STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395702	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Ridge	1515 Wayne Avenue Indiana, PA 15701

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on review of facility policies, and clinical records, as well as resident and staff interviews, it was determined that the facility failed to provide necessary treatment and services for a Stage 3 pressure ulcer (pressure wound involving the fat layers beneath the skin) for one of 40 residents reviewed (Resident 43), resulting in a deterioration of the wound and delayed healing. Findings include: The facility's pressure ulcer policy, dated January 22, 2026, indicated that the facility will ensure that a resident with pressure ulcers receives necessary treatment and services to promote healing, prevent infection, and prevent new sore from developing. Document in the resident's record and the Treatment Administration Record (TAR) that wound care was administered as prescribed. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 43, dated August 25, 2025, indicated that the resident was cognitively impaired, was dependent on staff for bed mobility, transfers, dressing/grooming and hygiene, was incontinent of bowel and bladder, had a Stage 3 pressure ulcer present on admission, had diagnoses including cerebral vascular accident (an event caused by poor blood flow or bleeding to in the areas of the brain), hemiparesis and hemiplegia (paralysis or weakness to one side of the body due to brain injury) affecting right dominant side, and wound infection. A care plan for the resident, dated August 19, 2025, revealed that the resident had a Stage 3 pressure ulcer to her right hip on admission and staff were to administer medications as ordered. Review of hospital documentation for Resident 43, dated August 17, 2025, revealed that the resident had a wound to her right hip with purulent discharge (a thick, opaque, and often foul-smelling fluid, ranging in color from yellow and green to brown or white, that indicates a likely bacterial infection) along with surrounding erythema (abnormal skin redness or rash caused by dilated blood vessels near the skin's surface, typically resulting from inflammation, infection, or injury) and warmth. A Computed Tomography (CT) scan of the right hip, completed on August 17, 2025, for suspected abscess (a localized collection of a mixture of white blood cells, bacteria, and dead tissue that forms in the body, often due to bacterial infections, viruses, or foreign objects) and infection showed subcutaneous fat stranding in the anterior pelvic wall, and lateral to the right hip, consistent with cellulitis (a common, potentially serious bacterial skin infection affecting deep dermis layers, often caused by Streptococcus or Staphylococcus bacteria entering through skin breaks). She was treated with vancomycin at the hospital to cover Methicillin-resistant Staphylococcus aureus (MRSA) (type of staph bacteria resistant to many antibiotics making treatment difficult). An admission screen for Resident 43, dated August 19, 2025, revealed that the resident had a Stage 3 pressure ulcer to her right lateral hip measuring 2.5 centimeters (cm) length x 1.5 cm width x 0.1 cm depth, and it was noted that a treatment was ordered. A physician's order for Resident 43, dated August 19, 2025, included orders to cleanse the right hip with normal saline (a sterile solution used for the moistening of wound dressings and wound debridement), apply adaptic (non-adhering wound dressing made of knitted cellulose acetate fabric impregnated with a petrolatum emulsion used to protect regenerating tissue in draining, partial- and full-thickness wounds) and cover with bordered dressing daily and as needed for soilage/dislodgement until resolved. Review of the resident's TAR for August 2025, revealed that the treatment order was not transcribed to appear on the TAR for the treatment to be completed as (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	ordered. There was no documented evidence that the treatment was completed as ordered from August 19, 2025, through August 26, 2025, delaying treatment to the wound. A physician's note for Resident 43, dated August 21, 2025, revealed that the resident had a Stage 3 pressure ulcer over her right hip. A weekly skin assessment, completed August 23, 2025, indicated that the resident had no open areas or skin issues. A wound consultation note for Resident 43, dated August 26, 2025, revealed the resident was seen for a pre-existing ulcer of the right hip. The wound was classified as a Stage 3 pressure ulcer present on admission. The wound base contained 40 percent slough (dead tissue within a wound, often appearing as a yellow, tan, or white fibrous material) and a surgical wound debridement was completed and indicated removal of necrotic tissue (dead, non-viable tissue that impedes healing and increases the risk of infection, requiring prompt identification and removal). The wound prior to and after surgical debridement measured 7.5 cm x 6 cm x 0.3 cm, revealing that the wound worsened since admission to the facility on August 19, 2025. Interview with the Assistant Director of Nursing on April 22, 2026, at 10:42 a.m. confirmed that the treatment order, dated August 19, 2025, to Resident 43's right hip was not transcribed to appear on the TAR for the treatment to be completed as ordered, and that there was no documented evidence that the treatment was completed as ordered from August 19, 2025, through August 26, 2025. Interview with the Director of Nursing on April 23, 2026, at 2:31 p.m. revealed that Resident 43's wound to her right hip was not very big when she was admitted , about 0.1 cm deep and had no drainage or necrotic tissue. A physician's order for Resident 43, dated October 14, 2025, included orders to cleanse the right hip with 0.125 percent Dakins solution (a solution used to treat and prevent tissue infections) and pack with Dakins soaked rolled gauze and cover with silicone bordered super absorb dressing (designed for moderate to heavily exuding wounds, such as ulcers and surgical wounds) twice daily and as needed for soilage/dislodgement. There was no documented evidence that the treatment was completed as ordered on November 17, 2025. A physician's order for Resident 43, dated November 24, 2025, included orders to irrigate the right hip with normal saline solution, apply Plurogel (designed to create a moist wound healing environment that promotes debridement, softens necrotic tissue/debris) to wound base, pack with normal saline moistened gauze and cover with silicone bordered super absorb dressing daily and as needed for soilage/dislodgement. There was no documented evidence that the treatment was completed as ordered on December 8, 2025. A physician's order for Resident 43, dated December 9, 2025, included orders to irrigate the right hip with normal saline solution, apply Plurogel to wound base, pack with normal saline moistened gauze, apply calmoseptine (moisture barrier) to periwound and cover with silicone bordered super absorb dressing daily and as needed for soilage/dislodgement. There was no documented evidence that the treatment was completed as ordered on December 14, 2025. A physician's order for Resident 43, dated December 14, 2025, included orders to irrigate the right hip with normal saline solution, apply calmoseptine to periwound, pack wound with Dakins 0.125% moistened rolled gauze, and cover with silicone bordered super absorb dressing daily and as needed for soilage/dislodgement. There was no documented evidence that the treatment was completed as ordered on December 15, 2025. A physician's order for Resident 43, dated December 19, 2025, included orders to irrigate the right hip with acetic acid solution (topical antimicrobial agent used to treat infected wounds) 0.25 percent, sprinkle flagyl powder (antifungal used to treat wounds with infection, necrotic (dead) tissue, or bacterial growth) 500 milligram (mg) crushed tablet into wound bed, then pack wound with acetic acid 0.25% moistened rolled gauze, and cover with silicone bordered super absorb dressing twice daily and as needed for soilage/dislodgement. There was no documented evidence that the treatment was completed as ordered on December 23 and December 27, 2025, on the night shift. A physician's order for Resident 43, dated January 27, 2026, included orders to irrigate the right hip with normal saline solution, then pack wound with calcium alginate rope (may cut in half to fit into wound bed) and cover with super absorb bordered dressing once daily and as needed for soilage/dislodgement. There was no documented evidence that the treatment was completed as ordered on March 13, 2026, and April 12, (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	2026. Interview with the Assistant Director of Nursing on April 22, 2026, at 10:42 a.m. confirmed that there was no documented evidence that the treatments to Resident 43's right hip were completed as ordered on the above-mentioned dates. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to serve food that was palatable and at safe and appetizing temperatures.Findings include: The facility's policy regarding food preparation, dated January 22, 2026, indicated that all foods will be held at appropriate temperatures, greater than 135 degrees Fahrenheit (or as state regulations requires) for hot holding, and less than 41 degrees Fahrenheit for cold food holding. A dietary tracking form of tray delivery times revealed that on April 20, 2026, breakfast trays were delivered to Bayside at 7:40 a.m. Observations on Bayside on April 20, 2026, at 8:09 a.m. revealed a breakfast cart containing nine undelivered breakfast trays. Two trays had protective lids only covering half of the dish and the eggs were exposed. At 8:18 a.m. the Regional Dietary Manager arrived on unit, and the trays were still on the cart. The Regional Dietary Manager took temperatures of the uncovered eggs which were 103 degrees Farenheit. Eggs with the protective coverings temped at 112.8 degrees Farenheit. Interview with the Regional Dietary Manager on April 20, 2026, at 8:20 a.m. confirmed that the breakfast tray should have been covered and that the eggs were cold and not palatable and should not be served to the residents. 28 Pa. Code 201.18(b)(1)(2)(e) Management. 28 Pa. Code 211.6(c) Dietary Services.

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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 review of policies, observations and staff interviews, it was determined that the facility failed to ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety in the kitchen.Findings include:The facility's policy for food temperatures, dated January 22, 2026, revealed the temperature of potentially hazardous cold foods must be served at a temperature of 41 degrees Fahrenheit or below.The facility policy regarding food storage, dated January 22, 2026, revealed that food should be stored in such a manner as to prevent contamination and to maintain the safety and wholesomeness of the food for human consumption.Observations on April 20, 2026, at 6:07 a.m. in the main kitchen walk in cooler revealed that the temperature inside the walk-in cooler was in the danger zone of 42 degrees Fahrenheit. Observations on April 20, 2026, at 6:07 a.m. in the main kitchen walk in cooler revealed that there were 56 cartoons of milk that expired on April 19, 2026, and were not discarded.Observations on April 20, 2026, at 6:10 a.m. in the main kitchen prep cooler revealed that there were six pies that were on Styrofoam plates that were open to the air. Interview with the Regional Dietary Manager on April 20, 2026, at 11:37 a.m. confirmed that the main cooler should have been below 41 degrees Fahrenheit, that the pies should have been sealed in such a way to prevent air from entering the food, and that expired food should have been removed from the main cooler.Observations on April 22, 2026, at 11:27 a.m. revealed a fan was blowing on three pans of apple crisp desert that were not covered. Interview with the Dietary Manager on April 22, 2026, at11:27 a.m. confirmed that there should not be a fan blowing on food prep area.28 Pa. Code 211.6(f) Dietary services.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to notify the resident and/or the resident's representative in writing regarding the reason for transfer to the hospital for six of 40 residents reviewed (Residents 7, 8, 9, 43, 67, and 81).Findings include: A nursing note for Resident 7, dated February 11, 2026, revealed that at 12:00 p.m. the resident had an unwitnessed fall. Resident 7 was yelling for help which staff responded to and found her sitting on the floor near her dresser. Resident 7 did not appear to hit her head, but stated her right arm hurt. A new order was received to send to the emergency for evaluation and treatment. A nursing note for Resident 7, dated April 2, 2026, revealed that at 12:55 p.m. the x-ray results showed the right elbow and shoulder showed a subacute displaced fracture in the right humerus (upper arm bone). A new order was received to send to the emergency for evaluation and treatment. Review of Resident 7's clinical record revealed that there was no documented evidence that the resident's representative or emergency contact were notified in writing of the purpose for the resident's transfer regarding her hospitalization of February 11, 2026 and April 2, 2026. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated March 8, 2026, indicated that the resident was cognitively impaired, required assistance from staff for her daily care needs and had diagnoses that included paralytic syndrome following cerebral infarction (persistent, bilateral muscle weakness or paralysis affecting both sides of the body as a long-term consequence of a stroke). A nursing note for Resident 8, dated March 12, 2026, revealed that at 12:10 a.m. the resident had increased shortness of breath and abdominal pain. The physician was notified and orders were obtained to transfer the resident to the hospital for evaluation. A nursing note dated March 12, 2026, at 5:10 a.m., revealed the resident was admitted to the hospital with a diagnosis of sepsis (a life-threatening reaction to an infection). Review of Resident 8's clinical record revealed that there was no documented evidence that the resident or the resident's responsible party were notified in writing of the reason for the resident's transfer to the hospital on March 12, 2026. A quarterly MDS assessment for Resident 9, dated February 12, 2026, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs and had diagnoses that included dementia. A nursing note for Resident 9, dated April 16, 2026, at 11:09 a.m. the resident had abnormal lung sounds irregular breathing. The physician was notified and orders were received to transfer her to the hospital for evaluation. A nursing note dated April 16, 2026, at 6:25 p.m. revealed that the resident was admitted to the hospital with diagnosis of atrial fibrillation (an irregular and often very rapid heart rhythm) and urinary tract infection. Review of Resident 9's clinical record revealed that there was no documented evidence that the resident or the resident's responsible party were notified in writing of the reason for the resident's transfer to the hospital on April 16, 2026. A quarterly MDS assessment for Resident 43, dated February 20, 2026, indicated that the resident was cognitively impaired, had limited range of motion to her upper and lower extremity on one side, required assistance from staff for daily care needs, had an indwelling urinary catheter (a thin, flexible tube inserted into the bladder to drain urine from the bladder), had a feeding tube (a mechanical device surgically implanted into the stomach to provide nutrition, fluids and medications), had a Stage 3 pressure ulcer (pressure wound involving the fat layers beneath the skin) present on admission, and had diagnoses including cerebral vascular accident (an event caused by poor blood flow or bleeding to in the areas of the brain) and hemiparesis and hemiplegia (paralysis or weakness to one side of the body due to brain injury) affecting right dominant side. A nursing note for Resident 43, dated March 24, 2026, at 1:02 p.m. revealed that the facility received a call from a nurse in the hospital emergency room stating that per the attending hospitalist, the resident had results of positive blood cultures of Staphylococcus epidermidis. The resident's physician was contacted, and orders were received to send the resident to the hospital for treatment of positive blood cultures. A nursing note for the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident, dated March 24, 2026, at 3:51 p.m. revealed that the resident was admitted with a diagnosis of bacteremia (the presence of bacteria in the bloodstream). Review of Resident 43's clinical record revealed that there was no documented evidence that the resident or the resident's responsible party were notified in writing of the reason for the resident's transfer to the hospital on March 24, 2026. A nursing note for Resident 67, dated April 15, 2026, revealed that at 9:15 a.m. the resident had a witnessed fall in the Bayside lounge and had no injuries at that time. A nursing note dated April 15, 2026, revealed that at 4:26 p.m. the therapy department reported that the resident was complaining of pain in her left hip during therapy. Physician was notified and ordered for the resident to have an x-ray of the left hip. A nursing note on April 15, 2026, at 7:38 p.m. revealed that had a left femoral neck fracture (left hip fracture) and was to be sent to the local hospital. Review of Resident 67's clinical record revealed that there was no documented evidence that the resident and legal guardian were notified in writing of the purpose for the resident's transfer regarding her hospitalization of April 15, 2026. A quarterly MDS assessment for Resident 81, dated February 12, 2026, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs and had diagnoses that included hemiplegia (severe or complete paralysis affecting one side of the body) or hemiparesis (one-sided muscle weakness) after a stroke. A nursing note for Resident 81, dated January 20, 2026, at 10:47 a.m. the resident was having stroke-like symptoms. She was evaluated by the physician, who provided orders to transfer the resident to the hospital for evaluation. A nursing note dated January 20, 2026, at 1:51 p.m. revealed that the resident was admitted to the hospital with diagnosis of stroke. Review of Resident 81's clinical record revealed that there was no documented evidence that the resident or the resident's responsible party were notified in writing of the reason for the resident's transfer to the hospital on January 20, 2026. Interview with the Nursing Home Administrator on April 22, 2026, at 11:02 a.m. confirmed that they were not completing written transfer letters to the families regarding the reason for transfer for the residents listed above. 28 Pa. Code 201.29(j) Resident Rights.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on a review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set (MDS) assessments for six of 40 residents reviewed (Residents 2, 10, 12, 34, 43, 57).Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (required assessments of a resident's abilities and care needs), dated October 2025, revealed that Section N0415K1 Anticoagulant was to be checked if the resident took the medication during the seven-day look-back period. Physician's orders for Resident 2, dated June 7, 2026, included an order for the resident to receive 500 milligrams (mg) of Divalproex Sodium (anticonvulsant) two times a day for seizure disorder. Review of the Medication Administration Record (MAR) for Resident 2, dated March 2026, revealed that staff administered the 500 mg of Divalproex two times a day from March 1 through March 31, 2026. However, a quarterly MDS assessment for Resident 2, dated, March 16, 2026, revealed that Section NO415K1 was not checked, indicating that the resident did not receive an anticoagulant medication during the seven-day look-back assessment period. Interview with Licensed Practical Nurse Assessment Coordinator on April 21, 2026, at 2:09 p.m. confirmed that Resident's 2 MDS was coded inaccurately. The RAI User's Manual, dated October 2025, revealed that Section P0100A Restraints used in bed: bedrails, was to be coded (0) if not used, (1) if used less than daily, and (2) if used daily during the seven-day look-back period. Review of Side Rail/Enabler Bar Assessments for Resident 10 dated January 30, 2026, and February 11, 2026, indicated that side rails/enabler bars were not indicated. There was no documented evidence that Resident 10 had side rails in place during the seven-day look-back period. However, a quarterly MDS assessment for Resident 10, dated February 12, 2026, revealed that Section P0100A was coded (2) to indicate that the resident used side rails daily. The RAI User's Manual, dated October 2025, revealed that Section N0415A1 Antipsychotic; N0415B1 Antianxiety; N0415G1; and N0415K1 was to be checked if the resident took the medication during the seven-day look-back period. Physician's orders for Resident 12 dated November 3, 2025 included orders for the resident to receive 250 mg of Seroquel (a antipsychotic) at bedtime for schizoaffective disorder; orders for the resident to receive 5 mg of buspirone (a antianxiety) two times a day for anxiety; orders for the resident to receive 40 mg of Furosemide (a diuretic) one time a day for edema, and orders for the resident to receive 0.5 mg Clonazepam (a antianxiety and anticonvulsant) two times a day for anxiety. Review of the Medication Administration Record (MAR) for Resident 12, dated February 2026, revealed that staff administered 250 mg of Seroquel at bedtime, 5 mg of Buspirone two times a day, 40 mg of Furosemide one time a day, and 0.5 mg of Clonazepam two times a day starting February 1, 2026, through February 28, 2026. A quarterly MDS assessment for Resident 12, dated, February17, 2026, revealed that Section NO415A1, N0415B1, N0415G1, and N0415K1 were not checked, indicating that the resident did not receive an antipsychotic, antianxiety, diuretic and anticonvulsant medication during the seven-day look-back assessment period. Interview with Licensed Practical Nurse Assessment Coordinator on April 21, 2026, at 2:09 p.m. confirmed that Resident 10 and 12's MDS was coded inaccurately. The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (required assessments of a resident's abilities and care needs), dated October 2025, revealed that Section N0415F1 Antibiotics were to be checked if the resident took the medication during the seven-day look-back period. Physician's orders for Resident 34, dated January 31, 2026, included an order for the resident to receive 100 mg of Doxycycline Hyclate (an antibiotic) two times a day for two days for urinary tract infection, and an order dated February 4, 2026 for the resident to receive 2% of Mupirocin (an antibiotic) one time a day to the right great toe ulcer. Review of the MAR and Treatment Administration Record (TAR) for Resident 34, dated February 2026, revealed that staff administered 100 mg of Doxycycline Hylcate two times a day and 2% of Mupirocin (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	one time a day starting February 1 through February 28, 2026. A quarterly MDS assessment for Resident 34, dated February 6, 2026, revealed that Section NO415F1 was not checked, indicating that the resident did not receive an antibiotic during the seven-day look-back assessment period. Interview with Licensed Practical Nurse Assessment Coordinator on April 21, 2026, at 2:09 p.m. confirmed that Resident's 34 MDS was coded inaccurately. The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (required assessments of a resident's abilities and care needs), dated October 2025, revealed that Section O0110H1B intravenous medications was to be checked if the resident received intravenous medications while a resident during the 14 day look-back period. Review of the MAR for Resident 43, dated February 2026, revealed that staff administered 1 gram of Meropenem intravenously every eight hours from February 2, 2026, through February 6, 2026. However, a quarterly MDS assessment for Resident 43, dated February 20, 2026, revealed that Section O0110H1B was coded, indicating that the resident received intravenous medications during the 14 day look-back assessment period. Interview with Licensed Practical Nurse Assessment Coordinator on April 22, 2026, at 10:42 a.m. confirmed that Resident 43's MDS was coded in error. The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (required assessments of a resident's abilities and care needs), dated October 2025, revealed that Section M0150 should be coded 0-?no' if the resident is not at risk for developing a pressure ulcer/injury, and coded 1- ?yes' if the resident is at risk for developing a pressure ulcer/injury. This answer is based on the items reviewed for determination of pressure ulcer risk in Section M0100 items A through Z; check M0100A if the resident has a Stage 1 or greater pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device; check M0100B if a formal assessment has been completed; check M0100C if the resident's risk for pressure ulcer/injury development is based on clinical assessment; and check M0100Z if none of the above apply. A quarterly MDS assessment for Resident 43, dated February 20, 2026, revealed that Section M0100A, M0100B, and M0100C were all checked indicating that the resident was at risk for developing a pressure ulcer/injury; however, Section M0150 was coded 0-?no', indicating that the resident was not at risk for developing a pressure ulcer/injury. Interview with the Nursing Home Administrator on April 23, 2026, at 2:15 p.m. indicated that the Licensed Practical Nurse Assessment Coordinator confirmed that Resident 43's MDS was coded in error. The RAI User's Manual, dated October 2025, revealed that Section N0415A1 Antipsychotic was to be checked (1) yes if the resident took the medication during the seven-day look-back period. Physician's orders for Resident 57 dated August 27, 2025, included for the resident to receive 50 milligrams (mg) of Seroquel (an antipsychotic medication) daily at bedtime. Physician's orders dated March 6, 2026, included for the resident to receive 25 mg of Seroquel two times a day for bipolar disorder. Review of the MAR for Resident 57 dated March 2026 revealed that 50 mg of Seroquel was administered daily at 9:00 p.m. and 25 mg of Seroquel was administered at 9:00 a.m. and 2:00 p.m. daily during the seven-day look-back period. However, a quarterly MDS assessment for Resident 57 dated March 29, 2026, indicated that Section N0415A1 Antipsychotic was checked (0) no, indicating that the Resident did not receive an antipsychotic medication during the seven-day look-back period. Interview with Licensed Practical Nurse Assessment Coordinator on April 21, 2026, at 2:09 p.m. confirmed that Resident 57's MDS was coded inaccurately. 28 Pa. Code 211.5(f) Medical records

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to develop and implement an individualized care plan for two of 40 residents reviewed (Residents 1, 2, and 43). Findings include: A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated February 3, 2026, revealed that the resident was cognitively impaired, required assistance from staff with daily care needs, received antipsychotic medications (medications used to treat mental health disorders), had a diagnosis of dementia, depression with severe psychosis and obsessive-compulsive disorder (a chronic mental health condition characterized by uncontrollable repeated thoughts and/or behaviors). A physician's order for Resident 1, dated January 16, 2026, included orders for the resident to receive o.25 milligrams (mg) of risperidone twice daily related to severe depression with psychotic features. There was no documented evidence that a care plan was developed to address Resident 1's use of antipsychotic medication. There was no documented evidence that a care plan was developed to address that the resident had dementia and cognitive impairment. Interview with the Assistant Director of Nursing on April 22, 2026, at 12:17 p.m. confirmed that Resident 1 did not have care plans developed to address her use of antipsychotic medication and to address her dementia with cognitive impairment. A quarterly MDS assessment for Resident 2, dated January 2, 2026, revealed that the resident was cognitively impaired, required assistance with daily care needs, and had medical diagnosis that included dementia and high blood pressure. Physician's orders for Resident 2 dated December 4, 2025, included an order for the resident to receive 40 milligrams of Furosemide, a diuretic medication used for edema. There was no documented evidence that a care plan was developed to address Resident 2's diuretic medication. Interview with Licensed Practical Nurse Assessment Coordinator dated April 23, 2026, at 11:22 a.m. confirmed that Resident 2 did not have a diuretic care plan and that he should have in place. A quarterly MDS assessment for Resident 43, dated February 20, 2026, indicated that the resident was cognitively impaired, had limited range of motion to her upper and lower extremity on one side, required assistance from staff for daily care needs, had an indwelling urinary catheter (a thin, flexible tube inserted into the bladder to drain urine from the bladder), had a feeding tube (a mechanical device surgically implanted into the stomach to provide nutrition, fluids and medications), had a Stage 3 pressure ulcer (pressure wound involving the fat layers beneath the skin) present on admission, and had diagnoses including cerebral vascular accident (an event caused by poor blood flow or bleeding to in the areas of the brain) and hemiparesis and hemiplegia (paralysis or weakness to one side of the body due to brain injury) affecting right dominant side. A physician's order for Resident 43, dated March 27, 2026, included orders for the resident to receive a 50 mg capsule of Nitrofurantoin Macrocrystal (an antibiotic) daily every Monday, Wednesday and Friday via her feeding tube for prophylaxis for urinary tract infections. There was no documented evidence that a care plan was developed to address Resident 43's long term use of antibiotic therapy for prophylaxis for urinary tract infections. Interview with the Nursing Home Administrator on April 23, 2026, at 11:39 a.m. confirmed that there was no documented evidence that a care plan was developed to address Resident 43's long term use of antibiotic therapy for prophylaxis for urinary tract infections. 28 Pa. Code 211.11(d) Resident care plan. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to provide medication as ordered by the physician, resulting in a significant medication error for two of 40 residents reviewed (Residents 44 and 73).Findings include:A facility policy for medication and treatment administration dated January 22, 2026, indicated that medications are administered in accordance with prescriber orders.A admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 44 dated January 12, 2026, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs and had diagnoses that included atrial fibrillation (a heart rhythm disorder characterized by a rapid and irregular heartbeat).A nursing note dated January 6, 2026, revealed that the resident was admitted to the facility as a hospice respite stay.Hospice medication orders for Resident 44 dated November 12, 2025, included physician's orders to administer 5mg of Jantoven (a blood thinner medication) once daily three times a week and administer 7.5 mg of Jantoven four times a week. A review of his Medication Administration Record (MAR) revealed that the facility did not clarify physician orders for Jantoven dose to be administered. The MAR revealed that the resident did not receive Jantoven on January 6, 2026, January 7, 2026, and January 8, 2026.Interview with the Director of Nursing on April 22, 2026, at 1:41 p.m. confirmed that Resident 44's Jantoven was not clarified by the physician and that the resident had missed three doses of Jantoven. A admission MDS assessment for Resident 73 dated April 14, 2026, revealed that the resident is cognitively intact, required assistance with daily care needs, and had medical diagnosis that included a nondisplaced fracture of right tibia (bone in lower leg). Physician orders for resident 73 dated April 9, 2026, included orders for the resident to receive 70 milligrams of Enoxaparin Sodium injection (an anticoagulant) to prevent deep vein thrombosis (a blood clot) one time a day. Observation on April 21, 2026, at 8:00 a.m. revealed that Licensed Practical Nurse 3 administered a prefilled 80 mg dose of Enoxaparin into Resident 73's abdomen.Interview with Licensed Practical Nurse 3 on April 21, 2026, at 8:05 a.m. confirmed that the Enoxaparin Sodium is an 80 mg prefilled syringe from pharmacy and that she administered the incorrect dose to Resident 73. Interview with the Director of Nursing on April 21, 2026, at 8:41 a.m. confirmed that the Licensed Practical Nurse 3 administered the Enoxaparin Sodium 80 mg prefilled syringe and did not follow physician's orders resulting in a medication error.28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on review of hospice contracts and clinical records, as well as staff interviews, it was determined that the facility failed to coordinate care with the hospice provider by failing to follow recommendations for changes in medications for one of 40 residents reviewed (Resident 38). Findings include: The Hospice contact, effective June 3, 2022, indicated that hospice and the facility shall communicate with one another regularly and as needed for each particular hospice patient. Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of the hospice patients are met 24 hours per day. If there are physician orders that are inconsistent with the hospice plan of care or hospice protocols, a nurse with facility shall notify hospice. An authorized representative of hospice shall resolve differences directly with the physician and secure the necessary orders. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 38, dated March 20, 2026, revealed that the resident was cognitively impaired, required assistance from staff with daily care needs, received antipsychotic and antianxiety medications, received hospice services, and had diagnoses including dementia, psychotic disorder, anxiety and depression. A care plan for the resident, dated January 8, 2025, indicated that the facility would coordinate care with the resident's hospice provider. Physician's orders for Resident 38, dated June 18, 2024, revealed that the resident was receiving hospice services effective June 19, 2024. A current physician's order for Resident 38, dated March 14, 2025, included orders for the resident to receive ABHR cream (a compounded topical medication often used in hospice for terminal agitation, anxiety, or nausea) containing 1 milligram (mg) of Ativan (an antianxiety medication used to treat anxiety/agitation) per 12.5 mg of Benadryl (an antihistamine used to treat nausea) per 2 mg of Haldol (an antipsychotic medication used to treat nausea/agitation) per 10 mg of Reglan (used to treat nausea). Apply to inner wrist topically twice daily for anxiety and psychosis. A hospice order for Resident 38, dated February 16, 2026, included orders for the resident to receive ABHR cream containing 1 mg of Ativan per 25 mg of Benadryl per 2 mg of Haldol per 10 mg of Reglan. Apply one syringe to wrist or neck every a.m. and p.m. for anxiety and agitation with care. A hospice order for Resident 38, dated April 13, 2026, included orders for the resident to receive ABHR cream containing 1 mg of Ativan per 25 mg of Benadryl per 2 mg of Haldol per 10 mg of Reglan. Apply one syringe to wrist or neck every a.m. and p.m. for anxiety and agitation with care. There was no documented evidence in Resident 38's clinical record that the hospice orders, dated February 16, 2026, and April 13, 2026, were transcribed into the resident's orders. Interview with the Nursing Home Administrator, dated April 23, 2026, at 1:01 p.m. confirmed that there was no documented evidence in Resident 38's clinical record that the hospice orders, dated February 16, 2026, and April 13, 2026, were transcribed into the resident's orders and they should have been. 28 Pa. Code 211.12(d)(3)(5) Nursing services.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on review of policies and clinical records, as well as observations and resident and staff interviews, it was determined that the facility failed to ensure that call bells were within reach for two of 40 residents reviewed (Residents 32 and 78).Findings include:A review of the facility policy for resident call system dated January 22, 2026, indicated that each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 32 dated February 6, 2026, indicated that the resident was sometimes understood and sometimes able to understand others, required assistance from staff for daily care needs and had diagnoses that included Parkinson's disease (brain condition that causes problems with movement, mental health, sleep, pain and other health issues) and dementia. Care plan for Resident 32 dated March 20, 2019, indicated that the resident had a self-care performance deficit and staff were to encourage the resident to use the call bell for assistance. An intervention dated February 10, 2021, indicated that staff where to assure the call pendant is in place and functioning properly. Observation of Resident 32 on April 20, 2026, at 9:00 a.m. revealed the resident lying in her bed with her call pendant on her nightstand on the left side of her bed, out of reach. An interview with the Director of Nursing at the time revealed that the resident was unable to use the call pendant and proceeded to place the call pendant in place around the resident's neck. During an interview with Resident 32 on April 20, 2026, at 9:05 a.m., when the resident was asked how she would call for a nurse, she replied push this button, and pointed to her call pendant.Interview with Resident 32 on April 21, 2026, at 3:21 p.m., when the resident was asked how she would call for a nurse, she replied they tell me there is a bell somewhere to use. Observations at that time revealed the resident was wearing a call pendant and had a tap bell on her overbed table that was not within reach. Interview with Licensed Practical Nurse 1 on April 22, 2026, at 1:04 p.m. revealed that the resident prefers to stay in bed and that she sometimes does use her call pendant to call for assistance if she wants something. An annual MDS assessment for Resident 78 dated March 20, 2026, indicated that the resident was usually understood and was usually able to understand others, required assistance from staff for daily care needs and had diagnosis that included dementia and stroke.Care plan for Resident 78 dated April 11, 2017, indicated that the resident had a self-care performance deficit and staff were to encourage the resident to use the call bell for assistance. Observation of Resident 78 on April 20, 2026, at 8:56 a.m. revealed the resident lying in his bed with his call pendant on his nightstand on the right side of his bed, out of reach. An interview with Nurse Aide 2 at the time of the observation revealed that the resident should have had his call pendant within reach. During an interview with Resident 78 on April 21, 2026, at 1:15 p.m., when the resident was asked how he would call for a nurse if needed, he showed me his call pendant hanging on his neck. Interview with the Director of Nursing on April 20, 2026, at 9:00 a.m. revealed that all residents that are able to use their call pendants should have them within reach. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for two of 40 residents reviewed (Residents 8 and 43).Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated March 8, 2026, indicated that the resident was cognitively impaired, required assistance from staff for her daily care needs and had diagnoses that included paralytic syndrome following cerebral infarction (persistent, bilateral muscle weakness or paralysis affecting both sides of the body as a long-term consequence of a stroke). Care plan for Resident 8 dated March 18, 2026, indicated that the Resident was receiving diuretic (medicines that help reduce fluid buildup in the body) therapy for edema (swelling caused by excess fluid trapped in the body's tissues) and staff were to administer diuretic medication as ordered by the physician. Review of the Medication Administration Record (MAR) for Resident 8 dated April 2026, revealed that the resident was not receiving diuretic medication during the time of the survey. Interview with the Director of Nursing on April 4, 2026, at 3:21 p.m. confirmed the Resident's care plan should have been revised when the diuretic was discontinued. A quarterly MDS assessment for Resident 43, dated February 20, 2026, indicated that the resident was cognitively impaired, had limited range of motion to her upper and lower extremity on one side, required assistance from staff for daily care needs, had an indwelling urinary catheter (a thin, flexible tube inserted into the bladder to drain urine from the bladder), had a feeding tube (a mechanical device surgically implanted into the stomach to provide nutrition, fluids and medications), had a Stage 3 pressure ulcer (pressure wound involving the fat layers beneath the skin) present on admission, and had diagnoses including cerebral vascular accident (an event caused by poor blood flow or bleeding to in the areas of the brain) and hemiparesis and hemiplegia (paralysis or weakness to one side of the body due to brain injury) affecting right dominant side. A care plan for Resident 43, dated March 24, 2026, indicated that the resident was receiving intravenous (administration of fluids and/or medications directly into a person's vein) medications related to an Extended-Spectrum Beta-Lactamase (ESBL-multi-drug resistant bacterial infection) infection in the urine. There was no documented evidence in the resident's clinical record that she was receiving intravenous medications. Interview with the Nursing Home administrator on April 23, 2026, at 11:39 a.m. confirmed that Resident 43's care plan should have been revised to reflect that she was no longer receiving intravenous medications. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on review of Pennsylvania's Nursing Practice Act and clinical records, as well as staff interviews, it was determined that the facility failed to clarify a provider's order for two of 40 residents reviewed (Resident 9, 34).Findings include:The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain and restore the well-being of individuals. A quarterly MDS assessment for Resident 9, dated February 12, 2026, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs and had diagnoses that included dementia.Physician's progress note for Resident 9 dated April 7, 2026, included that the resident was to have routine Tylenol for pain control. Physician's orders for Resident 9 dated November 12, 2024, indicated that the resident was to receive 500 milligrams (mg) of Acetaminophen (generic name for Tylenol), two tablets every eight hours as needed for pain. There was no documented evidence that physician's orders for Tylenol to be given routinely were implemented. Interview with the Assistant Director of Nursing on April 22, 2026, at 1:15 p.m. revealed that the order for routine Tylenol in the physician's progress note was missed, therefore it was not added to the resident's medication orders, and it should have been. A quarterly MDS assessment for Resident 34 dated February 6, 2026, revealed that the resident is cognitively impaired, required assistance with daily care needs, and had medical diagnosis that included diabetes mellitus and cellulitis of the right lower limb.Physician's orders for Resident 34 dated February 4, 2026, included orders for 2% Mupirocin ointment apply to right great toe ulcer one time a day for wound care. Physician orders dated April 3, 2026, included orders to cleanse right great toe diabetic ulcer with wound cleanser, apply Iodosorb ointment to wound bed and surrounding callus area, and cover with dry dressing and secure with rolled gauze daily.A wound consultant note for Resident 34 dated April 1, 2026, indicated that the Certified Registered Nurse Practitioner recommended that staff cleanse the right great toe wound with wound cleaner, apply Iodosorb ointment to wound bed and surrounding callus area, then cover with a dry dressing and secure with rolled gauze change daily. Review of the Treatment Administration Record for Resident 34, dated April 2026, revealed that the resident was receiving two separate wound treatments to the same right great toe wound.Interview with the Director of Nursing on April 22, 2026, at 1:41 p.m. confirmed that Resident 34 was receiving two wound treatment orders and that the order for Mupirocin ointment should have been discontinued and the wound consultant recommendation should have been followed.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. Based on review clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that residents were provided with proper colostomy care for one of 40 residents reviewed (Resident 16).Findings include:The facility's policy regarding colostomy care (care for an artificial opening in the bowel), dated January 22, 2026, colostomy care will be provided per physician orders to provide the stoma with good skin care and check the condition of the stoma and surrounding skin.An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 16 dated March 17, 2025,indicated that the resident was cognitively impaired, required assistance from staff for daily care needs, had medical diagnosis that included intellectual disabilities and had an ostomy (a surgically created opening in the abdomen for bowel elimination. A review of Resident 16's clinical record revealed that there was no physician order for the resident colostomy size or orders to change the colostomy appliance. Interview with the Nursing Home Administrator on April 22, 2026, at 9:35 a.m. confirmed that there was no physician order for the ostomy size and that there was no documented evidence that colostomy appliance was being changed for Resident 16.28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents who were receiving enteral feedings (delivers liquid nutrients directly into the stomach) received appropriate treatment and services to prevent complications for one of 40 residents reviewed (Resident 43). Findings include: A facility policy for feeding tubes, dated January 22, 2026, indicated that the licensed practical nurse will change feeding tube dressings at least every 24 hours unless the physician's orders say otherwise and they are to document the dressing change in the resident's chart. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 43, dated February 20, 2026, indicated that the resident was cognitively impaired, had limited range of motion to her upper and lower extremity on one side, required assistance from staff for daily care needs, had an indwelling urinary catheter (a thin, flexible tube inserted into the bladder to drain urine from the bladder), had a feeding tube (a mechanical device surgically implanted into the stomach to provide nutrition, fluids and medications), had a Stage 3 pressure ulcer (pressure wound involving the fat layers beneath the skin) present on admission, and had diagnoses including cerebral vascular accident (an event caused by poor blood flow or bleeding to in the areas of the brain) and hemiparesis and hemiplegia (paralysis or weakness to one side of the body due to brain injury) affecting right dominant side. Physician's orders for Resident 43, dated August 19, 2025, included orders to cleanse the feeding tube site with normal saline (a sterile solution used for the moistening of wound dressings and wound debridement), pat dry and apply drain sponge (specialized wound gauze used around tubes, drains and catheters) daily and as needed for soilage or dislodgement. Review of Resident 43's Treatment Administration Record (TAR) for August 2025 through December 2025, and for March and April 2026, revealed that there was no documented evidence that the resident's feeding tube site care was completed as ordered on August 19, 20, 22, and 24; September 15, 16, 19, and 29; October 4, 5, 8, 9, and 13; November 30; December 27; March 21, 29, 31; April 9, 13, 17, and 19. Interview with the Assistant Director of Nursing on April 22, 2026, at 10:42 a.m. confirmed that there was no documented evidence that Resident 43's feeding tube site care was completed as ordered on the above-mentioned dates. 28 Pa. Code 211.12(d)(3)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, and staff interviews, it was determined that the facility failed to provide a separately locked, permanently affixed compartment in the refrigerator for the storage of controlled drugs (medications with the potential to be abused) in one of two medication rooms reviewed. Findings include:Observations in the facility's medication room on the Landings unit on April 22, 2026, at 1:11 p.m. revealed one small, locked refrigerator containing five bottles of liquid Ativan (a controlled medication used to treat anxiety). The liquid Ativan was not in a secured, locked compartment separate from other non-narcotic medications. Interview with Licensed Practical Nurse 1 at the time of the observation confirmed that the five bottles of liquid Ativan were not in a secured, locked compartment separate from other non-narcotic medications. Interview with the Nursing Home Administrator on April 22, 2026, at 1:40 p.m. confirmed the five bottles of liquid Ativan were not in a secured, locked compartment separate from other non-narcotic medications. 28 Pa. Code 211.9(a)(1) Pharmacy Services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395702	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Ridge	1515 Wayne Avenue Indiana, PA 15701

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on a review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that laboratory services were obtained as ordered by the physician for one of 40 residents reviewed (Resident 57).Findings include:Facility policy for Laboratory Services dated January 22, 2026, indicated that the facility will provide or obtain laboratory services to meet the needs of the residents, and will promote practices to ensure the quality and timeliness of laboratory services. The day shift unit nurse will fill out and send laboratory requests for newly ordered laboratory tests. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 57, dated March 29, 2026, indicated that the resident was cognitively intact, was independent with daily care needs, and had a history of urinary tract infection. Nurse's note for Resident 57 dated February 24, 2026, at 1:31 p.m. revealed that the resident complained of burning and pain on urination, that the physician was notified, and orders were received to obtain a UA flex to culture (diagnostic test that performs a standard urine analysis first, and automatically orders a urine culture if specific indicators of infection are present) to rule out a urinary tract infection.Nurse's note for Resident 57 dated February 24, 2026, at 5:58 p.m. revealed that the physician was notified of the urinalysis results and ordered 100 milligrams (mg) of Macrobid (an antibiotic) to be given twice a day for seven days pending the culture and sensitivity (C&S- laboratory procedure that identifies infectious germs (culture) and determines the most effective antibiotic (sensitivity) to treat the infection) results. Review of Resident 57's lab results for February 2026 revealed no documented evidence that a C&S was obtained from the resident's urine sample on February 24, 2026, as ordered by the physician. Interview with the Nursing Home Administrator on April 23, 2026, at 10:25 a.m. revealed that a urine C&S was not obtained for Resident 57 as ordered and it should have been. Interview with the Nursing Home Administrator on April 23, 2026, at 11:30 a.m. revealed that the order for laboratory services that were to be obtained on Resident 57's urine sample on February 24, 2026, was transcribed wrong and therefore a urine C&S was never completed by the lab.28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.