position will perform various resident care activities and related non-professional nursing services while ensuring the care of our residents is provided in a safe, caring, timely, and appropriate manner by maintaining the appropriate competencies and skills through continued education that encompasses all of these areas. Essential Functions/Professional competencies: maintain compliance with yearly education requirements according to facility policies and DOH (Department of Health) regulations. Maintains competencies and skills through continued education, including in-service education , programs, floor conferences and nursing staff meetings. During an interview on 6/18/26, at 10:30 a.m. the Nursing Home Administrator (NHA) stated that education is distributed electronically to be completed within calendar year running January through December. Review of NA Employee E19's current employee file failed to reveal that NA Employee E19 had received a minimum of 12 hours of yearly in-service training for calendar year 2025. During an interview on 6/18/26, at 11:05 a.m. the NHA confirmed that the facility failed to ensure that all nurse aide staff received a minimum of twelve hours of in-service education training each year for NA Employee E19. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a)(d) Staff development.