STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395651	A. Building B. Wing	03/31/2026

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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 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** Based on review of select facility policies and procedures and clinical records, observations, and staff interviews, it was determined the facility failed to ensure a resident who needs respiratory care is provided such care, consistent with the professional standard of practice and the comprehensive person-centered care plan for one out of 27 residents reviewed (Resident 38) and failed to ensure tracheostomy care was provided consistently with professional standards of practice for one out of four residents reviewed with the presence of a tracheostomy (Resident 81).Findings include: A review of a facility policy entitled Tracheostomy Care, last reviewed by the facility on February 9, 2026, indicated tracheostomy care should be provided as often as needed, at least once daily for old, established tracheostomies, and at least every eight hours for residents with unhealed tracheostomies. The policy indicated tracheostomy care includes checking physician orders, explaining the procedure to the resident, cleaning the removable inner cannula (inner tube within the tracheostomy tube that can accumulate secretions), cleaning the stoma (the surgically created opening in the neck) and surrounding site, and documenting completion of care in the resident's clinical record. Clinical record review revealed Resident 81 was admitted to the facility on [DATE], with diagnoses that included malignant neoplasm (a cancerous tumor) of overlapping sites of the esophagus (a hollow muscular tube that carries food and liquids from the throat to the stomach) and pharynx (the throat, a muscular tube in the neck that assists with breathing and swallowing), and tracheostomy (a surgical procedure in which an opening, called a stoma, is created through the front of the neck into the trachea or windpipe, allowing placement of a tube to maintain an open airway and assist breathing). Review of the resident's care plan initiated November 4, 2025, identified impaired respiratory status related to respiratory failure and need for a tracheostomy with goals for the resident to remain free of abnormal drainage around the tracheostomy site and free from complications related to altered respiratory status. Interventions included tracheostomy care as ordered, suction as per physician orders (suction removes mucus from the airway using a medical device, resident may self suction), and elevating the head of the bed to promote optimal breathing.A review of Resident 81's 5-day Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 8, 2025, revealed that Resident 81 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13 through 15 indicates no cognitive impairment/cognitively intact). Additionally, Section O0110. Special Treatments, Procedures, and Programs E1. Tracheostomy care was coded to indicate Resident 81 received tracheostomy care while a resident. Clinical record review from admission on [DATE], through March 4, 2026, revealed no physician orders for tracheostomy care were obtained and no documented evidence licensed nursing staff consistently performed tracheostomy care in accordance with professional standards of practice or facility policy.Review of a nurse progress note completed by Employee 6, Registered Nurse (RN), dated February 28, 2026, at 5:01 PM, revealed the nurse was called to assess the resident's tracheostomy site and identified a wound measuring 4 centimeters (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(cm) in diameter by 0.3 cm in depth classified as Stage 3 (a full-thickness wound extending through the skin into the fatty tissue layer, potentially forming a crater but not exposing muscle, bone, or tendon) located under the tracheostomy plate (the external portion of the tracheostomy tube that rests against the neck) at the 6 o'clock position. Documentation indicated a moderate amount of yellow slough (dead tissue) in the wound bed with a pink perimeter and moderate greenish-brown drainage with odor. Documentation indicated the resident was afebrile (without fever) and often positioned with chin to chest with complaints of pain to the area at times. Documentation indicated a call was placed to the physician and new orders were received to pack the wound with Dakin's 1/4 strength solution (a diluted antiseptic solution used to prevent or treat infection in wounds effective against a broad spectrum of pathogens, including bacteria, viruses, fungi, and yeasts, while being gentle on the skin) soaked gauze and cover with bordered gauze daily and as needed for soiling or dislodgement. Documentation indicated the resident and responsible party were notified of the wound and treatment orders. Clinical record review revealed that on March 4, 2026, at 8:37 AM, a contracted wound care Certified Registered Nurse Practitioner (CRNP) documented the area under the tracheostomy plate was a radiation ulceration (a wound caused by tissue damage from radiation therapy).During interview on March 30, 2026, at 10:30 AM, Resident 81 reported nursing staff performed tracheostomy care daily and were currently treating the site twice daily due to a small radiation ulceration under the tracheostomy plate. The resident reported the area was almost healed and denied current pain at the site. The facility was unable to provide documented evidence, licensed nursing staff performed tracheostomy care in accordance with professional standards of practice, physician orders, or facility policy.During interview on March 31, 2026, at 12:45 AM, the Director of Nursing (DON) reviewed the above findings and confirmed the facility did not have physician orders for Resident 81's tracheostomy care and could not provide documented evidence tracheostomy care was consistently completed according to facility policy.A review of the facility policy entitled Oxygen Administration, last reviewed February 6, 2026, indicated staff are to administer oxygen at the flow rate ordered by the physician and ensure the appropriate oxygen delivery device is in place, such as a nasal cannula (a flexible tube with two small prongs placed into the nostrils to deliver supplemental oxygen). The policy indicated that staff should ensure the oxygen device is functioning properly and delivering the prescribed oxygen flow.A clinical record review revealed that Resident 38 was admitted to the facility on [DATE], with diagnoses that included chronic respiratory failure (a condition where the respiratory system is unable to remove carbon dioxide from or provide oxygen to the body).Review of physician orders revealed Resident 38 had an order dated February 3, 2026, for oxygen at four liters per minute via nasal cannula continuously related to chronic respiratory failure.Observation on March 28, 2026, at 11:15 AM revealed Resident 38 was seated in her wheelchair in her room wearing a nasal cannula connected to an oxygen tank. Observation revealed the oxygen tank was empty. During interview on March 28, 2026, at 11:23 AM, Employee 4, Registered Nurse (RN), confirmed the oxygen tank was empty and replaced the tank with a full oxygen tank. Employee 4 assessed the resident's vital signs and documented an oxygen saturation level of 94 percent (measurement of oxygen level in the blood) and heart rate of 62 beats per minute. Employee 4 indicated the resident's skin color appeared normal and there were no signs of distress. Employee 4 confirmed the resident had physician orders for continuous oxygen and staff should monitor oxygen tank levels. During interview on March 29, 2026, at 9:30 AM, the above findings were reviewed with the Director of Nursing (DON) and Nursing Home Administrator (NHA). The facility failed to ensure Resident 38 received oxygen continuously in accordance with physician orders. 28 Pa. Code 211.10(c) Resident care policies. 28 Pa. Code 211.12 (d)(1)(5) Nursing services.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, select facility policy review, and staff interview, it was determined the facility failed to ensure effective pain management by administering pain medication as prescribed by the physician and failed to attempt non-pharmacological interventions prior to administering an opioid pain medication ordered on an as needed basis for one of four residents reviewed for pain management (Resident 81).Findings include: A review of the facility policy titled Pain Assessment and Management, last reviewed by the facility on February 9, 2026, indicated that non-pharmacological interventions may be appropriate alone or in combination with medications to relieve pain. Examples of non-pharmacological interventions included environmental interventions such as adjusting room temperature, providing a pressure-reducing mattress, and repositioning the resident; physical interventions such as application of ice packs or warm or cool compresses; exercise interventions such as range of motion exercises (movement of joints to maintain flexibility and prevent stiffness); and cognitive or behavioral interventions such as relaxation techniques, music, or diversional activities. The policy indicated pharmacological interventions (analgesics, or medications used to relieve pain) may be prescribed; however, medications may not address the underlying cause of pain and may result in adverse effects such as drowsiness, decreased appetite, and increased risk for falls. Clinical record review revealed Resident 81 was admitted to the facility on [DATE], with diagnoses that included malignant neoplasm (a cancerous tumor) of overlapping sites of the esophagus (a hollow muscular tube that carries food and liquid from the throat to the stomach) and pharynx (the throat, a muscular passage that allows breathing and swallowing), severe aspiration (occurs when food, liquid, saliva, or stomach contents enter the airway or lungs instead of the stomach), aspiration pneumonia (a lung infection caused by inhaling food, liquid, saliva, or stomach contents into the lungs), respiratory failure (a serious condition in which the lungs cannot provide enough oxygen to the blood or remove carbon dioxide), and tracheostomy (a surgically created opening in the neck into the trachea, or windpipe, to assist with breathing). Review of Resident 81's physician orders revealed an order dated November 18, 2025, at 12:15 PM for Hydromorphone HCL Oral Liquid 1 mg/ml (an opioid medication used to treat moderate to severe pain), administer 4 ml via PEG tube (Percutaneous Endoscopic Gastrostomy tube, a feeding tube inserted directly into the stomach through the abdominal wall to provide nutrition or medications when a resident cannot swallow safely) every four hours as needed for a reported pain level of 4 to 10 (moderate to severe pain on the pain scale). A pain level refers to a numeric rating scale typically ranging from 0 to 10, in which 0 indicates no pain, 1 to 3 indicates mild pain, 4 to 6 indicates moderate pain, and 7 to 10 indicates severe pain. Review of the resident's Medication Administration Record (MAR, a permanent legal record documenting medications administered to a resident by licensed nursing staff) revealed licensed nurses administered Hydromorphone HCL without documented evidence that non-pharmacological interventions were attempted prior to administration of the opioid medication. Documentation also included entries of N/A for pain level. N/A indicates not available or not assessed, meaning the clinical record did not contain documentation of the resident's pain level at the time the medication was administered. Documentation revealed the following: MAR dated November 18, 2025, through November 30, 2025, indicated Hydromorphone HCL was administered twenty-seven (27) times out of seventy-eight (78) opportunities for administration.MAR dated December 1, 2025, through December 31, 2025, indicated Hydromorphone HCL was administered ninety-two (92) times out of one hundred eighty-six (186) opportunities for administration.MAR dated January 1, 2026, through January 31, 2026, indicated Hydromorphone HCL was administered eighty (80) times out of one hundred eighty-six (186) opportunities for administration.MAR dated February 1, 2026, through February 28, 2026, indicated Hydromorphone HCL was administered seventy-nine (79) times out of one hundred sixty-eight (168) opportunities for administration.MAR dated March 1, 2026, through (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	March 31, 2026, indicated Hydromorphone HCL was administered sixty-eight (68) times out of one hundred eighty-six (186) opportunities for administration. Review of Resident 81's MAR revealed licensed nursing staff administered Hydromorphone HCL outside of the physician ordered pain scale range of 4 to 10 on the following dates:November 18, 2025, at 12:16 PM, the recorded pain level was documented as N/A.November 20, 2025, at 11:59 AM, the recorded pain level was documented as N/A.November 21, 2025, at 12:02 PM, the recorded pain level was documented as N/A.November 23, 2025, at 8:10 AM, the recorded pain level was documented as N/A.November 24, 2025, at 7:28 AM, the recorded pain level was documented as N/A.December 1, 2025, at 7:50 AM, the recorded pain level was documented as N/A.December 1, 2025, at 12:16 PM, the recorded pain level was documented as N/A.December 4, 2025, at 11:53 AM, the recorded pain level was documented as N/A.December 10, 2025, at 12:04 PM, the recorded pain level was documented as N/A.December 19, 2025, at 9:19 AM, the recorded pain level was documented as N/A.January 2, 2026, at 7:50 AM, the recorded pain level was 3.January 3, 2026, at 9:02 AM, the recorded pain level was 2.January 4, 2026, at 9:08 AM, the recorded pain level was 0.January 5, 2026, at 9:05 AM, the recorded pain level was 1.January 6, 2026, at 2:40 PM, the recorded pain level was 2.January 7, 2026, at 11:50 AM, the recorded pain level was 1.January 8, 2026, at 9:06 AM, the recorded pain level was 0.January 9, 2026, at 2:14 PM, the recorded pain level was 3.January 16, 2026, at 9:18 AM, the recorded pain level was 0.January 17, 2026, at 9:35 AM, the recorded pain level was 0.January 19, 2026, at 9:10 AM, the recorded pain level was 3.January 23, 2026, at 9:09 AM, the recorded pain level was documented as N/A. The clinical record lacked documentation that licensed nursing staff attempted non-pharmacological interventions prior to administration of the opioid medication and lacked documentation that the medication was administered in accordance with the physician ordered pain scale parameters. During an interview on March 31, 2026, at 10:30 AM, the Director of Nursing was informed of the above findings. The Director of Nursing confirmed the facility could not provide documented evidence that non-pharmacological interventions were attempted prior to administering the opioid medication and confirmed that licensed nursing staff administered Hydromorphone HCL outside of the physician ordered pain scale for Resident 81.28 Pa Code 211.10 (c) Resident care policies. 28 Pa. Code 211.5(f) Medical records 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, select facility policy, and staff interview, it was determined the facility failed to ensure accurate reconciliation and documentation of controlled substance medications for 3 out of 27 residents reviewed (Residents 6, 94, and 115).Findings include: A facility policy titled Controlled Substances, last reviewed by the facility on February 9, 2026, revealed the facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications. A facility policy titled Administering Medications, last reviewed by the facility on February 9, 2026, revealed that medications are administered in a safe and timely manner, as prescribed, and the individual administering the medications initials the resident's eMAR after giving each medication and before administering the next ones. A review of facility clinical records revealed the facility utilizes a controlled substance (medications or drugs regulated by federal law due to their potential abuse, dependence or diversion) record to track, monitor, and reconcile each controlled medication, such as lorazepam. Review of facility clinical records revealed the facility tracks medication administration for each resident by way of the Medication Administration Record (MAR). The MAR indicates the medication administered, time and date of administration, staff administering the medication, pain prior to the administration of medication, and clinical rationale for the administration of medication. Clinical record review revealed Resident 6 was admitted to the facility on [DATE], with diagnoses that included rheumatoid arthritis (a chronic autoimmune disease in which the immune system attacks the lining of the joints, causing inflammation, pain, and joint damage) and generalized anxiety disorder (a mental health disorder characterized by persistent and excessive worry that interferes with daily activities). Review of Resident 6's clinical record revealed a physician's order dated October 4, 2025, for Ativan (lorazepam) 0.5 milligrams (mg) oral tablet every 12 hours as needed for increased anxiety. Lorazepam is a Schedule IV controlled substance (a medication with a recognized medical use and a lower potential for abuse relative to Schedule II or III medications). A comparison of Resident 6's Controlled Substance Record with the MAR from December 2025 through March 2026 revealed four (4) entries indicating lorazepam 0.5 mg was removed from controlled substance inventory; however, there was no corresponding documentation on the MAR indicating the medication was administered. Discrepancies were identified on the following dates:January 30, 2026, at 9:00 AMFebruary 7, 2026, at 1:00 PMFebruary 12, 2026, at 10:25 AMFebruary 17, 2026, at 12:30 PM A clinical record review revealed Resident 94 was admitted to the facility on [DATE], with diagnoses that include dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and major depressive disorder (a mental health disorder characterized by a persistently low or depressed mood, decreased interest in pleasurable activities, feelings of worthlessness, lack of energy, poor concentration, appetite changes, sleep disturbances, or suicidal thoughts). A review of Resident 94's Quarterly Minimum Data Set Assessment (MDS, a federally mandated standardized assessment process conducted at specific intervals to plan resident care) of Resident 94 dated December 23, 2025, revealed the resident was severely cognitively impaired with a BIMS score of 03 (Brief Interview for Mental Status, a tool to assess the residents' attention, orientation, and ability to register and recall new information; a score of 0 through 7 indicates severe cognitive impairment). Clinical record review revealed a physician's order dated March 6, 2026, for morphine sulfate 20 mg per milliliter (ml), administer 0.25 ml every two hours as needed for pain or shortness of breath. Morphine is a Schedule II controlled substance (a medication with accepted medical use but a high potential for abuse and dependence). A comparison of Resident 94's Controlled Substance Record with the March 2026 MAR revealed thirteen (13) entries indicating morphine was removed from inventory; however, there was no corresponding (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation on the MAR indicating administration of the medication on the following dates: March 9, 2026, at 9:00 AMMarch 10, 2026, at 2:11 PMMarch 11, 2026, at 12:30 PMMarch 12, 2026, at 9:30 AMMarch 13, 2026, at 10:00 AMMarch 16, 2026, at 6:14 AMMarch 16, 2026, at 4:17 PMMarch 17, 2026, at 1230 PMMarch 23, 2026, at 8:43 PMMarch 24, 2026, at 2:00 PMMarch 25, 2026, at 9:00 AMMarch 25, 2026, at 3:00 PMMarch 26, 2026, at 8:35 AM.A clinical record review revealed Resident 115 was admitted to the facility on [DATE], with diagnoses that included traumatic subdural hemorrhage (bleeding between the brain and its outer protective covering, often caused by head injury) and malignant neoplasm of the prostate (prostate cancer). A review of the clinical record for Resident 115 revealed a physician's order dated March 8, 2026, for Oxycodone HCL 5 mg oral tablet (Schedule II opiate narcotic medication; Schedule II drugs have a high potential for abuse) twice daily, and an additional physician's order dated March 12, 2026, for Oxycodone HCL 5 mg oral tablet every 24 hours as needed for chronic pain and breakthrough pain (sudden increase in pain despite ongoing treatment) rated 6 through 10. A comparison of Resident 115's Controlled Substance Record with the MAR from February 2026 through March 2026 revealed three (3) entries indicating Oxycodone HCL 5 mg was removed from inventory; however, there was no corresponding documentation on the MAR indicating administration of the medication on the following dates:March 7, 2026, at 9:00 PMMarch 8, 2026, at 3:39 PMMarch 9, 2026, at 9:00 PM Comparison of Resident 115's Controlled Substance Record and MAR revealed two (2) entries documenting administration of Oxycodone HCL 5 mg on the MAR; however, there was no corresponding documentation on the Controlled Substance Record indicating removal of the medication from inventory on the following dates: March 21, 2026, at 9:00 PMMarch 22, 2026, at 9:00 PM. An interview conducted on March 31, 2026, at 8:30 AM with the Director of Nursing (DON) confirmed the above findings related to discrepancies between the Controlled Substance Records and the Medication Administration Records. The DON acknowledged the facility failed to ensure effective reconciliation procedures for controlled medications. 28 Pa Code 211.10 (a)(c) Resident care policies.28 Pa Code 211.5(f)(xi) Medical records 28 Pa Code 211.9(a)(1)(k) Pharmacy services.28 Pa Code 211.12 (d)(1)(3)(5) Nursing services.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **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 displayed past non-compliance by failing to protect one of 27 residents reviewed (Resident 34) from sexual abuse perpetrated by another resident (Resident 33). Findings include: A review of the facility policy titled Abuse Policy, last reviewed by the facility on February 9, 2026, revealed it is the facility policy that residents have the right to be free from abuse. The policy indicates sexual abuse is defined as, but not limited to, non-consensual sexual harassment, sexual coercion, contact, or sexual assault. Residents have the right to engage in consensual sexual activity. However, anytime the facility has reason to suspect that a resident may not have the capacity to consent to sexual activity, the facility must take steps to ensure that the resident is protected from abuse. The policy indicates that staff will prevent abuse by identifying residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issues. A clinical record review revealed that Resident 34 was admitted to the facility on [DATE], with diagnoses that included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks) and dementia (a condition characterized by the 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). A review of Resident 34's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 24, 2026, revealed that Resident 34 had severe cognitive impairment with a BIMS score of 2 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 00 through 07 indicates cognition severely impaired). A clinical record review revealed that Resident 33 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD, a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe). A review of Resident 33's quarterly Minimum Data Set assessment dated [DATE], revealed that Resident 33 had moderate cognitive impairment with a BIMS score of 11 (a score of 8 through 12 indicates cognition is moderately impaired). Further clinical record review revealed a care plan focus indicating Resident 33 had behaviors related to going into other residents' rooms, initiated on September 2, 2025. Interventions implemented to ensure Resident 33 had no adverse effects related to these behaviors including monitoring and documenting episodes of inappropriate behaviors, redirecting the resident when exhibiting behaviors, and offering activities of interest to keep the resident engaged in positive interactions. A progress note dated August 4, 2025, at 2:50 PM revealed Resident 33 was observed in a female resident's room. Resident 33 was rubbing the female resident's arm and leg. The director of nursing (DON) was made aware, staff were advised to watch for any further behaviors. A progress note dated August 6, 2025, at 3:00 PM revealed Resident 33 was propelling through hallways and entering other resident rooms. Resident 33 was educated and advised not to enter other resident rooms. Resident 33 verbalized understanding and agreed not to continue doing this action. A progress note dated November 27, 2025, at 11:46 AM revealed Resident 33 was observed coming out of a female resident's room. Education was provided to Resident 33. Review of facility-provided investigative documentation revealed a written witness statement from Employee 2, Activity Aide (AA), regarding an allegation of resident-to-resident sexual abuse that occurred on January 29, 2026. Employee 2 documented that between 2:30 PM and 4:00 PM she was facilitating a resident activity on the first floor. During the activity, Employee 2 observed Resident 33 and Resident 34 seated next to one another. Employee 2 documented that Resident 33 attempted to touch Resident 34's lower body multiple times and would stop when he noticed that she was observing him. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employee 2 documented that when the activity concluded, she moved Resident 34 to the second-floor hallway near the nurses' station. Employee 2 documented that she left the unit and indicated that Resident 33 was not present on the second floor at that time. Employee 2 documented that upon returning to the second-floor nursing unit she observed Resident 33 and Resident 34 facing each other in the second-floor activity room. Employee 2 documented that Resident 33 was leaning toward Resident 34 with his right hand down Resident 34's pants. Employee 2 documented that Resident 33 removed his hand from Resident 34's pants when he noticed he was being observed. Employee 2 documented that she notified Employee 3, Licensed Practical Nurse (LPN). Review of facility-provided investigative documentation revealed a written witness statement from Employee 3, LPN, regarding the same incident on January 29, 2026. Employee 3 documented that she was administering medications when Employee 2 AA reported that Resident 33 was touching Resident 34. Employee 3 documented that she directed Employee 2 to notify the Registered Nurse Supervisor (RNS). Employee 3 documented that she proceeded to the second-floor activity room to separate Residents 33 and 34. Employee 3 documented that upon entering the activity room, Residents 33 and 34 were seated facing one another and holding hands. Employee 3 documented that she provided education to Resident 33 and that Resident 33 left the room. Employee 3 documented that Resident 34 appeared her normal self after the incident. A skin inspection form dated January 29, 2026, revealed Resident 34 had no new observed skin issues.A trauma evaluation form dated January 29, 2026, documented that Resident 34 was inappropriately touched by another resident. The evaluation indicated no identified psychosocial harm. The assessment indicated that Resident 34 was unable to express feelings regarding the incident due to a BIMS score of 3 (Brief Interview for Mental Status score of 3 indicates severe cognitive impairment, meaning the resident has significantly impaired memory and ability to communicate needs or experiences). A progress note dated January 29, 2026, at 4:15 PM documented that Resident 33 was placed on one staff-to-one resident supervision. A progress note dated January 30, 2026, at 4:30 PM documented that the Director of Nursing (DON) assessed Resident 34 and observed no injuries, redness, complaints of pain, discomfort, or facial grimacing. The note documented that Resident 34's affect remained unchanged and no tearfulness was observed. The DON documented that Resident 34 smiled throughout the assessment. The DON documented that Resident 34's resident representative and Power of Attorney (POA, a legally authorized individual designated to make decisions on behalf of another person) were notified and offered the option of a forensic examination (a specialized medical examination performed to assess, document, and preserve evidence of possible abuse or assault, including collection of physical evidence and evaluation for injury) at the hospital emergency department. The POA declined the forensic examination, indicating that the examination would be more detrimental to the resident's health than the alleged incident. The physician was notified A progress note dated January 30, 2026, at 10:36 AM documented that Resident 33 reported rubbing Resident 34's leg and indicated that Resident 34 was wearing pants. Resident 33 stated, I didn't mean no harm. I guess it was a mixed signal.A psychiatric progress note dated February 2, 2026, documented that Resident 34 was evaluated and appeared stable with current psychiatric medications. The psychiatrist documented that Resident 34 had no recollection of the resident-to-resident incident and did not appear distressed. During an interview conducted on March 28, 2026, at 11:10 AM, Resident 33 remained on one staff-to-one resident supervision and was unable to recall details of the incident. Resident 34 was unable to participate in an interview due to severe cognitive impairment. During an interview conducted on March 28, 2026, at 12:05 PM, Employee 2, AA, confirmed that on January 29, 2026, she observed Resident 33 attempting to touch Resident 34's lower body during an activity. Employee 2 confirmed that Resident 33 stopped attempting to touch Resident 34 when he noticed that she was observing him. Employee 2 reported that she did not implement interventions to redirect or separate Residents 33 and 34 during the activity. Employee 2 reported that Resident 33 has a history of touching female residents. Employee 2 confirmed that after the activity she escorted Resident 34 to (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the second-floor nursing station area and left the unit without notifying other staff of Resident 33's behaviors. Employee 2 confirmed that upon returning to the second-floor unit she observed Resident 33 facing Resident 34 in the activity room with his hands down Resident 34's pants. During the interview, Employee 2 reported that she removed Resident 34 from the activity room and ran down the hall to notify Employee 3, LPN, and was then directed to notify the RNS. This statement was inconsistent with Employee 2's written witness statement and inconsistent with Employee 3's written witness statement regarding the sequence of events and staff notification. During a telephone interview conducted on March 28, 2026, at 12:38 PM, Employee 3, LPN, confirmed that Employee 2 reported that Resident 33 had placed his hands down Resident 34's pants in the activity room. Employee 3 confirmed that she directed Employee 2 to notify the RNS and then proceeded to the second-floor activity room to separate the residents. Employee 3 reported observing Residents 33 and 34 seated face-to-face and holding hands. Employee 3 reported that she removed Resident 34 from the activity room and remained with her until an assessment was completed. Employee 3's interview was consistent with the written witness statement provided to the facility. During an interview conducted on March 31, 2026, at 11:00 AM, the above findings were reviewed with the Director of Nursing (DON) and Nursing Home Administrator (NHA).The facility failed to ensure Resident 33 was free from resident-to-resident sexual abuse when Resident 33 was observed with his hand down Resident 34's pants on January 29, 2026. The facility failed to ensure residents were protected from abuse when Employee 2 observed Resident 33 attempting to touch Resident 34 during the group activity and did not immediately intervene. The facility failed to ensure the immediate safety of residents when Employee 2 did not promptly separate Residents 33 and 34 or notify licensed nursing staff upon first observing inappropriate touching behaviors. This deficiency is cited as past noncompliance. The facility's corrective actions included completion of a registered nurse assessment for Resident 34, which identified no skin alterations or behavioral changes of a sexual nature. Resident 33 was placed on one staff-to-one resident supervision. The physician and resident representative were notified. The Nursing Home Administrator initiated the investigation and completed required agency notifications. The facility completed skin assessments on current female residents with BIMS scores below 12 on January 29, 2026, with no new skin alterations identified. No current female residents with BIMS scores above 12 reported allegations of abuse. The facility re-educated staff on the abuse prevention program and resident behavior management process, including implementation of interventions for residents exhibiting new or increased negative behaviors. The Nursing Home Administrator or Director of Nursing will conduct weekly audits for four weeks, then monthly audits for two months, to ensure residents identified with new or increased negative behaviors have appropriate interventions implemented and to ensure staff adherence to the abuse prevention program. The Quality Assurance Committee will review audit results and implement additional follow-up as needed. The facility's date of compliance was February 2, 2026. 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 211.10 (c) Resident care policies.28 Pa. Code 211.12 (d)(3)(5) Nursing services.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and resident and staff interviews, it was determined the facility failed to develop and implement a discharge plan that accurately reflects a resident's discharge goals or preferences for one out of 27 residents reviewed (Resident 26). Findings included:A review of the facility policy titled Discharge Summary and Plan, last reviewed by the facility on February 6, 2026, revealed it is the policy of the facility to develop a post-discharge plan by the care planning interdisciplinary team with the assistance of the resident and his or her family and includes (1) where the individual plans to reside; (2) arrangements for follow-up care; (3) the degree of support availability, capacity, and capability to perform required care; (4) transition planning; (5) factors that may make the resident vulnerable to readmission; (5) a plan to address those factors. The policy indicates that if returning to the community is not feasible, it will be documented why this is the case and who made the determination. Furthermore, the policy indicates that every resident is evaluated for his or her discharge needs and has an individualized post-discharge plan. A clinical record review revealed that Resident 26 was admitted to the facility on [DATE], with diagnoses that included cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body) and cerebral infarction (brain damage that results from a lack of blood flow to the brain). A review of Resident 26's admission, Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 24, 2025, revealed that Resident 26 was cognitively intact with a BIMS score of 14 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13 through 15 indicates cognition is intact). A review of Resident 26's quarterly MDS assessment dated [DATE], revealed that Resident 26 had moderate cognitive impairment with a BIMS score of 11 (a score of 8 through 12 indicates cognition is moderately impaired). A care plan indicating Resident 26 was a short-term care resident and will return to the community was initiated on November 18, 2025. Interventions implemented to ensure Resident 26 would have a safe transition back to the community included providing the resident and family with written instructions upon discharge to ensure a safe return to the community. A review of Resident 26's Kardex (a tool nursing staff use to provide a quick, overview of patient's care needs) revealed Resident 26 was independent for bed mobility, transferring, dressing, eating, personal hygiene, and toileting. The Kardex indicated Resident 26 required physical help with bathing. A court document dated March 9, 2026, revealed Resident 26 suffered from cardiomyopathy, congestive heart failure, and kidney failure. Resident 26 was unable to receive and evaluate information effectively and make and communicate decisions essential requirements for his physical health and safety. A guardian was appointed with the authority to decide how Resident 26 shall live and how meals, personal care, transportation and recreation shall be provided. The Guardian shall authorize consent to medical treatment and surgical procedures necessary for the well-being of Resident 26. During an interview on March 28, 2026, 10:30 AM, Resident 26 indicated that he was frustrated and upset that he is in the nursing facility. He indicated that he is [AGE] years old and feels like he is missing out on his life in the community. Resident 26 indicated that he is independent and does not require nursing care. He explained the facility is not working with him on discharge planning. Resident 26 indicated that he does not want to cause any problems, but he wants to leave the facility. During an interview on March 29, 2026, at 9:30 AM, the above information was reviewed with the director of nursing (DON). The DON was unable to provide evidence the facility had documented Resident 26's discharge needs, determined capacity for self-care (e.g., self-administering medications or treatments), or identified required support necessary for the Resident 26's guardian to make an informed decision regarding safe discharge planning. The (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility failed to identify Resident 26's capacity and capability for self-care and failed to communicate these clinical findings to the Guardian. This failure prevented the development of a discharge plan that addressed identified deficits necessary for a safe transition to the community consistent with the resident's expressed goals and the guardian's oversight.28 Pa. Code 201.18 (b)(2) Management.28 Pa. Code 201.29 (a) Resident rights.28 Pa. Code 211.10 (d) Resident care policies.28 Pa. Code 211.12 (d)(3) 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** Based on review of the Resident Assessment Instrument (RAI) Manual, clinical records, and staff interviews, it was determined the facility failed to complete an accurate Minimum Data Set (MDS) for one of 27 residents reviewed (Residents114).Findings include: The Long-Term Care Facility RAI User's Manual, which provides instructions and guidelines for completing the Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 2026 requires that each MDS assessment accurately reflect the resident's status during the assessment reference period (the specific look-back period of days the assessor must review). The Manual requires that a registered nurse conduct or coordinate each assessment with participation of appropriate health professionals. The assessment process must include direct observation of the residents and communication with the residents and direct care staff on all shifts. A clinical record review revealed Resident 114 was admitted to the facility on [DATE], with diagnoses that included malignant neoplasm of the head of the pancreas (pancreatic cancer), hemiplegia (paralysis on one side of the body), and moderate protein-calorie malnutrition (occurs when the body does not receive enough protein and calories to maintain proper health and functioning. It is common among terminally ill patients due to numerous factors, such as reduced appetite, difficulty eating, and weakened immune system). A review of Resident 114's clinical record revealed a physician's order dated February 25, 2026, at 11:05 AM, which revealed to admit the resident to hospice services (coordinated program of care and support for individuals with a serious or terminal illness that focuses on comfort symptom management) due to diagnosis of pancreatic cancer. A review of Resident 114's admission MDS assessment dated [DATE], revealed the assessment was coded to indicate the resident did not require special treatments, procedures and programs. Section O0110-K1 (Hospice Care) was coded to indicate the resident was not under Hospice Care. Section O of the MDS captures the use of Special treatments, procedures and programs such as Hospice, Chemotherapy, Radiation therapy, Oxygen therapy or Intravenous therapy. An interview conducted on March 29, 2026, at 1:30 PM with the Registered Nurse Assessment Coordinator (RNAC) acknowledged the admission MDS dated [DATE] did not accurately reflect the resident's admission to Hospice. An interview was conducted with the Nursing Home Administrator (NHA) on March 31, 2026, at 8:30 AM, to review the above information related to the facility's failure to accurately capture Resident 114's Hospice admission on the admission MDS dated [DATE], Section O (Special treatments). 28 Pa. Code 211.5(f)(iii) Medical records. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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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 clinical record review, facility policy review, and staff interview, it was determined the facility failed to develop and implement a comprehensive person-centered care plan to address the presence, care, monitoring, and maintenance of a vascular access device for 1 of 17 residents reviewed (Resident 114).Findings include: A review of the policy titled Care Plans, Comprehensive Person Centered last reviewed by the facility on February 9, 2026, revealed a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Clinical record review revealed Resident 114 was admitted to the facility on [DATE], with diagnoses that included malignant neoplasm of the head of the pancreas (pancreatic cancer, a disease in which abnormal cells grow uncontrollably in the pancreas), hemiplegia (paralysis affecting one side of the body), and moderate protein-calorie malnutrition (a condition occurring when the body does not receive enough protein and calories to maintain proper health and functioning, commonly seen in individuals with serious illness due to reduced appetite, difficulty eating, and weakened immune system). A review of a nursing progress note dated February 21, 2026, at 8:04 PM documented, Resident has POC right upper chest. An implanted venous port (a small device surgically placed under the skin and connected to a catheter inserted into a large vein near the heart to allow medications, fluids, or blood products to be administered) requires ongoing monitoring and maintenance to prevent complications such as infection (invasion and growth of harmful microorganisms in the body), occlusion (blockage of the catheter), or device malfunction. A review of a physician's order dated February 21, 2026, documented Implanted Venous Port -Not Accessed -Maintenance: Flush each lumen (separate internal channel within the catheter used to administer fluids or medications) every month with 10 ml Normal Saline (sterile saltwater solution used to maintain catheter patency and prevent blockage) and 5 ml Heparin 100 units/ml (an anticoagulant medication used to prevent blood clots from forming within the catheter). Review of Resident 114's comprehensive care plan, initiated February 21, 2026, revealed the facility failed to develop a care plan that addressed the presence of the implanted venous port located in the resident's right upper chest, including interventions necessary to monitor the site and ensure the ordered maintenance treatment was implemented according to the physician's order. An interview was conducted with the Director of Nursing (DON) on March 29, 2026, at 9:30 AM to review the above findings related to the facility's failure to develop and implement a comprehensive person-centered care plan to address the resident's physical needs associated with the vascular access device. 28 Pa. Code 211.12(d)(1)(5) Nursing services 28 Pa. Code 211.10(c)(d) Resident care policies

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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** Based on a review of clinical records, select facility policy, and staff interviews, it was determined the facility failed to provide nursing services consistent with professional standards of quality by failing to ensure that licensed nurses timely administered residents' medications for two of 27 residents reviewed (Residents 94 and 121).Findings include: According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates 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. A review of the facility policy titled Administering Medications, last reviewed by the facility on February 9, 2026, revealed that medications are administered in a safe and timely manner, as prescribed, and are administered within one hour of their prescribed time, unless otherwise specified. A clinical record review revealed Resident 94 was admitted to the facility on [DATE], with diagnoses that include dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and major depressive disorder (a mental health disorder characterized by a persistently low or depressed mood, decreased interest in pleasurable activities, feelings of worthlessness, lack of energy, poor concentration, appetite changes, sleep disturbances, or suicidal thoughts). A review of Resident 94's Quarterly Minimum Data Set Assessment (MDS, a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated December 23, 2025, revealed the resident was severely cognitively impaired with a BIMS score of 03 (Brief Interview for Mental Status, a tool to assess the residents' attention, orientation, and ability to register and recall new information; a score of 0 through 7 indicates severe cognitive impairment). A review of Resident 94's Medication Administration Record (MAR) for March 2026 revealed the resident was prescribed and scheduled to receive the following medications: Lorazepam (an anti-anxiety medication) 0.5 mg, 1 tablet by mouth at 7:00 PMTramadol (pain medication) 50 mg, 1 tablet by mouth at 4:00 PMTylenol (medication used for pain and fever) 325 mg, 1 tablet by mouth at 5:00 PMValproic acid (medication used for mood stabilization) 250 mg, by mouth at 6:00 PM. A review of the resident's medication administration audit report for March 2026 indicated that on March 23, 2026, all the above scheduled medications were documented as administered on March 23, 2026, at 8:22 PM. All the above medications were administered more than one hour later than ordered and as scheduled for the resident. A review of the clinical record revealed that Resident 121 was admitted to the facility on [DATE], with diagnoses to include hypertension (blood pressure that is higher than normal) and atrial fibrillation (a condition that causes the heart to beat irregularly and sometimes much faster than normal). A review of Resident 121's Quarterly MDS dated [DATE], revealed that Resident 121 was cognitively intact with a BIMS score of 15 (a score of 13 through 15 indicates cognition is intact). A review of Resident 121's March 2026 MAR revealed that the resident was prescribed and scheduled to receive the following medications: Atorvastatin (medication to lower cholesterol) 20 mg, 1 tablet by mouth at 9:00 PMPotassium chloride (potassium supplement) 20 mEq, 2 tablets by mouth at 9:00PMCitalopram (an antidepressant) 20 mg, 1 tablet by mouth at 9:00 PMFlomax (medication used to improve urine flow) 0.4 mg, 1 tablet by mouth at 9:00 PM.Losartan (medication to help lower blood pressure) 25 mg, 1 tablet by mouth at 9:00 PMLyrica (medication used to help treat nerve pain) 50 mg, 1 tablet by mouth at 9:00 PMRopinirole (medication used to help with (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	restless leg syndrome) 2 mg, 1 tablet by mouth at 9:00 PM.Sotalol (medication used to help lower blood pressure and heart rate) 40 mg, 1 tablet by mouth at 9:00 PMXarelto (a blood-thinning medication) 20 mg, one tablet by mouth at 9:00 PM. A review of the resident's medication administration audit report for March 2026 indicated on March 23, 2026, all the above-scheduled medications were documented as administered on March 23, 2026, at 11:00 PM, two hours after the scheduled time for the resident. During an interview on March 31, 2026, at 8:30 AM, the above information was reviewed with the director of nursing, and it was confirmed that the late medication administration is not consistent with the professional standards and medications should be received in a timely manner. 28 Pa Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, and staff interview, it was determined that the facility failed to ensure timely identification, confirmation, and physician notification of a significant unplanned weight loss for 1 of 27 residents reviewed (Resident 118). Findings include:A review of a facility policy entitled Weight Assessment and Intervention last revised by the facility February 9, 2026, indicated any weight change of 5 percent or more since the last weight assessment is retaken the next day for confirmation. The threshold for significant unplanned/undesired significant weight is 5 percent or more since the last weight assessment is significant, and would be evaluated by the dietitian, physician, and multidisciplinary team to develop interventions to stabilize/improve the residents' weight. A review of Resident 118's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included Alzheimer's disease (the most common form of dementia, a brain disorder that slowly destroys a person's memory and thinking skills and characterized by a loss of cognitive functioning such as thinking, remembering, and reasoning that interfere with a person's daily life and activities) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Review of the resident's nutrition plan of care initiated October 23, 2023, indicated the resident was at risk for altered nutritional status related to dementia and weight fluctuations. The plan indicated a goal for the resident to avoid significant weight changes (gain or loss). Interventions included obtaining weights periodically and reporting significant weight changes to the Registered Dietitian (RD) physician, and family. A review of the resident's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 3, 2025, revealed that Resident 118 was cognitively intact with a BIMS score of 13 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13 through 15 indicates no cognitive impairment).Review of Resident 118's weight record revealed the following:On December 10, 2025, at 11:07 AM, the clinical record documented the resident's weight as 115.1 pounds (lbs.).On January 6, 2026, at 4:22 PM, the clinical record documented the resident's weight as 109 lbs., representing a weight loss of 6.1 lbs. (5.3 percent) within one month.The clinical record failed to reveal documented evidence that a reweight was obtained the following day to confirm the significant weight loss as required by facility policy. Clinical record review revealed a nutrition progress note completed by the Registered Dietitian dated January 12, 2026, at 7:27 AM, documented the resident's weight as 109 lbs., reflecting a 6.1 lb. (5.2 percent) weight loss in one month. The RD documented the resident historically weighed approximately 112 lbs., meal intake ranged between 76 to 100 percent with few exceptions, and the resident was receiving a regular diet with regular texture and liquids. The RD documented questioning the weight loss and indicated fortified foods (food enhanced with additional calories and protein to help maintain or increase body weight) would be requested and weekly weights would be monitored.Review of the weight record revealed that on January 14, 2026, at 9:57 PM, the clinical record documented the resident's weight as 108.2 lbs., confirming a 6 percent weight loss within 30 days. The clinical record failed to reveal documented evidence that the resident's attending physician was notified of the significant weight loss to allow timely medical evaluation and intervention. The facility failed to ensure that reweighing was completed timely to confirm significant weight loss and failed to ensure timely interdisciplinary evaluation and physician notification to address significant weight loss in accordance with facility policy and professional standards of practice. During an interview on March 30, 2026, at 2:00 PM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) the above findings were reviewed and confirmed. 28 Pa Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c) (d)(3)(5) Nursing services.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of select facility policy, clinical records, and staff interviews, it was determined the facility failed to timely notify the physician of abnormal lab results for one resident out of 27 residents reviewed (Resident 15).Findings included: A review of the facility policy entitled Change in a Resident's Condition or Status, last reviewed on February 9, 2026, indicated the nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition. A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical intervention. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. A review of the facility policy entitled Lab and Diagnostic Test Results, last reviewed on February 9, 2026, indicated that nursing staff will consider the following factors to help identify situations requiring prompt physician notification concerning lab or diagnostic test results: Whether the resident's clinical status is unclear or they have symptoms of acute illness or condition change and are not stable or improving, or there are no previous results for comparison. A review of the clinical record revealed that Resident 15 was admitted to the facility on [DATE], and had diagnoses that included anxiety disorder (a condition in which excessive worry causes clinically significant distress or impairment in social, occupational, or other areas of functioning) and hypertension (blood pressure that is higher than normal). A review of Resident 15's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 10, 2026, revealed that Resident 15 was cognitively intact with a BIMS score of 14 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13 through 15 indicates cognition is intact). A review of a physician's order for Resident 15 dated March 23, 2026, revealed a laboratory order for urinalysis (UA) and C & S (culture and sensitivity). A urine culture is a method to grow and identify bacteria that may be in the urine. The sensitivity test helps select the best medicine to treat the infection. A review of the final urine culture (C&S) results dated March 25, 2026, identified abnormal findings of greater than 100,000 colonies per milliliter of Enterococcus species (a bacterium). A review of nursing progress notes for Resident 15 dated March 24, 2026, at 11:47 AM revealed the urine culture results from March 24, 2026, were reviewed with the physician, and there were no new orders at that time. However, the final culture report did not result until March 25, 2026, at 3:22 PM. An interview with Resident 15 on March 28, 2026, at 2:00 PM, revealed they were upset because she had been experiencing urinary frequency and urgency and stated that when she asked the staff about her urine culture results, she had been told they were waiting for the final culture report. The resident stated she felt awful and fatigued and felt like something was off. She stated she had had sepsis (a serious condition that occurs when the body has an extreme reaction to an infection) in the past due to a UTI and was worried about having a bad infection again. An interview with Employee 7, Registered Nurse (RN) on March 28, 2026, at 2:10 PM, confirmed that the physician would not have been made aware of the final culture results as they did not result until March 25, 2026. A review of a nurse's progress note dated March 28, 2026, at 2:45 PM, revealed there was a call placed to the on-call physician and was updated on the resident's urine culture results with new orders to start Macrobid (an antibiotic). A review of a physician's order dated March 28, 2026, at 2:47 PM, revealed an order for Macrobid 100 mg twice a day for five days for a UTI. A review of an antibiotic stewardship evaluation note dated March 28, 2026, at 4:32 PM, revealed the infection met McGeer's criteria (a standardized set of clinical guidelines used by healthcare professionals to help determine whether a resident in a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395651	A. Building B. Wing	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Rehabilitation & Healthcare Center	395 Middle Road Nanticoke, PA 18634

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

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	long-term care facility has a true infection, based on specific signs, symptoms, and clinical findings. The criteria help ensure infections are identified consistently and not based on vague or non-specific symptoms alone). During an interview on March 29, 2026, at 12:45 PM, the director of nursing confirmed the above findings and that Resident 15 met McGeer's criteria and that the physician should have been made aware in a timely manner of the final culture results. 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa. Code 211.12 (d)(3)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of select facility policy, and staff interview, it was determined the facility failed to ensure an environment free from potential spread of infection and failed to properly store resident personal care equipment on 2 of 2 nursing units (First Floor and Second Floor).Findings include: A review of the Infection Control Program Policy last reviewed February 9,2026 indicated the infection control program exists to assure a safe, sanitary, and comfortable environment for residents and personnel. It is designed to help prevent the development and transmission of communicable disease and infection. Personal care equipment such as bedpans and graduates may come into contact with bodily fluids. Bodily fluids (such as urine or stool) may contain microorganisms (germs) capable of causing infection. Infection prevention practices require contaminated equipment to be stored in a manner that prevents contamination of clean surfaces and reduces risk of transmission of communicable disease. An observation on March 28, 2026, at 11:02 AM in a resident room on the Second Floor nursing unit (room [ROOM NUMBER]) revealed a pink bedpan placed on the bedside table next to a roll of toilet paper and a telephone. The bedpan was not enclosed in a protective plastic bag and was not stored in a designated cabinet. A second observation of the same room on March 28, 2026, at 1:40 PM revealed the same bedpan remained unbagged on the bedside table next to the toilet paper and the resident's telephone. An interview with Employee 1 nurse aide on March 28,2026, at 1:44 PM stated the bedpan should be placed in a plastic bag and stored in the cabinet underneath the bedside table. An observation on March 28, 2026, at 12:15 PM revealed a graduate (a container used to measure urine output) placed on top of the counter next to the sink in the shared bathroom for resident rooms [ROOM NUMBERS]. At the time of the observation, Employee 5 nurse aide confirmed the graduate should not be placed on the bathroom counter next to the sink where handwashing occurs due to risk of contamination. An interview was conducted with the Director of Nursing on March 29, 2026, at 1:00 PM regarding the above findings related to the facility's failure to ensure personal care equipment, including a bedpan and graduate, were stored and maintained according to infection prevention practices. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa code 211.12 (d)(1)(5) Nursing services.