

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395719	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Riverside Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 8th Street McKeesport, PA 15132	
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 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 a review of facility policies, observations, and staff interviews, it was determined that the facility failed to properly label and date food, clean and sanitize food service items/dishes, and maintain cleanliness in the Main Kitchen. Findings include: Review of the Dietary Services policy, Sanitation dated 9/12/25, indicated food and nutrition services staff will maintain a clean and sanitary environment in food services areas through compliance with a written, comprehensive cleaning schedule. During an observation of the Main Kitchen on 1/6/26, at 9:05 a.m. revealed the following: -Dishwasher was not reaching temperature to effectively sanitize. -Plate warmer was not operational. -Hole in the ceiling related to a pipe burst. Hole was covered with plastic and pipe was fixed. -Styrofoam was being used to serve the residents. During an interview at this time, Dietary Manager Employee E40 confirmed that they were using Styrofoam to serve the residents due to the dishwasher and plate warmer not being in working order. During a second observation of the Main Kitchen on 1/7/26, at 1:48 p.m. the following was observed: -Hole in the ceiling now had two fans placed in the ceiling with extension cords hanging down from the hole. -Dehumidifier was placed in the kitchen to remove excess moisture. -Three-compartment sink in the food preparation area was noted to have drainage hose from the dehumidifier wrapped around the facet. The drainage hose was attached to the dehumidifier on the floor, along to the three-compartment sink, and then down to the drain. During an interview at this time, Dietary Manager Employee E40 confirmed that dehumidifier and fans were placed by the restoration company due to the discovery of free-standing water behind the wall. During an interview on 1/15/26, at approximately 12:30 p.m. the Nursing Home Administrator confirmed that the facility failed to properly label and date food, clean and sanitize food service items/dishes, and maintain cleanliness in the Main Kitchen and one of two nursing unit nutrition rooms. 28 Pa. Code: 211.6(c) Dietary services.		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on review of facility policy, observations, and resident and staff interviews, it was determined that the facility failed to provide concern forms assessable to resident's and visitor's from a wheelchair on one of six nursing units (700 Hall Memory Unit), failed to have a grievance box and forms accessible for four of four grievance boxes (Front Hall, Activities Room, Nurses Station 1, and Nurses Station 2) and failed to provide residents with the grievance official contact information (name, business address, email address, and business telephone number) for three of four grievance boxes (Nurses Station 1, Nurses Station 2, and 700 Hall Memory Unit). Findings include: A review of facility policy Resident Grievances and Concerns dated 9/12/25, indicated the facility recognizes that residents have the right to voice grievances to the facility, or other agencies or entities that hear grievances, without discrimination or reprisal and without fear of discrimination or reprisal. The facility will make available to all residents via a posting in a prominent location in the facility, information of the right to file grievances orally or in writing; the right to file grievances anonymously; contact information for the Grievance Official; a reasonable time frame for completing the review of the grievance; the right to obtain a written decision regarding the grievance; and contact information of independent entities with whom grievances may be filed (e.g., State agency, Quality Improvement Organization, State Long-Term Care Ombudsman Program or protection and advocacy system). During an observation on 1/6/26, at 12:40 p.m. revealed a grievance box in the front lobby blocked by two wheelchairs. During an interview on 1/6/26, at 12:43 p.m. Licensed Practical Nurse (LPN) Employee E13 stated residents can get grievance forms from the nurses at the nurses' stations. She stated the residents must ask for the grievance forms from staff, because they are kept behind the desk at both nurse's stations. During an observation on 1/6/26, at 12:43 p.m. revealed a grievance box located in the Activity Room blocked by storage items (a folded table, boxed room divider, empty yellow PPE (personal protective equipment) cart, an over-the-bed table, and a laundry bin used for soiled bibs. The grievance official name and contact information was not posted. During an interview on 1/6/26, at 12:50 p.m. LPN Employee E11 stated a grievance box was in the front lobby, or she would ask the supervisor, and point the resident in the correct direction. During an observation on 1/6/26, at 2:00 p.m. the grievance box and forms located in the 700 Hall Memory Unit were over 51 inches from the floor, making them assessable from a wheelchair. During an interview on 1/6/26, at 2:00 p.m. Social Worker Employee E3 confirmed residents and visitors did not have access to file a grievance due to items blocking the boxes, forms not readily available, and a box not accessible from a wheelchair. 28 PA Code: 201.18(e)(4) Management. 28 PA Code: 201.29(a)(b)(c) 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 review of the Resident Assessment Instrument User's Manual and clinical records, and staff interview, it was determined that the facility failed to make certain that comprehensive Minimum Data Set assessments were accurate and fully completed for seven of thirteen residents (Resident R1, R50, R89, R94, R95, R103, and R114). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set Assessments (MDS - periodic assessment of care needs) dated October 2025, indicated that Section C: Cognitive Patterns, Question C0100 Should Brief Interview for Mental Status Be Conducted? (BIMS) should be coded as 0 if the resident is rarely/never understood, or it should be coded 1, and the BIMS assessment should be completed if the resident is at least sometimes understood. Section D: Mood, Question D0100 Should Resident Mood Interview Be Conducted? should be coded as 0 if the resident is rarely/never understood, and or it should be coded 1, and the assessment should be completed if the resident is at least sometimes understood. Resident R1 had an MDS completed on 11/29/25. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R1 was understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R1 is rarely understood, and the BIMS assessment was not completed. Resident R50 had an MDS completed on 11/28/25. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R50 was usually understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R50 is rarely understood, and the BIMS assessment was not completed. Review of Section D: Mood, Question D0100 indicated that Resident R50 is rarely understood, and the Resident Mood Interview was not completed. Resident R89 had an MDS completed on 11/21/25. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R89 is usually understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R89 is rarely understood, and the BIMS assessment was not completed. Resident R94 had an MDS completed on 12/20/25. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R94 is sometimes understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R94 is rarely understood, and the BIMS assessment was not completed. Review of Section D: Mood, Question D0100 indicated that Resident R94 is rarely understood, and the Resident Mood Interview was not completed. Resident R95 had an MDS completed on 10/20/25. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R95 is understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R95 is rarely understood, and the BIMS assessment was not completed. Review of Section D: Mood, Question D0100 indicated that Resident R95 is rarely understood, and the Resident Mood Interview was not completed. Resident R103 had an MDS completed on 12/9/25. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R103 is understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R103 is rarely understood, and the BIMS assessment was not completed. Resident R114 had an MDS completed on 12/14/25. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R114 is understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R114 is rarely understood, and the BIMS assessment was not completed. During an interview on 1/8/26, at approximately 1:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to make certain that comprehensive Minimum Data Set assessments were accurate and fully completed for seven of thirteen residents 28 Pa. Code: 211.5(f) Clinical records.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to make certain controlled substances were accounted for accurately for seven of thirteen residents (Resident R1, R5, R32, R53, R60, R113, R115). Findings include: Review of the facility policy General Dose Preparation and Medication Administration dated 9/12/25, indicated for staff to Document the administration of controlled substances in accordance with applicable law. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2025, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aids in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of the clinical record revealed that Resident R53 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of care needs) dated 12/23/25, included diagnoses of coronary artery disease (CAD, damage or disease in the heart's major blood vessels) and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time. Review of Section C revealed Resident R1's BIMS score to be 15. Review of a physician's order dated 1/1/26, indicated Resident R53 received hydromorphone (narcotic pain medication) 4 mg three every four hours as needed for pain. During an interview and observation on 1/6/26, at approximately 8:30 a.m. Licensed Practical Nurse (LPN) Employee E5 reviewed the electronic medication administration record (MAR) and noted that Resident R53 was not documented as having received hydromorphone since 1/5/26, at 3:59 p.m. LPN Employee E5 stated she was told in report that Resident R53 had been given hydromorphone just prior to shift change (7:00 a.m.). Review of Resident R53's MAR revealed that hydromorphone 4 mg was signed out on the paper controlled medication utilization record (sign-out sheet) on 1/6/26, at 2:50 a.m. and 6:55 a.m. During an interview on 1/6/26, at approximately 8:35 a.m. when asked if he received pain medication throughout the night, Resident R53 stated he probably slept the middle of the night dose, and he might have gotten the dose before shift change. Further review of Resident R53's sign-out sheet, from 1/2/26, through 1/6/26, revealed additional doses of hydromorphone signed out on paper and not documented in the electronic medical record: 01/02/26: 4 mg at 4:10 a.m. 01/02/26: 4 mg at 1:45 p.m. 01/03/26: 4 mg at 9:06 p.m. 01/05/26: 4 mg at 10:35 a.m. 01/05/26: 4 mg at 6:30 p.m. 01/05/26: 4 mg at 10:45 p.m. Review of Resident R1's sign-out sheet, from 11/27/25, through 1/5/26, revealed additional doses of oxycodone (narcotic pain medication) signed out on paper and not documented in the electronic medical record: 11/29/25: 5 mg at 9:30 a.m. 12/04/25: 5 mg at 10:17 p.m. 12/05/25: 5 mg at 12:00 p.m. 12/18/25: 5 mg at 9:18 a.m. 12/20/25: 5 mg at 12:27 p.m. 01/05/26: 5 mg at 9:00 p.m. Review of Resident R5's sign-out sheet, from 12/19/25, through 1/5/26, revealed additional doses of oxycodone signed out on paper and not documented in the electronic medical record: 12/20/25: 5 mg at 6:00 a.m. Review of Resident R32's sign-out sheet, from 1/3/26, through 1/6/26, revealed additional doses of oxycodone signed out on paper and not documented in the electronic medical record: 01/04/26: 2.5 mg at 11:00 a.m. 01/05/26: 2.5 mg at 2:40 p.m. Review of Resident R60's sign-out sheet, from 12/12/25, through 1/5/26, revealed additional doses of tramadol (narcotic pain medication) signed out on paper and not documented in the electronic medical record: 12/12/25: 50 mg at 7:00 a.m. 12/12/25: 50 mg at 1:00 p.m. 12/17/25: 50 mg at 9:00 a.m. 12/17/25: 50 mg at 9:00 p.m. 12/18/25: 50 mg at 6:30 p.m. 12/20/25: 50 mg at 9:00 a.m. 12/22/25: 50 mg at 9:30 a.m. 12/24/25: 50 mg at 9:00 a.m. 12/29/25: 50 mg at 9:00 a.m. 01/01/26: 50 mg at 3:00 p.m. 01/02/26: 50 mg at 10:30 a.m. 01/03/26: 50 mg at 10:00 a.m. 01/05/26: 50 mg at 9:00 a.m. Review of Resident R113's sign-out sheet, from 12/12/25, through 1/5/26, revealed additional doses of tramadol signed out on paper and not documented in the electronic medical record: 12/15/25: 50 mg at 9:00 a.m. 12/17/25: 50 mg at 9:00 a.m. 12/29/25: 50 mg (no time documented). 01/02/26: 50 mg at 8:30 p.m. 01/05/26: 50 mg at 9:00 a.m. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R115's sign-out sheet, from 12/11/25, through 1/5/26, revealed additional doses of oxycodone signed out on paper and not documented in the electronic medical record:12/15/25: 5 mg at 9:30 a.m.12/16/25: 5 mg at 8:00 p.m.12/17/25: 5 mg at 10:00 p.m.12/22/25: 5 mg at 9:13 p.m.12/24/25: 5 mg at 8:15 p.m.12/28/25: 5 mg at 9:00 p.m.12/31/25: 5 mg at 9:00 p.m.01/05/26: 5 mg at 10:30 p.m. During an interview on 1/8/25, at approximately 1:30 p.m. the Nursing Home Administrator confirmed that the facility failed to make certain controlled substances were accounted for accurately for seven of thirteen residents. 28 Pa. Code: 211.12 (d)(1)(5) Nursing services.28 Pa. Code: 201.29(j) Resident rights.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, observations, and staff interviews, it was determined that the facility failed to make certain that medications and medical supplies were properly stored and/or disposed of in two of three medication rooms (700-Hall medication room and [DATE]-Hall medication room). Findings include: Review of the facility policy Storage and Expiration Dating of Medications and Biologicals dated [DATE], indicated, Facility should ensure medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier. During an observation on [DATE], at 2:18 p.m. of the 700-Hall medication room, the following was noted: (5) Packages of Xeroform with an expiration date of [DATE]. (8) Packages of oil emulsion dressings with an expiration date of 05/2023 (2) Central Line Dressing Trays with an expiration date of [DATE] (2) Luer Lock Y-Sites with an expiration date of [DATE]. (1) Administration Sets with an expiration date of [DATE]. (4) IV Start Kits with an expiration date of [DATE]. (10) Injection Site Ultrasite with an expiration date of [DATE]. (8) IV Catheters with an expiration date of [DATE]. (4) IV Catheters with an expiration date of [DATE]. (2) IV Extension Sets with an expiration date of [DATE]. Open and partially used vial of Tubersol, without an open date. During an observation on [DATE], at 2:30 p.m. of the Emergency Cart located in the 700-Hall medication room, the following was noted: (3) Yankauer with an expiration date of [DATE]. (1) Dressing Change Kits with an expiration date of [DATE]. (1) Central Line Dressing Change Kit with an expiration date of [DATE]. (1) IV Start Kit with an expiration date of [DATE]. (1) Luer Lock Y-Sites with an expiration date of [DATE]. (1) Bottles of sterile normal saline with an expiration date of [DATE]. (2) Bottles of sterile normal saline with an expiration date of [DATE]. (1) Bottles of sterile water with an expiration date of [DATE]. (4) IV Catheters with an expiration date of [DATE]. (1) Injection Site Ultrasite with an expiration date of [DATE]. (4) Heparin flushes with an expiration date of [DATE]. During an interview on [DATE], at approximately 2:45 p.m. the Registered Nurse Employee E6 confirmed the expired items in the 700-Hall medication room. During an observation on [DATE], at 11:00 a.m. of the [DATE]-Hall medication room, the following was noted: (73) 3ml syringes with an expiration date of 01/2022. (4) vials of lidocaine 1% with an expiration date of 08/2025. (5) culture swabsticks with an expiration date of [DATE]. (7) IV Catheters with an expiration date of [DATE]. (2) IV Catheters with an expiration date of [DATE]. (1) Vacutainer with an expiration date of [DATE]. (9) pH test kits with an expiration date of [DATE]. (2) pH test kits with an expiration date of [DATE]. (2) Containers for coagulation test kits with an expiration date of [DATE]. During an interview on [DATE], at 11:06 a.m. the Assistant Director of Nursing confirmed the expired items in the [DATE] medication room. During an interview on [DATE], at approximately 11:20 a.m. the Director of Nursing and the Nursing Home Administrator confirmed the facility failed to make certain that medications and medical supplies were properly stored and/or disposed of in two of three medication rooms. 28 Pa. Code: 201.14 (a) Responsibility of Licensee. 28 Pa. Code: 201.18 (b)(1)(e)(1) Management. 28 Pa. Code: 211.19 (a)(1) Pharmacy services. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.		

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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 Quality Assurance attendance records, and staff interview, it was determined that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all the required committee members for two of four quarterly meetings (second and third quarters). Findings Include: Review of Quality assurance and Performance Improvement sign in sheets and attendance records for 2025, failed to reveal a quarterly meeting with at least three other staff, one of whom must be the facility's administrator, owner, board member, or other individual in a leadership role who has knowledge of facility systems and the authority to change those systems. During an interview on 1/8/26, at 12:20 p.m. the Nursing Home Administrator confirmed that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all the required committee members for two of four quarterly meeting (second and third quarters), as required.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on facility policy, observations, and staff interviews it was determined that the facility failed to prevent the potential for cross-contamination during medication administration for two of four Licensed Practical Nurses (LPN) (Employees E5 and E11). Review of facility General Dose Preparation and Medication Administration dated 9/12/25, indicated, Medications should not come in contact with any surface except for the medication cup and, Facility staff should avoid touching the medication with bare hands when opening a bottle or unit dose package. During an observation on 1/6/26, at approximately 8:30 a.m. LPN Employee E5 was observed opening bottles of over the counter medications, pouring the tablets into the palm of her hand, then placing the tablets in the medication cup. During an observation on 1/8/26, at approximately 9:00 a.m. LPN Employee E1 was observed popping the tablets/capsules from the medication blister packs into the palm of her hand, then placing the tablets in the medication cup. During an interview on 1/8/26, at approximately 1:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to prevent the potential for cross-contamination during medication administration for two of four Licensed Practical Nurses.		

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on review of facility personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on infection control for two of ten staff members (Nurse Aide Employee E9 and Dietary Aide Employee E10). Findings include: Review of facility provided documents and training records revealed the following staff members did not have documented training on infection control. Nurse Aide (NA) Employee E9 had a hire date of 7/1/23, failed to have infection control in-service education between 7/1/24, and 7/1/25. Dietary Employee E10 had a hire date of 7/1/23, failed to have infection control in-service education between 7/1/24, and 7/1/25. During an interview on 1/8/26, at approximately 1:30 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on infection control for two of ten staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and observation, it was determined that the facility failed to provide an environment and care to promote dignity during medication administration for each resident's quality of life for one of four residents observed (Resident R52). Findings: Review of facility policy General Dose Preparation and Medication Administration reviewed 9/12/25, indicated during medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: 5.6 - Observe each resident's privacy and rights in accordance with applicable law (e.g., knocking before entering the room, pulling privacy curtains, informing resident what is to occur before administration, blocking unnecessary access to the MAR [Medication Administration Record]). Review of facility policy Resident Rights and Facility Responsibilities Policy reviewed 9/12/25, indicated it is the facility's policy to comply with all Resident's Rights. Staff will receive education on Resident's Rights upon hire and annually thereafter. Review of the Resident's Rights required by Title XIX of the Social Security Act of 1965, indicated Privacy: You have the right to privacy with regards to accommodations, medical treatment, written and telephone communications, visits and meetings with family and other resident groups. Review of the clinical record indicated Resident R52 was admitted to the facility on [DATE], with diagnoses that included dementia (decline in memory, thinking, and social abilities, and daily functioning), depression, and diabetes. Review of the Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated 12/29/25, indicated the diagnoses remain current. During an observation on 1/7/25, at 10:31 a.m. Licensed Practical Nurse (LPN) Employee E1 was observed administering Resident R52's medications in the Activities Room, during an ongoing activity with other residents nearby in the same activity. During an interview on 1/7/25, at 10:33 a.m. Licensed Practical Nurse (LPN) Employee E1 stated she did not think Resident R52 had a physician order to dispense medication in a common room. Review of physician orders for Resident R52 failed to indicate medications are allowed to be administered in a common room. Review of the electronic Medication Administration Record (eMAR) on 1/7/26, indicated LPN Employee E1 administered the following medications to Resident R1: -Escitalopram 5 mg (milligram), one tablet by mouth (for depression)-Metformin 500 mg, one tablet by mouth (for diabetes)-Miralax 17 grams, one dose (for constipation)-Omeprazole 20 mg, one tablet by mouth (for acid reflux)-Senna 8.6 mg, two tablets by mouth (for constipation)-Multivitamin with Iron, one tablet by mouth (supplement) Review of the care plan failed to indicate Resident R52 gave consent to receive medications administered in common areas. During an interview on 1/7/26, at 2:00 p.m. the Director of Nursing confirmed the facility failed to provide an environment and care to promote privacy and dignity for Resident R52.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, facility documents, and staff interviews, it was determined that the facility failed to provide in a timely manner, notice of Medicare non coverage (payment) for one of three residents (Resident R600). Findings include: The form Notice Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123 indicated a Medicare provider/plan must deliver a completed copy of the NOMNC to beneficiaries/enrollees receiving covered skilled nursing, home health, comprehensive outpatient rehabilitation facility, and hospice services. The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to the last day or services if care is not being provided daily. Review of the clinical record revealed Resident R600 was admitted to the facility on [DATE], with diagnoses that included high blood pressure, muscle weakness, and GERD (acid reflux). Resident R600 discharged home with home health services on 12/5/25. During an interview on 1/7/26, at 1:40 p.m. Field Medicaid Specialist Employee E12 was unable to provide a signed copy of the NOMNC for Resident R600. Field Medicaid Specialist Employee E12 confirmed the NOMNC should have been completed and available for review. 28 Pa. Code: 201.29(e) Resident rights.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, observations, and staff interviews, it was determined that the facility failed to ensure equipment was in safe operating condition for one of two crash carts (carts maintained with equipment used in emergencies) (700-Hall crash cart). Findings include: Review of the facility policy Emergency Equipment Check Policy dated 9/12/25, indicated, Emergency equipment/cart[s] will be checked daily and items which are outdated or opened will be replaced. During an observation on 1/6/26, at 2:30 p.m. of the Emergency Cart located in the 700-Hall medication room, the following was noted: (3) Yankauer with an expiration date of 2/28/24. (1) Dressing Change Kits with an expiration date of 3/20/25. (1) Central Line Dressing Change Kit with an expiration date of 1/31/24. (1) IV Start Kit with an expiration date of 6/30/25. (1) Luer Lock Y-Sites with an expiration date of 4/13/22. (1) Bottles of sterile normal saline with an expiration date of 9/1/25. (2) Bottles of sterile normal saline with an expiration date of 10/1/25. (1) Bottles of sterile water with an expiration date of 6/1/23. (4) IV Catheters with an expiration date of 7/31/23. (1) Injection Site Ultrasite with an expiration date of 10/31/23. (4) Heparin flushes an expiration date of 12/31/24. During an interview on 1/6/26, at approximately 2:45 p.m. the Registered Nurse Employee E6 confirmed the expired items in the 700-Hall crash cart. Review of the Crash Cart MIU (memory impaired unit, 700-Hall) [DATE] checklist indicated that the crash cart had been checked daily, and all items were marked as present. No documentation was noted to indicate expired medications or supplies. During an interview on 1/7/26, at approximately 11:20 a.m the Director of Nursing and the Nursing Home Administrator confirmed the facility failed to ensure equipment was in safe operating condition for one of two crash carts. 28 Pa. Code: 201.14 (a) Responsibility of Licensee. 28 Pa. Code: 201.18 (b)(1)(e)(1) Management. 28 Pa. Code: 211.19 (a)(1) Pharmacy services. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.		

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of facility policy, staff education records, and staff interviews, it was determined that the facility failed to conduct at least 12 hours of in-service education, within 12 months of their hire date anniversary, for nurse aides as required for two of five nurse aides (Nurse Aide Employees E8 and E9). Findings include: Review of facility provided documents and training records revealed the following staff members did not have 12 hours of in-service education: NA Employee E8 had a hire date of 7/1/23, with 4.10 hours of in-service education between 7/1/24, and 7/1/25. NA Employee E9 had a hire date of 7/1/23, with 0.00 hours of in-service education between 7/1/24, and 7/1/25. During an interview on 1/8/26, at approximately 1:30 p.m. the Nursing Home Administrator confirmed that the facility failed to conduct at least 12 hours of in-service education, within 12 months of their hire date anniversary, for nurse aides as required for two of five nurse aides.		

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interview, it was determined that the facility to ensure that the resident and/or their representative received written notice of the facility bed-hold policy at the time of transfer for two of three residents reviewed for hospitalization. (Residents R1 and R102). Findings Include: Review of federal regulation S483.15(d) Notice of Bed-Hold Policy, indicated, facilities must provide written information about these policies to residents prior to and upon transfer for such absences. This information must be provided to all facility residents, regardless of their payment source. These provisions require facilities to issue two notices related to bed-hold policies. The first notice could be given well in advance of any transfer, i.e., information provided in the admission packet. Reissuance of the first notice would be required if the bed-hold policy under the State plan or the facility's policy were to change. The second notice must be provided to the resident, and if applicable the resident's representative, at the time of transfer, or in cases of emergency transfer, within 24 hours. It is expected that facilities will document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative. The notice must provide information to the resident that explains the duration of bed-hold, if any, and the reserve bed payment policy. It should also address permitting the return of residents to the next available bed. Review of facility Bed Hold Policy dated 9/12/25, indicated, It is the policy of the facility to track Medicaid bed hold days and notify appropriate parties via Medicaid Bed Hold Letter. Review of the clinical record indicated Resident R1 was readmitted to the facility on [DATE]. Review of Resident R1's minimum data set (MDS, periodic assessment of resident care needs) dated 11/29/25, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Section C: Cognitive Patterns indicated Resident R1 had moderate cognitive impairment. Review of a progress note dated 9/26/25, at 9:59 a.m. indicated that Resident R1 was transported to the hospital for out-of-range laboratory blood work. Review of a progress note dated 10/20/25, at 10:36 a.m. indicated that Resident R1 was transported to the hospital for malodorous drainage into wound vac. Further review of Resident R1's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the resident or resident representative upon transfer on 9/26/25, and 10/20/25. Review of the clinical record indicated Resident R102 was admitted to the facility on [DATE]. Review of Resident R102's MDS dated [DATE], included diagnoses of Alzheimer ' s disease (a type of brain disorder that causes problems with memory, thinking and behavior) and Parkinsonism (group of neurological disorders characterized by tremors, stiffness, slowness of movement, and difficulty maintaining balance). Review of Section C: Cognitive Patterns indicated Resident R102 had moderate cognitive impairment. Review of a progress note dated 9/26/25, at 6:48 p.m. indicated CNA (nurse aide) went in resident room to check on resident, resident had removed clothes, binder was in place, resident had pulled out peg tube. RNS (registered nurse supervisor) notified. MD (doctor of medicine) notified and ordered for resident being sent out for peg tube replacement. Further review of Resident 44's clinical record failed to reveal notation that the written notice of bed hold notification was provided to the resident or resident representative upon transfer. During an interview on 1/8/26, at approximately 12:20 p.m. the Nursing Home Administrator confirmed the facility failed to ensure that the resident and/or their representative received written notice of the facility bed-hold policy at the time of transfer for two of three residents reviewed for hospitalization. 28 Pa. Code 201.14(a) Responsibility of licensee		

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F 0942 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. Based on review of facility personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on resident rights for three of ten staff members (Employee E8, E9, and E10). Findings include: Review of facility provided documents and training records revealed the following staff members did not have documented training on resident rights. Nurse Aide (NA) Employee E8 had a hire date of 7/1/23, failed to have effective communication in-service education between 7/1/24, and 7/1/25. Nurse Aide (NA) Employee E9 had a hire date of 7/1/23, failed to have effective communication in-service education between 7/1/24, and 7/1/25. Dietary Employee E10 had a hire date of 7/1/23, failed to have effective communication in-service education between 7/1/24, and 7/1/25. During an interview on 1/8/26, at approximately 1:30 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on effective communication for three of ten staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.		

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F 0944 Level of Harm - Potential for minimal harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on review of facility personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on Quality Assurance and Performance Improvement (QAPI) for three of ten staff members (Employee E8, E9, and E10). Findings include: Review of facility provided documents and training records revealed the following staff members did not have documented training on QAPI. Nurse Aide (NA) Employee E8 had a hire date of 7/1/23, failed to have QAPI in-service education between 7/1/24, and 7/1/25. Nurse Aide (NA) Employee E9 had a hire date of 7/1/23, failed to have QAPI in-service education between 7/1/24, and 7/1/25. Dietary Employee E10 had a hire date of 7/1/23, failed to have QAPI in-service education between 7/1/24, and 7/1/25. During an interview on 1/8/26, at approximately 1:30 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on QAPI for three of ten staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.		

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F 0946 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide training in compliance and ethics. Based on review of facility personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on compliance and ethics for three of ten staff members (Nurse Aide Employees E8 and E9, and Dietary Employee E10). Findings include: Review of facility provided documents and training records revealed the following staff members did not have documented training on compliance and ethics. Nurse Aide (NA) Employee E8 had a hire date of 7/1/23, failed to have compliance and ethics in-service education between 7/1/24, and 7/1/25. Nurse Aide (NA) Employee E9 had a hire date of 7/1/23, failed to have compliance and ethics in-service education between 7/1/24, and 7/1/25. Dietary Employee E10 had a hire date of 7/1/23, failed to have compliance and ethics in-service education between 7/1/24, and 7/1/25. During an interview on 1/8/26, at approximately 1:30 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on compliance and ethics for three of ten staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.		

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F 0949 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on review of facility personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on behavioral health for three of ten staff members (Nurse Aide Employees E8 and E9 and Dietary Aide Employee E10). Findings include: Review of facility provided documents and training records revealed the following staff members did not have documented training on behavioral health. Nurse Aide (NA) Employee E8 had a hire date of 7/1/23, failed to have behavioral health in-service education between 7/1/24, and 7/1/25. Nurse Aide (NA) Employee E9 had a hire date of 7/1/23, failed to have behavioral health in-service education between 7/1/24, and 7/1/25. Dietary Employee E10 had a hire date of 7/1/23, failed to have compliance and behavioral health education between 7/1/24, and 7/1/25. During an interview on 1/8/26, at approximately 1:30 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on behavioral health for three of ten staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.		