STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395691	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverstreet Manor	440 North River Street Wilkes-Barre, PA 18702

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, review of select facility policy, and staff interviews, the facility failed to maintain sanitary conditions in the dietary department, including the main kitchen and a nursing unit pantry (Station 2), to ensure food was stored, prepared, and served in a manner that prevented contamination and microbial growth in food, which increased the risk of food-borne illness. Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). A review of facility policies entitled Sanitation, last reviewed May 1, 2025, indicated that all kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects. The food services manager will be responsible for scheduling staff for regular cleaning of the kitchen and dining areas. Food service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment. An initial tour of the dietary department, conducted on April 14, 2026, at 9:15 AM with the facility's Certified Dietary Manager (CDM), revealed unsanitary conditions with the potential to contaminate food and increase the risk of foodborne illness (illness caused by consuming contaminated food).Observations revealed: The bottom shelves of multiple metal food preparation tables contained liquid stains and food debris. Several silver banquet trays stored on these shelves contained dried food residue and standing water. Multiple coffee cups identified as clean contained a white film and brown staining. Multiple cereal bowls contained dried food debris. The kitchen floor perimeter contained a sticky black substance, along with food, paper, and plastic debris. The floor behind the steamer unit contained a large accumulation of a sticky black and brown substance. The floor drain beneath the unit contained a buildup of the same black/brown material. The floor beneath the kitchen ice machine contained food debris and paper and plastic waste. A sticky black and brown substance was present on the floor and surrounding the drain. The ice machine drainpipe discharged directly into the floor drain without an air gap (an air gap is the open space between a drainpipe, and a sewer drain that prevents contaminated water from flowing back into equipment). The drainpipe contained a thick accumulation of dark residue extending from the pipe to the machine. Observation of the Station 2 pantry revealed additional unsanitary conditions. The ice machine drainpipe discharged directly into the floor drain with no visible air gap. A review of the facility menu for April 16, 2026, indicated portion-controlled serving requirements for the lunch meal which included 3 ounces of breaded chicken tenders, 4 ounces of tater tots, 4 ounces of seasoned green peas and 4 ounces of pears. During observation of the tray line on April 16, 2026, at 12:00 PM, the surveyor observed Employee 2 (cook) serve food items using gloved hands instead of using portion-controlled utensils (measured serving tools used to ensure consistent portions and sanitary handling). The employee handled chicken tenders and tater tots directly with gloved hands. During the (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	same observation, the employee turned away from the serving line, handled a plate from a cart, placed it onto a meal tray, and then resumed serving food with the same gloves without performing hand hygiene or changing gloves. The surveyor observed this practice for multiple residents. During an interview on April 16, 2026, at 1:00 PM, the Certified Dietary Manager stated dietary staff are expected to use appropriate serving utensils to portion and serve food items from the tray line. During an interview on April 17, 2026, at 12:30 PM, the Nursing Home Administrator was informed of the above observations and acknowledged that the dietary department is required to be maintained in a clean and sanitary condition. 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 211.6 (f) Dietary Services. 28 Pa. Code 211.10 (c) Resident care policies.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on review of scheduled mealtimes, resident council meeting minutes, resident interviews, and staff interviews, the facility failed to ensure residents were consistently offered a nutritious evening snack when more than 14 hours elapsed between the substantial evening meal and breakfast the following day, for 5 of 5 residents reviewed who expressed a desire for a bedtime snack (Residents 10, 53, 9, 65, and 105).Findings include: A review of scheduled facility mealtimes revealed the interval between the substantial evening meal and breakfast exceeded 14 hours across multiple resident care areas. Dinner was served between 4:40 PM and 5:15 PM, and breakfast was served between 7:35 AM and 8:15 AM the following morning, resulting in overnight intervals ranging from 14 hours 55 minutes to 15 hours, as follows: Pine Hall: Dinner 4:40 PM, Breakfast 7:35 AM (14 hours 55 minutes)Oak Hall: Dinner 4:55 PM, Breakfast 7:50 AM (14 hours 55 minutes)Willow Hall: Dinner 5:05 PM, Breakfast 8:05 AM (15 hours)Spruce Hall: Dinner 5:15 PM, Breakfast 8:15 AM (15 hours) When more than 14 hours elapse between the substantial evening meal and breakfast the next day, the resident must be offered a nutritious snack (a food or beverage that provides calories and nourishment, such as milk, fruit, or a sandwich, rather than items with little nutritional value) at bedtime. A review of Food Committee meeting minutes revealed ongoing concerns regarding failure to provide evening snacks to residents: February 3, 2026: Residents reported snacks were not always being passed.March 3, 2026: Residents reported snacks were still not consistently passed.April 8, 2026: Residents reported snacks were not being offered despite snacks being delivered to the units and placed in the pantry. They stated that nursing puts the snacks in the pantry and no one passes them to the residents. During a resident council meeting conducted on April 14, 2026, at 10:30 AM, 5 of 5 residents interviewed (Residents 10, 53, 9, 65, and 105) reported they were not offered a snack in the evening and all residents reported that they do not receive a snack before bedtime. During an interview on April 15, 2026, at 2:00 PM, the Nursing Home Administrator was unable to provide documentation showing that evening snacks were consistently offered to residents. 28 Pa. Code 211.12 (d)(3)(5) Nursing services. 28 Pa. Code 211.10 (c) Resident Care Policies.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on review of facility documentation and staff interview, the facility failed to ensure it conducted required quarterly Quality Assurance and Performance Improvement (QAPI) committee meetings and failed to ensure the attendance of the Medical Director or a physician designated by the Medical Director at required quarterly QAPI meetings for two of four quarters reviewed (Quarters 3 and 4 of 2025).Findings include: A review of the facility policy titled Quality Assurance Performance Improvement, last reviewed May 1, 2025, revealed the facility established a QAPI program (a facility-wide program that uses ongoing review of data and care practices to identify problems, correct them, and improve the quality and safety of services provided to residents). The policy indicated the program would be comprehensive, ongoing, and address the full range of services and departments. However, the policy did not specify the required participation of the Medical Director or a physician designated by the Medical Director and did not outline expectations for attendance or accountability for participation in quarterly QAPI meetings. A review of available QAPI committee meeting sign-in sheets and supporting documentation revealed the facility was unable to provide documented evidence that required quarterly QAPI committee meetings were conducted during the period of August 2025 through December 2025. In addition, the facility was unable to provide documentation that the Medical Director or a designated physician representative attended QAPI meetings conducted during the period of July 2025 through December 2025. The absence of documentation of required quarterly QAPI committee meetings and the absence of documentation of Medical Director or designated physician participation demonstrated the facility did not ensure the implementation of its QAPI program on a quarterly basis with required physician involvement in quality review activities. An interview conducted on April 17, 2026, at 10:30 AM, with the Director of Nursing and the Nursing Home Administrator included review of the above findings. During the interview, they acknowledged the facility was unable to provide documentation to support that required quarterly QAPI committee meetings were conducted for the identified time period and acknowledged that the Medical Director or designated physician representative had not attended the identified QAPI meetings. 28 Pa. Code 201.18 (e)(1)(3) Management. 28 Pa. Code 211.2 (d)(3)(4)(5)(6) Medical director. 28 Pa. Code 211.10(c)(d) Resident care policies.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **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 ensure appropriate duration and clinical rationale for an as-needed (PRN) psychotropic medication order and failed to document the use of non-pharmacological interventions prior to administration for one of 24 residents reviewed (Resident 56). Findings include: Federal requirements for the use of psychotropic medications expect that psychotropic medications are used only when necessary to treat a specific, documented condition. The requirements further limit PRN psychotropic medication orders to 14 days unless the prescriber documents a clinical rationale for continued use and specifies the duration of the extended order. Non-pharmacological interventions are approaches that do not involve medications, such as verbal reassurance, redirection, environmental adjustments, or comfort measures, and are expected to be attempted and documented when clinically appropriate prior to the use of a PRN psychotropic medication. A review of the facility's policy titled Psychotropic Medication Use, last updated May 1, 2025, indicated that PRN psychotropic medication orders are limited to 14 days. The policy further indicated that if the medication is to continue beyond 14 days, the prescriber must document the reason for the extended use and specify the duration. Resident 56 was admitted to the facility on [DATE], with diagnosis which included metabolic encephalopathy (brain dysfunction caused by underlying metabolic disturbances, leading to symptoms like confusion, memory loss, and altered awareness). A review of Resident 56's (admission) Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 14, 2026, revealed that Resident 56 was cognitively impaired with a BIMS score of 6 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 00-07 indicates severe cognitive impairment, suggesting significant difficulties with memory, orientation, and daily functioning). A review of the clinical record revealed a physician order dated February 13, 2026, for Lorazepam (a medication used to treat anxiety by slowing activity in the brain and nervous system) 2 milligrams per milliliter, administer 0.5 milliliters orally every six hours as needed for terminal agitation (a condition characterized by restlessness, confusion, or distress that may occur near the end of life). The clinical record did not indicate Resident 56 was receiving hospice services (specialized care focused on comfort rather than curing a terminal illness). A review of the electronic medication administration record (eMAR, an electronic system used to document medication administration) revealed Lorazepam was administered on February 13, 2026, at 3:48 PM; April 3, 2026, at 6:58 PM; and April 8, 2026, at 6:00 PM. Review of the February 13, 2026, physician order did not identify documentation of a clinical rationale or a specified duration to support continuation of the PRN psychotropic medication beyond 14 days. The clinical record confirmed the medication remained active and was administered beyond the 14-day limit without required prescriber documentation. Review of the eMAR and supporting documentation did not identify evidence that non-pharmacological interventions were attempted prior to administration of the medication on the above dates. Additionally, documentation dated February 13, 2026, did not indicate the presence of agitation at the time the medication was administered. During an interview on April 16, 2026, at 11:48 AM, the Director of Nursing confirmed the clinical record did not contain documentation specifying the duration or clinical rationale for continuation of the PRN psychotropic medication beyond 14 days. 28 Pa. Code 211.2(d)(3)(5) Medical Director. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(3)(5) 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** Based on clinical record review, review of facility policy, and staff interview, it was determined the facility failed to develop an individualized baseline care plan that addressed a resident's immediate needs and documented treatment preferences, including comfort-focused care and avoidance of hospital transfer when appropriate, for one of 24 residents reviewed (Resident 56).Findings include: A review of the facility's policy, Care Plans -Baseline last updated on May 1, 2025, revealed that a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight hours of admission. The policy indicated the immediate needs to be addressed in the baseline care plan include but are not limited to initial goals, physician orders, and interventions to meet the resident's needs. Resident 56 was admitted to the facility on [DATE], with diagnosis which included metabolic encephalopathy (brain dysfunction caused by underlying metabolic disturbances, leading to symptoms like confusion, memory loss, and decreased awareness). A review of Resident 56's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 14, 2026, revealed that Resident 56 was cognitively impaired with a BIMS score of 6 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 00-07 indicates severe cognitive impairment, suggesting significant difficulties with memory, orientation, and daily functioning). A review of the Physician Orders for Life Sustaining Treatment (POLST, a medical order documenting a resident's treatment preferences for life-sustaining care) signed February 11, 2026, indicated the resident's wishes for Do Not Attempt Resuscitation and Comfort Measures Only (care focused on relieving pain and suffering rather than prolonging life). The POLST specified the resident should remain in the facility and not be transferred to the hospital unless comfort needs cannot be met. A review of the baseline care plan initiated on February 11, 2026, indicated that Resident 56's advance directives would be followed and that the resident wished to allow a natural death and did not want resuscitation (Do Not Resuscitate). However, the baseline care plan did not include specific, person centered details about the resident's wishes to remain in the facility, avoid hospital transfer when possible, or specific measures to provide comfort such as symptom management or interventions to relieve pain and suffering A review of the clinical record revealed a change in condition on February 13, 2026, including altered responsiveness, inability to follow commands, and facial drooping. Documentation indicated the physician assistant and family were present, and the decision was made to continue comfort-focused care in the facility. During an interview on April 16, 2026, at 11:48 AM, the Director of Nursing (DON) confirmed the baseline care plan did not include individualized interventions addressing the resident's treatment preferences and immediate comfort care needs as required by facility policy. The DON also confirmed that the facility did not have a policy addressing comfort measures. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa Code 211.12 (d)(3)(5) Nursing services. 28 Pa. Code 211.5(f)(iii) Medical records.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of observations, clinical records, select facility policy, and staff interviews, it was determined the facility failed to provide adequate supervision to prevent a resident from exiting the facility without authorization (elopement) for one of 24 residents reviewed (Resident 28).Findings include: A review of the facility policy entitled Wandering and Elopements, last reviewed May 1, 2025, revealed it was the policy of the facility to identify residents who are at risk of unsafe wandering and will strive to prevent harm while maintaining the least restrictive environment for residents. The policy defined elopement as a resident leaving the premises or a safe area without authorization. Clinical record review revealed Resident 28 was admitted on [DATE], with diagnoses including localization-related symptomatic epilepsy (a seizure disorder that begins in one area of the brain and may spread) and essential thrombocythemia (a condition in which the body produces too many platelets, increasing the risk for blood clots or bleeding). Review of a quarterly Minimum Data Set assessment (MDS, federally mandated standardized assessment conducted at specific intervals to plan resident care) dated March 6,2026, revealed Resident 28 had a BIMS score of 13 (Brief Interview for Mental status, a tool to assess the resident's cognition, orientation, and ability to register and recall new information). A score of 13-15 indicates that cognition is intact. Information provided to the Department during the survey revealed that on April 14, 2026, at 7:00 PM, Resident 28 approached the front desk and requested to leave the facility. The receptionist asked if he was a resident, and the resident stated he was not. The receptionist then allowed the resident to exit the building. During an interview on April 16, 2026, at 9:30 AM, Resident 28 stated he intentionally provided incorrect information to the receptionist in order to go outside. The resident reported he walked toward the corner of the property before a nurse found him and returned him to the building. before being located by staff and returned to the building. Clinical record review revealed no documentation of the resident exiting the facility, and no evidence the physician or responsible party (an individual legally authorized to receive information or make decisions on behalf of the resident) was notified. A review of external medical (hospital record) documentation indicated Resident 28 reported to a physician on April 15, 2026, that he had left the facility with the intention of going to a pizza establishment. A review of the elopement risk assessment dated [DATE], indicated Resident 28 was not identified as being at risk for elopement. The care plan, initiated the same date, did not address elopement risk or include interventions related to supervision for leaving the facility. Nursing documentation indicated the resident was independently mobile with the use of a rollator walker (a wheeled walking aid that provides support and stability). During an interview on April 16, 2026, at 10:15 AM, the Nursing Home Administrator and Director of Nursing stated the resident was cognitively intact, frequently ambulated throughout the facility, and was not considered an elopement risk. They indicated the event was not considered an elopement because the resident remained close to the building. An interview with Employee 4 Receptionist, conducted via telephone on April 16, 2026, at 10:00 AM revealed Resident 28 approached the front desk requesting to be let out of the building. Employee 3 stated she asked the resident if he was a resident of the facility, and he replied No, stating he just needed fresh air. Employee 4 indicated she allowed the resident to exit the building. She further stated that after the resident exited and began walking toward the left side of the building, she observed him stumbling and felt something was not right. Employee 4 reported she immediately went to Nursing Station 1 to notify the nursing supervisor. She stated the nursing supervisor showed her a picture of a resident, and she confirmed it was the same individual she had allowed to leave. Employee 4 indicated the nursing supervisor then initiated a Code [NAME] (a facility-wide overhead announcement used to alert staff of a missing resident) on April 14, 2026, at 7:05 PM. An interview with Employee 3 Licensed Practical Nurse, conducted via telephone on April 16, 2026, at 10:24 AM revealed she heard (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a Code Green announced overhead and responded by searching for Resident 28. Employee 3 stated she exited the building and located Resident 28 walking on the sidewalk along the side of the facility closest to the cemetery (located near the road). She indicated it was still light outside and warm, approximately 76 degrees Fahrenheit, and the resident was wearing a shirt, sweatpants, and sneakers. Employee 3 reported she escorted the resident back into the facility at approximately 7:10 PM. On April 17, 2026, at 10:15 AM, the above findings were reviewed with the Nursing Home Administrator and Director of Nursing. The facility did not ensure adequate supervision to prevent Resident 28 from exiting the building without authorization.28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18 (e)(1) (2.1) (3) Management. 28 Pa. Code 211.10 (d) Resident care policies.

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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 facility policy review, clinical record review, and staff and resident interviews, it was determined the facility failed to monitor and manage hydration status in accordance with a physician-ordered fluid restriction to ensure proper fluid balance for one of 24 residents reviewed (Resident 39).Findings include: A review of the facility policy titled Fluid Restriction Policy, last reviewed May 1, 2025, indicated the facility will provide an appropriate amount of fluid to residents who have a prescribed physician order for fluid restriction. The policy further stated that when a fluid restriction (a medical order that limits the total amount of liquids a resident may consume within a specified time period, usually over 24 hours, to prevent complications such as fluid overload, which is excess fluid in the body, or worsening heart or kidney conditions) is ordered by the physician, the clinical nutrition staff will coordinate with nursing for a 24-hour distribution of the daily allowance of fluids for meals, supplements, and medication administration. The procedure dictated that fluid preferences will be reviewed with the resident by the clinical nutrition staff and residents with fluid restriction orders will be reviewed for adherence by the clinical nutritionist. A clinical record review revealed Resident 39 was admitted on [DATE], with diagnoses including Parkinsonism (a neurological condition that causes slowed movement, muscle stiffness, and tremors) and hypertensive heart and chronic kidney disease with heart failure (a condition in which long-standing high blood pressure has caused damage to the heart and kidneys, leading to reduced ability to pump blood effectively and remove excess fluid from the body, which can result in fluid buildup). These conditions place the resident at risk for fluid overload (a condition in which the body retains more fluid than it can safely manage, potentially causing swelling, breathing difficulty, and strain on the heart). A review of Resident 39's quarterly Minimum Data Set (MDS, a federally required standardized assessment used to evaluate a resident's condition and guide care planning) dated March 5, 2026, revealed a Brief Interview for Mental Status (BIMS, a structured interview used to assess memory, attention, and orientation) score of 9, indicating moderate cognitive impairment (some difficulty with memory and decision-making a score of 08-12 indicates moderate cognitive impairment). A clinical record review identified a physician order dated August 1, 2025, for a 1500 milliliter (mL) daily fluid restriction including 900 mL with meals and 600 mL during nursing care, including medication administration. A care plan addressing nutritional risk identified the need for fluid restriction due to fluid overload (condition in which the body has more fluid than it can effectively manage), along with a history of noncompliance (not consistently following a prescribed treatment plan) and a history of weight loss and gain. The goal indicated the resident would consume appropriate amounts of food and fluids to maintain nutritional status. An interview with Resident 39 on April 15, 2026, at 10:30 AM revealed the resident was unaware of the fluid restriction order and did not recall involvement in care planning related to fluid intake. A review of a nutrition evaluation completed by the clinical nutritionist dated March 9, 2026, documented the presence of the 1500 mL fluid restriction; however, the record did not include evidence of resident education regarding the restriction, review of fluid preferences, or monitoring of adherence to the ordered fluid limit, as required by facility policy. A clinical record review, including documentation of fluid intake during meals and medication administration, showed that Resident 39 exceeded the prescribed 1500 mL daily fluid restriction on multiple occasions, including:April 2, 2026: 1560 mLApril 10, 2026: 1920 mLApril 11, 2026: 1680 mLApril 15, 2026: 1660 mLAn interview was conducted on April 16, 2026, at 2:15 PM with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) to review the above information. The NHA and DON confirmed that the facility failed to monitor Resident 39's hydration status and adherence to the prescribed fluid restriction and failed to involve the resident in the plan of care regarding the fluid restriction as required by facility policy. 28 Pa Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c) (d)(3)(5) Nursing services.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, select facility policy review, and staff interviews, it was determined the facility failed to implement and adhere to procedures to ensure acceptable storage and use-by dates for multi-dose medications in two of two medication rooms (Station 1 Medication Room, and Station 2 Medication Room).Findings include: A review of the facility policy titled Medication Labeling and Storage last reviewed by the facility on May 1, 2025, revealed it is the policy of the facility that if a multidose vial (container of medication intended for use in more than one dose for multiple administrations, which contains a preservative to reduce bacterial growth and requires labeling with the date opened and adherence to manufacturer storage and beyond-use guidelines) of injectable medication has been opened or accessed (e.g., needle puncture) the vial should be dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the opened vial. An observation of the medication room in Station 2 Med Room on April 15, 2026, at 8:53 AM, in the presence of Employee 3 (Licensed Practical Nurse) of the medication stored in the medication refrigerator revealed one (1) multi-dose vial of Tuberculin Purified Protein Derivative, Diluted Aplisol (used primarily in the tuberculin skin test, also known as a Mantoux test, used to determine whether a person has been infected with Tuberculosis) that had been opened and available for use, but not dated when initially opened. An interview with Employee 3(LPN) on April 15, 2026, at 8:54 AM confirmed the multidose vial of Tuberculin Purified Protein Derivative was opened and available for use, was not dated when initially opened. An observation of the medication room in Station 1 Med Room on April 15 , 2026, at 9:02 AM, in the presence of the Assistant Director of Nursing (ADON) of the medication stored in the medication refrigerator, revealed two multi-dose vials of Tuberculin Purified Protein Derivative, Diluted Aplisol, that had been opened and available for use, but not dated when initially opened. An interview with the ADON on April 15, 2026, at 9:04 AM confirmed the two multidose vials of Tuberculin Purified Protein Derivative were open and available for use but were not dated when initially opened. Review of manufacturer safety information revealed the multidose vials of Tuberculin Purified Protein Derivative, Diluted Aplisol should be discarded within 30 days of opening. An interview was conducted on April 15, 2026, at 1:30 PM with the Director of Nursing (DON) to review the above findings related to the facilities failure to adhere to acceptable storage and use-by dates for multi-dose medications. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services 28 Pa Code 211.10 (a)(c) Resident care policies.