STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Rehabilitation & Healthcare Center	395 Middle Road Nanticoke, PA 18634

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on a review of the Resident Assessment Instrument (RAI) Manual, clinical record review, and staff interviews, it was determined that the facility failed to ensure Minimum Data Set (MDS) assessments were submitted to the Centers for Medicare & Medicaid Services (CMS) Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system within the required 14-day timeframe for 2 of 23 residents reviewed (Residents 41 and 45). Findings include: According to the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, version dated October 2019, federally mandated MDS assessments (mandated assessments of a resident's abilities and care needs) must be submitted within 14 calendar days after the MDS Completion Date (Section Z0500B + 14 days). Additionally, discharge tracking records must be completed and transmitted within 14 calendar days following the Event Date (Section A2000 + 14 days). A review of Resident 41's clinical record revealed a quarterly MDS assessment with an Assessment Reference Date (ARD) of January 2, 2024. This MDS was submitted with identified errors in Section A (Identification Information) and Section C (Cognitive Patterns). The MDS assessment was not corrected and resubmitted to the QIES ASAP system within 14 days of the MDS Completion Date, as required. A review of Resident 45's clinical record revealed that she was admitted to the facility on [DATE], and discharged from the facility on March 7, 2025. A review of Resident 45's clinical record revealed the resident was admitted to the facility on [DATE], and discharged on [DATE]. A Discharge - Return Not Anticipated MDS assessment was scheduled for March 7, 2025. However, this MDS assessment was in progress and had not been completed or submitted within 14 days of the MDS Completion Date (Section Z0500B + 14 days). The MDS remained unsubmitted until it was identified and completed during the on-site survey conducted April 1-4, 2025. During an interview conducted on April 3, 2025, at 10:00 AM, the facility's Registered Nurse Assessment Coordinator (RNAC) confirmed that the MDS assessments for Residents 41 and 45 were not submitted to the QIES ASAP system within the required 14-day timeframe. 28 Pa. Code 201.14(a) Responsibility of licensee (continued on next page)

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

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on a review of clinical records and staff interview, it was determined the facility failed to ensure the Minimum Data Set Assessment (MDS a federally mandated standardized assessment conducted at specific intervals to plan resident care) accurately reflected the status of one out of 23 residents sampled (Resident 49). Findings included: A review of Resident 49's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included end stage kidney disease (is a condition where the kidney reaches advanced state of loss of function that causes changes in urination, fatigue, swelling of feet, high blood pressure, and loss of appetite) and required hemodialysis (a machine filters wastes, salts and fluid from the blood when the kidneys are no longer healthy enough to do this work adequately and used to treat advanced kidney failure) three times per week. A review of Resident 49's quarterly review MDS assessment dated [DATE], revealed in Section O - O0011.0 Special Treatments, Procedures, and Programs J1. Dialysis was coded No and indicated that the resident was not receiving dialysis treatments. However, a review of the resident's clinical record revealed that she received dialysis treatments three times per week to manage kidney disease. Interview with the Nursing Home Administrator on April 3, 2025, at 1:20 PM, revealed that Resident 49 attended dialysis three times per week and confirmed the facility failed to code the February 2, 2025, quarterly MDS to reflect dialysis as a special treatment. 28 Pa. Code 211.5 (f)(iv) Medical records. 28 Pa. Code 211.12(d)(2)(3) Nursing services.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51306 Based on clinical record review and staff interview, it was determined the facility failed to develop and implement a baseline care plan that included the minimum healthcare information necessary to address the resident's immediate care and safety needs upon admission for one of 23 residents reviewed (Resident 318). Findings: A review of Resident 318's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including osteomyelitis (an infection in a bone) and diabetes mellitus (a metabolic disorder in which the body has elevated blood sugar levels for prolonged periods of time). A review of a social services progress note dated March 30, 2025, at 5:15 PM, indicated that Resident 318 did not speak English very well. Further review of Resident 318's baseline care plan revealed it failed to identify English as a second language as part of the resident's communication needs. Additionally, the baseline care plan failed to include measurable goals, objectives, or interventions to address the resident's communication barrier or outline strategies to ensure staff could effectively communicate with the resident to meet his immediate care and safety needs. During an interview on April 3, 2025, at approximately 2:00 PM, the Director of Nursing confirmed that Resident 318's baseline care plan did not include the resident's communication needs or any interventions to address the language barrier. The Director of Nursing acknowledged the baseline care plan failed to reflect the minimum necessary information to ensure staff were provided with clear instructions to meet the resident's immediate care needs upon admission. 28 Pa Code 211.12 (d)(1)(2)(3)(5) Nursing Services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on select facility policy, a review of clinical records and resident and staff interviews it was determined that the facility failed to provide nursing services consistent with professional standards of quality by failing to ensure that licensed nurses timely administered a resident's medications for one resident of 23 reviewed (Resident 56). Findings included: According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates that the registered nurse was to carry out nursing care actions that promote, maintain, and restore the well-being of individuals. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health-care team by exercising sound judgement based on preparation, knowledge, skills, understandings and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) Document and maintain accurate records. According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of patient care including Medication Records. A review of facility policy titled: Administering Medications last reviewed by the facility on March 3, 2025, indicated that medications are administered within one hour of their prescribed times, unless otherwise specified. Review of Resident 56's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include pulmonary hypertension (a type of high blood pressure that affects arteries in the lungs and in the right side of the heart), heart failure (chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), and osteoarthritis (a degenerative joint disease that occurs when tissues that cushion the ends of bones within the joints break down). During an interview with Resident 56 on April 1, 2025, at 11:00 AM she expressed frustration regarding delays in the administration of her medications. She reported that her physician prescribed morphine (an opioid pain-relieving medication used to treat moderate to severe pain) was often given late. As a result, the delayed administration caused an increase in her pain and led to extreme discomfort. A review of Resident 56's Medication Administration Record for March 2025, revealed that the resident was prescribed and scheduled to receive the following medications: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Gas-X Extra Strength tablet by mouth at 9:00 AM Artificial tears solution, two drops in both eyes at 9:00 AM Zyprexa 5 MG tablet (atypical antipsychotic) by mouth at 9:00 AM Detrol 2 MG tablet (antispasmodic)by mouth at 9:00 AM Acidophilus capsule (probiotic)by mouth at 9:00 AM Metoprolol 50 MG (antihypertensive) tablet my mouth at 9:00 AM Colace 100 MG capsules (stool softener) by mouth at 9:00 AM MS Contin (morphine sulfate narcotic pain medication) 60 MG tablet by mouth at 9:00 AM Acetaminophen 500 MG tablet by mouth at 9:00 AM Review of the facility's Medication Administration Audit Report for March 21, 2025, through March 24, 2025, revealed the following: On March 23, 2025, Resident 56's medications scheduled for 9:00 AM were not administered until 10:35 AM, 1 hour and 35 minutes after the scheduled time. On March 24, 2025, Resident 56's medications scheduled for 9:00 AM were not administered until 10:58 AM, 1 hour and 58 minutes after the scheduled time Interview with the Nursing Home Administrator on April 3, 2025, at approximately 1:30 PM confirmed medications should be administered timely in accordance with physician orders and professional standards of practice. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) 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** 43944 Based on clinical record review, facility policy review, and staff interviews, it was determined the facility failed to ensure a timely and thorough assessment of pressure ulcers/injuries upon admission for one of 23 sampled residents (Resident 39). Findings included: 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 a facility policy entitled Pressure Injuries Overview last reviewed by the facility on March 3, 2025, indicated that a pressure ulcer/injury (PU/PI) refers to localized damage to the skin and/or underlying soft tissue usually cover a bony prominence or related to a medical or other device. A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage and may be painful. Pressure ulcers/injuries occur as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by skin temperature, moisture, nutrition, perfusion, co-morbidities, and conditions of the soft tissue. A review of Resident 39's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included malignant neoplasm of the bladder (another term for bladder cancer, is a common type of cancer that begins in the cells of the bladder), malnutrition (condition that develops when the body is deprived of vitamins, minerals and other nutrients it needs), colostomy (surgical procedure that creates an opening in the abdominal wall to drain stool from the colon and can be temporary or permanent, depending on the condition of the bowel), abscess of the vulva (collection of pus that forms in the tissues of the vulva, which is the outer part of the female genitalia and is a condition that can be caused by a bacterial infection that enters the skin through a cut or a hair follicle), and cutaneous abscess of the perineum (painful, pus-filled bump near the anus or rectum. It occurs when an anal gland gets clogged and infected). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's admission/readmission evaluation - v2 completed by Employee 6, a Registered Nurse (RN), dated January 30, 2025, at 5:09 PM, revealed the resident was observed with skin impairments that included pressure and other skin impairments that included an abscess of the perineum and vulva and excoriation (scratching or rubbing the skin, leading to abrasions or erosions) of the colostomy peristomal (area of skin around the colostomy). Employee 6 completed an admission body audit form dated January 30, 2025, that revealed that Resident 39 had a stage III pressure ulcer (pressure injury characterized by full-thickness skin loss where the ulcer has broken through the top two layers of skin and into the fatty tissue below, resembling a hole or crater with potential for a foul odor) to the sacrum (triangular-shaped bone that connects the spine with the hip and supports the pelvic organs). However, there was no documented evidence that Employee 6 completed a thorough wound assessment of the pressure ulcer/injury, as required, to include specific measurements (length, width, depth, and surface area) or a detailed description of the wound characteristics. A review of a skin and wound note completed by the facility's contracted wound care specialist CRNP (Certified Registered Nurse Practitioner) dated February 3, 2025, at 9:01 PM (four days after admission), identified wound number two (#2) as a stage IV pressure ulcer/injury full-thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dead tissue) may be present on some parts of the wound bed. (to the right gluteal fold that was present on admission. Current size at 5.0 centimeters (cm) in length by 3.0 in width cm by 0.5 cm in depth and calculated area was 15 square centimeters (sq cm) with 100% granulation (is new connective tissue and microscopic blood vessels that form on the surfaces of a wound during the healing process) present at the wound base and moderate amount of serosanguineous exudate (is a type of wound drainage secreted by an open wound in response to tissue damage). The facility was unable to provide documentation to demonstrate that a timely and thorough assessment of Resident 39's pressure ulcer/injury was completed by an RN upon admission to include measurements and a detailed wound description. During an interview with the Director of Nursing (DON) on April 3, 2025, at 1:30 PM, the DON stated that it is the expectation that upon admission, the RN is to complete a thorough wound assessment that includes measurements and wound description, which should be documented in the resident's clinical record. An interview with the Director of Nursing (DON) on April 3, 2025, at 1:30 PM, stated that it is the expectation that upon admission to the facility the RN is to complete a thorough wound assessment that includes measurements and wound description, which should be documented in the resident's clinical record. During a follow-up interview with the DON on April 4, 2025, at 10:15 AM, the DON confirmed that the facility failed to ensure a timely and thorough wound assessment of Resident 39's pressure ulcer/injury was completed upon admission, including measurements and description of the wound by an RN. 8 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on observations, select policy review, a review of clinical records, and staff interview it was determined the facility failed to provide care and services designed to prevent potential complications associated with tube feedings for one resident receiving an enteral feeding out of 23 residents sampled (Resident 58). Findings include: Review of a facility policy titled Enteral Feedings - Safety Precautions last reviewed by the facility on March 3, 2025, indicated that all personnel responsible for preparing , storing and administering enteral nutrition (tube inserted through the abdomen directly into the stomach, used to deliver nutrition, fluids, and medications when a person cannot eat or drink safely or consume enough calories orally) formulas will be trained, qualified and competent and that the facility will remain current in and follow accepted best practices in enteral nutrition. Further it indicated that to prevent aspiration (occurs when food or liquid enters the lungs instead of the stomach, which can lead to serious health problems) elevate the head of the bed at least 30 degrees during tube feeding and at least 1 hour after feeding. Review of Resident 58's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include dysphagia (difficulty swallowing) and functional quadriplegia (complete immobility due to severe disability or facility, stemming from a medical condition without brain or spinal cord injury). Resident 58 required a PEG tube (Percutaneous endoscopic gastrostomy- an endoscopic medical procedure in which a tube is passed into the patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate) for enteral feeding (enteral nutrition generally refers to any method of feeding that uses the gastrointestinal (GI) tract to deliver part or all of a person's caloric requirements). A review of the Resident 58's plan of care for PEG tube dated September 4, 2023, revealed an intervention to elevate the head of the bed 30 degrees during feeding and medication administration. Review of the plan of care for activities of daily living revealed an intervention to keep the head of bed elevated at all times. A review of resident 58's current physician's order dated April 2, 2024, revealed an order to elevate the head of the bed 30 degrees or higher during and 1 hour post feeding. Another current physician's order dated May 9, 2024, revealed on order for enteral feed (a method of providing nutrition directly into the GI tract through a tube), elevate the head of the bed at least 30 degrees during feeding, any medication administration, and for 30 minutes after feeding. Another current physician's order dated August 28, 2024, revealed an order to elevate the head of the bed at least 30 degrees during feeding and any mediation administration. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on April 1, 2025, at 12:15 PM revealed Resident 58's enteral tube feeding was actively infusing. The resident was awake and lying in bed. The head of the bed was not elevated, and the resident was lying flat on her back on the bed while the enteral tube feed was infusing. Interview with Employee 1 (licensed practical nurse) on April 1, 2025, at 12:20 PM confirmed that Resident 58's tube feeding was actively infusing, and the head of the bed was not elevated. Interview with the Director of Nursing on April 4, 2025, at approximately 2:15 PM, confirmed the facility failed to provide care and services designed to prevent potential complications associated with tube feedings. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on review of clinical records, select facility policy, observation, and staff interview, it was determined the facility failed to obtain physician orders for oxygen therapy and failed to maintain oxygen equipment in a functional and sanitary manner for four residents out of 23 sampled (Residents 6, 56, 60 and 68). Findings include: Review of the facility policy titled Departmental (Respiratory Therapy)-Prevention of Infection last reviewed by the facility on March 3, 2025, revealed that the oxygen cannula (flexible plastic tubing with small prongs inserted into the nostrils to deliver supplemental oxygen) and tubing are to be changed every seven days, or as needed. The oxygen cannula and tubing used PRN (as needed) are to be kept in a plastic bag when not in use. The oxygen concentrator (bedside machine that concentrates ambient air to supply an oxygen-rich gas stream) filters are to be washed every seven days with soap and water, then rinsed and squeezed dry. Review of Resident 56's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include pulmonary hypertension (a type of high blood pressure that affects arteries in the lungs and in the right side of the heart), and obstructive sleep apnea (intermittent airflow blockage during sleep). The resident had a current physician's order dated February 4, 2025, for the following: (1) provide oxygen therapy at 3.0 liters/minute via nasal cannula (pronged tubing plaed in the nostrils to deliver oxygen) every shift; (2) change the oxygen tubing and canister every Sunday during the night shift; and (3) clean the oxygen concentrator filter (on the oxygen concentrator- a bedside machine that concentrates ambient air to supply an oxygen-rich gas stream) every Sunday during the night shift. An observation conducted on April 1, 2025, at 11:00 AM revealed that Resident 56 was awake and sitting upright in bed with supplemental oxygen in place via an oxygen concentrator with the liter flow set at 3.0 liters per minute. The resident's oxygen tubing was not dated, and the resident's oxygen concentrator filter was missing. A second observation on April 2, 2025, at 2:15 PM in the presence of Employee 2 (licensed practical nurse) revealed Resident 56's oxygen tubing was not dated, and the oxygen concentrator filter was missing. Interview with Employee 2, at the time of the observation, confirmed that Resident 56's oxygen tubing was not dated and that the filter for the oxygen concentrator was missing. Review of Resident 68's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include chronic obstructive pulmonary disease (COPD- lung disease that blocks airflow and makes it difficult to breathe), and respiratory failure with hypoxia (not enough oxygen passes from the lungs to the blood, making it difficult to breath). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident had a current physician's order dated December 18, 2024, for the following: (1) oxygen therapy at 2.0 liters via nasal cannula every shift; (2) change the oxygen tubing and canister every Sunday during the night shift; and (3) clean the oxygen concentrator filter every Sunday during the night shift. An observation conducted on April 1, 2025, at 12:17 PM revealed that Resident 68 was awake and sitting upright in bed with supplemental oxygen in place via an oxygen concentrator with the liter flow set at 2.0 liters per minute. The resident's oxygen concentrator filter was visibly covered in dust. Review of Resident 6's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include chronic obstructive pulmonary disease, and cor pulmonale (right-sided heart failure that occurs when a lung condition causes the right ventricle of the heart to enlarge and thicken) The resident had a current physician's order dated March 3, 2025, for the following: (1) change the oxygen tubing and canister every Sunday during the night shift for 14 days; and (2) clean the oxygen concentrator filter every Sunday during the night shift for 14 days. An observation conducted on April 1, 2025, at 12:26 PM revealed that Resident 6 was awake and sitting upright in bed with supplemental oxygen in place via an oxygen concentrator with the liter flow set at 2.0 liters per minute. The resident's oxygen concentrator filter was visibly covered in dust. A second observation of Resident 68 and 6's oxygen therapy administration was made on April 2, 2025, at 2:10 PM in the presence of Employee 3 (nurse aide). Employee 3 confirmed that Resident 68 and 6's oxygen concentrator filters were covered in dust. She reported that night shift is responsible for changing the oxygen tubing and cleaning the concentrator filters. Further review of Resident 6's physician orders failed to reveal a current physician's order for supplemental oxygen. There were no physician orders to indicate the amount of oxygen Resident 6 was to receive or the frequency (continuous, as needed) she was to receive it. Interview with Employee 1 (licensed practical nurse) on April 3, 2025, at 10:48 AM confirmed that Resident 6 did not have a current physician's order for oxygen. Employee 1 reported that Resident 6 had been receiving oxygen therapy since March for a decline in respiratory status. Interview with the Director of Nursing on April 3, 2025, at 1:45 PM confirmed the facility failed to obtain a physician's order for the administration of oxygen and the condition of the oxygen concentrators was not consistent with facility policy for maintenance of oxygen delivery equipment. A review of facility policy entitled Departmental (Respiratory Therapy) Prevention of Infection last reviewed on March 3,2025, revealed a nebulizer (a piece of medical equipment that a person with asthma or other respiratory conditions use to administer medication directly and quickly to the lungs) mask and tubing should be stored in a plastic bag with the date and the residents name between uses. Additionally, the policy states that the nebulizer set up (mask and tubing) should be discarded every 7 days. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 60's clinical record revealed the resident was admitted to the facility on December31, 2024, with diagnoses which included Respiratory failure (a condition in which the lungs have trouble loading the blood with oxygen or removing carbon dioxide) A review of the resident's clinical record revealed a physician's order dated March 23,2025, for Albuterol Sulfate Nebulizer solution (2.5mg/3 ml.) 0.083%, one inhalation orally via nebulizer every four hours as needed for shortness of breath. An observation on April 2,2025, at approximately 11;10 AM revealed a nebulizer machine in the resident's room. The bag containing the nebulizer mask and tubing was dated January 2, 2025 An observation on April 3, 2025, at 9:29 AM, revealed the bag containing the mask and tubing dated January 2, 2025. An interview with Employee 4 (nurse aide) on April 3,2025, at 9:30 confirmed the bag containing the nebulizer mask and tubing was dated for January 2, 2025. An interview with the Director of Nursing (DON) on April 3, 2025, at approximately 1:45 PM revealed the nebulizer mask and tubing should be changed every 7 days. The DON acknowledged the nebulizer mask and tubing for Resident 60 had not been replaced per facility policy and confirmed the facility's failure to maintain the resident's nebulizer equipment. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services 28 Pa. Code 211.10 (a)(c) Resident Care Policies

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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** 43944 Based on clinical record and select facility policy review and staff interview, it was determined that the facility failed to provide effective pain management and administer pain medication as prescribed by the physician and failed to attempt non-pharmacological interventions to alleviate pain prior to the administration of a narcotic pain medication prescribed on an as needed basis for one resident out of four residents sampled for pain (Resident 114). Findings include: Review of the facility policy titled Pain Assessment and Management, last reviewed by the facility on March 3, 2025, revealed non-pharmacological interventions may be appropriate alone or in conjunction with medications to manage pain. Examples of non-pharmacological interventions included environmental adjustments (such as adjusting room temperature or providing pressure-reducing surfaces), physical interventions (such as ice packs or warm compresses), exercise (such as range of motion exercises), and cognitive or behavioral strategies (such as relaxation techniques, music, or diversional activities). The policy indicated that while pharmacological interventions (such as analgesics) may be prescribed to manage pain, they do not usually address the underlying cause of the pain and can have adverse effects on the resident, including drowsiness, increased risk of falling, and loss of appetite. A review of Resident 114's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included displaced bimalleolar fracture (severe injury that affects the ankle joint and the bones of the lower leg and occurs when both the medial malleolus (inner ankle bone) and the lateral malleolus (outer ankle bone) are fractured and displaced from their normal position) of left lower leg and repeated falls. Review of physician's orders dated February 25, 2025, revealed an order for Tramadol HCl 25 mg by mouth every 4 hours as needed for severe pain (pain rating 7-10), and an updated order dated February 27, 2025, for Tramadol HCl 25 mg every 4 hours as needed for moderate (pain rating 4-6) or severe pain (pain rating 7-10). A review the resident's MAR dated February 25, 2025, through March 31, 2025, revealed that Tramadol HCL Oral Tablet 25 MG, give 1 tablet by mouth every 4 hours as needed (PRN) for pain - Moderate (4-6) or Severe (7-10) was administered without documented attempts of nonpharmacological interventions and/or outside of the prescribed physician orders on the following dates as follows. February 26, 2025, at 4:10 AM, administered an opioid PRN pain medication for a reported pain level at 7 (severe pain) and without attempted nonpharmacological interventions. February 26, 2025, at 8:25 AM, administered an opioid PRN pain medication for a reported pain level at 7 (severe pain) and without attempted nonpharmacological interventions. February 26, 2025, at 12:29 PM, administered an opioid PRN pain medication for a reported pain level at 7 (severe pain) and without attempted nonpharmacological interventions. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	February 26, 2025, at 4:31 PM, administered an opioid PRN pain medication for a reported pain level at 7 (severe pain) and without attempted nonpharmacological interventions. February 26, 2025, at 10:57 PM, administered an opioid PRN pain medication for a reported pain level at 7 (severe pain) and without attempted nonpharmacological interventions. February 27, 2025, at 4:59 AM, administered an opioid PRN pain medication for a reported pain level at 7 (severe pain) and without attempted nonpharmacological interventions. March 1, 2025, at 5:19 AM, administered an opioid PRN pain medication for a reported pain level at 7 (severe pain) and without attempted nonpharmacological interventions. March 1, 2025, at 1:24 PM, administered an opioid PRN pain medication for a reported pain level at 7 (severe pain) and without attempted nonpharmacological interventions. March 1, 2025, at 8:42 PM, administered an opioid PRN pain medication for a reported pain level at 8 (severe pain) and without attempted nonpharmacological interventions. March 2, 2025, at 9:12 AM, administered an opioid PRN pain medication for a reported pain level at 4 (moderate pain) and without attempted nonpharmacological interventions. March 2, 2025, at 5:45 PM, administered an opioid PRN pain medication for a reported pain level at 6 (moderate pain) and without attempted nonpharmacological interventions. March 3, 2025, at 1:37 AM, administered an opioid PRN pain medication for a reported pain level at 7 (severe pain) and without attempted nonpharmacological interventions. March 3, 2025, at 7:46 AM, administered an opioid PRN pain medication for a reported pain level at 7 (severe pain) and without attempted nonpharmacological interventions. March 3, 2025, at 12:14 PM, administered an opioid PRN pain medication for a reported pain level at 7 (severe pain) and without attempted nonpharmacological interventions. March 3, 2025, at 4:37 PM, administered an opioid PRN pain medication for a reported pain level at 4 (moderate pain) and without attempted nonpharmacological interventions. March 4, 2025, at 7:00 AM, administered an opioid PRN pain medication for a reported pain level at 6 (moderate pain) and without attempted nonpharmacological interventions. Further review of physician's orders revealed orders dated March 4, 2025, at 2:15 PM, for Tramadol HCl Oral Tablet 50 MG, give 50 mg by mouth every 4 hours as needed (PRN) for pain rated 4-10 for 14 days and was reordered on March 19, 2025, at 8:00 AM, Tramadol HCL tablet 50 mg, give 1 tablet every 4 hours for moderate pain (no numeric pain scale specified in orders). A review the resident's MAR dated March 4, 2025, through March 31, 2025, revealed that Tramadol HCl Oral Tablet 50 MG, give 50 mg by mouth every 4 hours as needed (PRN) for pain rating of 4-10 for 14 days was administered without documented attempts of nonpharmacological interventions and/or outside of the prescribed physician orders on the following dates as follows. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	March 4, 2025, at 10:25 PM, administered an opioid PRN pain medication for a reported pain level at 5 and without attempted nonpharmacological interventions. March 5, 2025, at 7:47 AM, administered an opioid PRN pain medication for a reported pain level at 8 and without attempted nonpharmacological interventions. March 5, 2025, at 12:26 PM, administered an opioid PRN pain medication for a reported pain level at 8 and without attempted nonpharmacological interventions. March 5, 2025, at 4:30 PM, administered an opioid PRN pain medication for a reported pain level at 7 and without attempted nonpharmacological interventions. March 5, 2025, at 8:32 PM, administered an opioid PRN pain medication for a reported pain level at 7 and without attempted nonpharmacological interventions. March 6, 2025, at 8:06 AM, administered an opioid PRN pain medication for a reported pain level at 7 and without attempted nonpharmacological interventions. March 6, 2025, at 4:38 PM, administered an opioid PRN pain medication for a reported pain level at 7 and without attempted nonpharmacological interventions. March 7, 2025, at 8:30 AM, administered an opioid PRN pain medication for a reported pain level at 4 and without attempted nonpharmacological interventions. March 7, 2025, at 12:50 PM, administered an opioid PRN pain medication for a reported pain level at 4 and without attempted nonpharmacological interventions. March 7, 2025, at 5:32 PM, administered an opioid PRN pain medication for a reported pain level at 6 and without attempted nonpharmacological interventions. March 8, 2025, at 10:33 PM, administered an opioid PRN pain medication for a reported pain level at 7 and without attempted nonpharmacological interventions. March 9, 2025, at 3:45 AM, administered an opioid PRN pain medication for a reported pain level at 7 and without attempted nonpharmacological interventions. March 10, 2025, at 6:05 AM, administered an opioid PRN pain medication for a reported pain level at 6 and without attempted nonpharmacological interventions. March 10, 2025, at 8:33 PM, administered an opioid PRN pain medication for a reported pain level at 7 and without attempted nonpharmacological interventions. March 11, 2025, at 6:28 PM, administered an opioid PRN pain medication for a reported pain level at 7 and without attempted nonpharmacological interventions. March 12, 2025, at 7:36 AM, administered an opioid PRN pain medication for a reported pain level at 7 and without attempted nonpharmacological interventions. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	March 12, 2025, at 6:14 AM, administered an opioid PRN pain medication for a reported pain level at 7 and without attempted nonpharmacological interventions. March 13, 2025, at 4:45 AM, administered an opioid PRN pain medication for a reported pain level at 7 and without attempted nonpharmacological interventions. March 13, 2025, at 12:43 PM, administered an opioid PRN pain medication for a reported pain level at 7 and without attempted nonpharmacological interventions. March 13, 2025, at 5:00 PM, administered an opioid PRN pain medication for a reported pain level at 7 and without attempted nonpharmacological interventions. March 14, 2025, at 1:48 AM, administered an opioid PRN pain medication for a reported pain level at 7 and without attempted nonpharmacological interventions. March 14, 2025, at 9:20 AM, administered an opioid PRN pain medication for a reported pain level at 8 and without attempted nonpharmacological interventions. March 14, 2025, at 8:00 PM, administered an opioid PRN pain medication for a reported pain level at 6 and without attempted nonpharmacological interventions. March 15, 2025, at 5:35 AM, administered an opioid PRN pain medication for a reported pain level at 7 and without attempted nonpharmacological interventions. March 16, 2025, at 8:02 AM, administered an opioid PRN pain medication for a reported pain level at 8 and without attempted nonpharmacological interventions. March 16, 2025, at 8:17 PM, administered an opioid PRN pain medication for a reported pain level at 8 and without attempted nonpharmacological interventions. March 17, 2025, at 1:23 AM, administered an opioid PRN pain medication for a reported pain level at 5 and without attempted nonpharmacological interventions. March 17, 2025, at 4:59 PM, administered an opioid PRN pain medication for a reported pain level at 6 and without attempted nonpharmacological interventions. March 19, 2025, at 5:05 PM, administered an opioid PRN pain medication for a reported pain level at 5 and without attempted nonpharmacological interventions. March 20, 2025, at 11:26 PM, administered an opioid PRN pain medication for a reported pain level at 7 and without attempted nonpharmacological interventions. March 21, 2025, at 12:08 AM, administered an opioid PRN pain medication for a reported pain level at 7 and without attempted nonpharmacological interventions. March 22, 2025, at 12:02 AM, administered an opioid PRN pain medication for a reported pain level at 7 and without attempted nonpharmacological interventions. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	March 29, 2025, at 10:08 PM, administered an opioid PRN pain medication for a reported pain level at 7 and without attempted nonpharmacological interventions. Further review of the MAR revealed the opioid pain medication continued to be administered throughout March 2025 without documentation that non-pharmacological interventions were attempted prior to administration, despite the facility's policy requiring such interventions. An interview with the Director of Nursing (DON) on April 4, 2025, at 10:30 AM, confirmed that there was no documented evidence that non-pharmacological interventions were attempted prior to the administration of opioid pain medication to Resident 114. 28 Pa. Code 211.5(f) Medical records 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51726 Based on observations, a review of clinical records, resident and staff interviews, it was determined the facility failed to provide sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as evidenced by one resident out of 21 sampled (Resident 97). Findings include: Review of the facility policy titled Behavioral Assessment, Intervention, and Monitoring last reviewed March 3, 2025, indicated the facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Furthermore, if the resident is being treated for altered behavior or mood, the interdisciplinary team will seek and document any improvements or worsening in the individual's behavior, mood, and function. An interview with Resident 97 on April 2, 2025 at 8:30 AM revealed the resident was experiencing increased anxiety over the past several weeks. The resident reported the nurse practitioner would not increase her anti-anxiety medication since the nursing documentation did not reflect any increase in symptoms. Review of Resident 97's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses to include bipolar disorder (a condition characterized by mood swings), generalized anxiety disorder, and depression. A quarterly Minimum Data Set Assessment (MDS a federally mandated standardized assessment conducted at specific intervals to plan resident care) for Resident 97 dated February 22, 2025, indicated the resident was cognitively intact with a BIMS score of 15 (brief interview for mental status, a tool to assess the residents' attention, orientation, and ability to register and recall new information, a score of 13-15 indicates cognition is intact). Review of Resident 97's care plan initially dated September 17, 2024, and revised on December 9, 2024, revealed the resident has an impaired psychiatric/mood status related to anxiety, bipolar disorder, and depression. Clinical record revealed on November 29, 2024, the physician, ordered Clonazepam 0.5 MG (anti anxiety medication) 1 tablet by mouth two times a day related to generalized anxiety disorder and antianxiety behavior tracking (documenting number of signs and symptoms of anxiety each shift based on individual observation of patient and discussion with other care team members). (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) dated from March 1, 2025, through March 31, 2025 indicated the following anxiety behavior chart codes: NB (no behaviors noted), OBI (observed individual), [NAME] (group observed all), and 7 (sleeping). The March MAR revealed only 11 incidences whereby anxiety behavior codes were documented for the corresponding shift. There were an additional 5 shifts (March 24 evening, March 26 -27 nights, March 29 nights and March 31 days) whereby behavioral status was addressed in the progress note as opposed to the MAR. The majority of shifts (77) for the month did not document anxiety behavior tracking in the MAR nor progress notes. A psychiatry note dated March 25, 2025 at 6:30 AM indicated that Resident 97 reported that anxiety continues and now it is affecting her sleep at night as well as some depression overall, staff and progress notes do not note any anxiety but resident does ambulate in a wheelchair throughout the facility and reports she is constantly worried about everything. Recommendations included continuing to monitor resident and document any changes in mood or behaviors in the electronic health record to assist with medication management. A review of the Medication Administration Record dated from April 1, 2025 through April 4, 2025 revealed no shift documentation of behaviors on the MAR but 3 progress notes that addressed anxiety symptoms. An interview with the Director of Nursing (DON) on April 4, 2025, at approximately 8:45 AM, confirmed anxiety behaviors were not documented per the physician orders. The facility failed to provide documented evidence the facility employed sufficient staff with the necessary competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of residents. 28 Pa. Code 211.12 (d)(3)(4)(5) Nursing services 28 Pa. Code 201.18 (e)(1)(3) Management

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51306 Based on review of the facility's Medication Storage and Labeling policy, observations, manufacturer's instructions, and staff interviews, it was determined that the facility failed to ensure medications and biologicals were stored and labeled in accordance with professional standards and manufacturer recommendations. Specifically, the facility failed to ensure that opened multi-dose medication vials were labeled with an open date and failed to ensure that expired intravenous (IV) supplies were not available for resident use on two of two nursing areas (First Floor Nursing Unit and First Floor Medication Room). Findings include: Review of the facility Medication Storage and Labeling policy last reviewed [DATE], indicated that medications and biologicals (medications that come from living organisms) are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. Multi dose vials which have been opened or accessed (e.g., needle puncture) should be dated and discarded withing 28 days unless the manufacturer specifies a different (longer or shorter) date for that opened vial. Observation of the medication refrigerator located in the nurse's station on the First Floor Nursing Unit on [DATE], at 9:11 AM, in the presence of Employee 5 LPN (Licensed Practical Nurse), revealed one vial of Acetylcysteine Solution 10% (a solution used via nebulizer to help loosen thick, sticky mucus) that had been opened but was not labeled with an open date. An interview with Employee 1LPN at the time of the observation confirmed the Acetylcyst Solution 10% stored in the medication refrigerator was opened and not dated. Review of the manufacturer's storage instructions for Acetylcysteine Solution 10% indicated the solution should be refrigerated after opening and discarded after 96 hours (4 days). An interview with the Director of Nursing (DON) on [DATE], at approximately 2:00 PM confirmed that the vial of Acetylcysteine Solution 10% stored in the medication refrigerator had been opened and was not dated. A second observation of the medication room located on the First Floor Nursing Unit on [DATE], at 9:11 AM, in the presence of Employee 5 LPN, revealed the following expired intravenous (IV) supplies available for use: Two (2) Intravenous Winged Infusion Sets 20 Gauge (a device specialized for venipuncture for either blood draws or intravenous injection) with an expiration date of [DATE]; and One (1) BD Safety IV Catheter Insertion Kit (used for intravenous infusion therapy) with an expiration date of [DATE]. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing (DON)) on [DATE], at approximately 2:00 PM confirmed the intravenous supplies stored in the medication room located on the First floor Nursing unit were expired. 28 Pa. Code 211.9 (a)(1)(k) Pharmacy Services 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services