STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395728	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lecom at Snyder Memorial	156 Snyder Memorial Rd Marienville, PA 16239

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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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on review of facility policy, facility documents, clinical records, and staff interview, it was determined that the facility failed to ensure that the attending physician documented required visits by writing, signing, and dating a physician progress note for each visit for 22 of 26 Residents reviewed (Residents R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R12, R13, R14, R18, R20, R23, R26, R36, R49, R59, R76, and R85). Findings include: Facility policy entitled Physician Visits dated 5/13/26, revealed The attending physician must make visits in accordance with applicable state and federal regulation. The attending physician must visit his/her patient at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter. A physician assistant or nurse practitioner may make alternate visits after the initial ninety (90) days following admission, unless restricted by law or regulation. and A physician visit is considered timely if it occur not later than ten (10) days after the date the visit was required. However, the subsequent visit must be timed in relation to when the previous one was due, not to when it was made. Review of Medical Director Agreement dated 9/16/26, indicated Duties and Responsibilities of a Medical Director: Coordinate and oversee medical care and treatment, including physician services.Monitor provision of physician services to provide services to meet the highest practicable physical, mental, and psychosocial well-being of each resident.Frequency of physician visits Resident R1's clinical record revealed an admission date of 10/7/25, with diagnoses that included benign prostatic hyperplasia (BPH - a noncancerous enlargement of the prostate gland, which can result in frequent urination, difficulty starting or stopping urination and a weak urine stream), transient ischemic attack (TIA - occurs when there is a brief interruption of blood flow to a part of the brain, leading to symptoms similar to those of a stroke that are temporary, typically lasting only a few minutes to a maximum of 24-hours), and dementia (loss of cognitive functioning affecting a person's memory and behaviors). Resident R1's clinical record revealed physician progress note dated 12/5/25, and then not again until 3/10/26. The clinical record lacked evidence of any physician progress notes being completed between 12/5/25, and 3/10/26, a span of 95 days. Resident R2's clinical record revealed an admission date of 7/19/24, with diagnoses that included schizoaffective disorder (a mental health condition that can be a mix of symptoms such as hallucinations [seeing things or hearing voices that other don't], delusions [believing things that are not real or true], and depression [persistent feeling of sadness loss of interest in activities once enjoyed]), Parkinson's Disease (a movement disorder of the nervous system that may result in tremors, stiffness, slowing of movement, and trouble with balance that worsens over time), and dementia. Resident R2's clinical record revealed physician progress note dated 9/26/25, and then not again until 3/10/26. The clinical record lacked evidence of any physician progress notes being completed between 9/26/25, and 3/10/26, a span of 165 days. Resident R3's clinical record revealed an admission date of 6/16/23, with diagnoses that included dementia, hypertension (high blood pressure), and atrial fibrillation (irregular heartbeat). Resident R3's clinical record revealed physician progress note dated 3/6/26. The clinical record lacked evidence of any physician progress notes being completed since the 3/6/26 visit, which is greater than the required 60 days (70 days including the 10-day grace period). (continued on next page)

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

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

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R4's clinical record revealed an admission date of 12/23/24, with diagnoses that included Paraplegia (a condition where a person is paralyzed from the waist down), acute kidney failure (a sudden loss of the kidney's ability to filter waste products and extra fluid from the body), and idiopathic hypotension (a condition with abnormally low blood pressure without a known cause). Resident R4's clinical record revealed physician progress note dated 12/5/25, and then not again until 3/10/26. The clinical record lacked evidence of any physician progress notes being completed between 12/5/25, and 3/10/26, a span of 95 days. Review of Resident R5's clinical record revealed an admission date of 10/23/23, with diagnoses that included seizure (a sudden, temporary disruption in the brains normal electrical activity that can cause symptoms such as changes in movement jerking or twitching, changes in awareness such as staring or loss on consciousness), and sleep apnea (a condition when a person repeatedly stops and starts breathing when they are sleeping). Resident R5's clinical record revealed physician progress note dated 10/29/25, and then not again until 3/10/26. The clinical record lacked evidence of any physician progress notes being completed between 10/29/25, and 3/10/26, a span of 132 days. Review of Resident R6's clinical record revealed an admission date of 12/21/12, with diagnoses that included hydronephrosis with renal and ureteral calculous obstruction (a condition where urine cannot properly drain from the kidney due to blockage), diabetes (a health condition that is caused by the body's inability to produce enough insulin), and hypertension (high blood pressure). Resident R6's clinical record revealed physician progress note dated 10/7/25, and then not again until 3/6/26. The clinical record lacked evidence of any physician progress notes being completed between 10/7/25, and 3/6/26, a span of 150 days. Resident R7's clinical record revealed an admission date of 10/10/19, with diagnoses that included congestive heart failure (CHF - a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply causing blood and fluids collect in your lungs and legs over time), diabetes (a health condition caused by the body's inability to produce enough insulin), and TIA. Resident R7's clinical record revealed physician progress note dated 9/19/25, and then not again until 3/10/26. The clinical record lacked evidence of any physician progress notes being completed between 9/19/25, and 3/10/26, a span of 172 days. Review of Resident R8's clinical record revealed an admission date of 3/9/26, with diagnoses that included schizoaffective disorder bipolar type (a mental illness that causes impaired thinking process with episodes of extreme mood swings with emotional highs and emotional lows), hypertension, and gastro esophageal reflux disease (a condition when stomach acid repeatedly flows back up into your throat). Resident R8's clinical record lacked any evidence of a physician progress note being completed at least once every thirty (30) days for the first ninety (90) days after Resident R8's admission. Resident R9's clinical record revealed an admission date of 10/18/12, with diagnoses that included schizoaffective disorder, gastroesophageal reflux disease (GERD-happens when stomach acid flows back up into the esophagus and causes heartburn), and dysphagia (a medical condition characterized by difficulty swallowing solids, liquids, or both, which can lead to choking, coughing, or the sensation of food being stuck in the throat). Resident R9's clinical record revealed physician progress note dated 9/19/25, and then not again until 3/6/26. The clinical record lacked evidence of any physician progress notes being completed between 9/19/25, and 3/6/26, a span of 168 days. Resident R10's clinical record revealed an admission date of 11/19/18, with diagnoses that included dysphagia, intellectual disabilities, and impulse disorder. Resident R10's clinical record revealed a physician progress note dated 11/5/25, and then not again until 3/10/26. The clinical record lacked evidence of any physician progress notes being completed between 11/5/25, and 3/10/26, a span of 125 days. Resident R11's clinical record revealed an admission date of 5/22/24, with diagnoses that included bi-polar disorder (a lifelong mental condition that causes extreme changes in mood and activity), anxiety, and depression. Resident R11's clinical record revealed a physician progress note dated 11/5/25, and then not again until 3/10/26. The clinical record lacked evidence of any physician progress notes being completed between 11/5/25, and 3/10/26, a span of 125 days. Resident R12's clinical record revealed an admission date of (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/5/11, with diagnoses that included dementia, hypertension, and diabetes. Resident R12's clinical record revealed a physician progress note dated 10/3/25, and then not again until 3/6/26. The clinical record lacked evidence of any physician progress notes being completed between 10/3/25, and 3/6/26, a span of 154 days. Review of resident R13's clinical record revealed an admission date of 7/20/23, with diagnoses that included quadriplegia (a condition where a person is paralyzed and unable to move their body from the neck down), anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and edema (swelling to an area of body due to holding excessive fluid). Resident R13's clinical record revealed physician progress note dated 9/8/25, and then not again until 3/6/26. The clinical record lacked evidence of any physician progress notes being completed between 9/8/25, and 3/6/26, a span of 179 days. Review of Resident R14's clinical record revealed an admission date of 5/14/25, with diagnoses that included Alzheimer's disease (brain disorder that slowly destroys memory, thinking skills, and, over time the ability to carry out the simplest tasks), hyperlipidemia (high cholesterol), and gastro esophageal reflux disease. Resident R14's clinical record revealed physician progress note dated 10/2/25, and then not again until 3/6/26. The clinical record lacked evidence of any physician progress notes being completed between 10/2/25, and 3/6/26, a span of 155 days. Resident R18's clinical record revealed an admission date of 1/9/26, with diagnoses that included anxiety, depression, and dementia. Resident R18's clinical record revealed a physician progress note dated 3/6/26, and then again on 4/14/26. The clinical record lacked evidence of any physician progress notes being completed upon admission at least once within the first 30 days. Review of Resident R20's clinical record revealed an admission date of 11/1/23, with diagnoses that included gastro esophageal reflux disease, hypertension, and peripheral vascular disease (a condition when there is restricted blood flow to the limb, usually legs). Resident R20's clinical record revealed physician progress note dated 10/29/25, and then not again until 3/10/26. The clinical record lacked evidence of any physician progress notes being completed between 10/29/25, and 3/10/26, a span of 132 days. Resident R23's clinical record revealed an admission date of 12/26/25, with diagnoses that included panic disorder, hypertension, and depression. Resident R23's clinical record revealed physician progress note dated 3/6/26. The clinical record lacked evidence of any physician progress notes being completed upon admission within the first 30 days, again at 60 days, and since the 3/6/26 visit, which is greater than the required 60 days (70 days including the 10-day grace period). Resident R26's clinical record revealed an admission date of 7/6/23, with diagnoses that included diabetes, hypertension, and atrial fibrillation. Resident R26's clinical record revealed a physician progress note dated 10/1/25, and then not again until 3/6/26. The clinical record lacked evidence of any physician progress notes being completed between 10/1/25, and 3/6/26, a span of 156 days. Resident R36's clinical record revealed an admission date of 1/25/25, with diagnoses that included COPD, diabetes, and osteoporosis (a condition where bone strength weakens and is susceptible to breaking). Resident R36's clinical record revealed a physician progress note dated 9/8/25, and then not again until 3/6/26. The clinical record lacked evidence of any physician progress notes being completed between 9/8/25, and 3/6/26, a span of 179 days. Resident R49's clinical record revealed an admission date of 3/10/25, with diagnoses that included paranoid schizophrenia (a type of severe brain disorder in which a person suffers from paranoia, hallucinations, and delusions), dysphagia, and anxiety. Resident R49's clinical record revealed a physician progress note dated 11/21/25, and then not again until 3/10/26. The clinical record lacked evidence of any physician progress notes being completed between 11/21/25, and 3/10/26, a span of 109 days. Resident R59's clinical record revealed an admission date of 2/6/26, with diagnoses that included dementia related to alcohol abuse, anxiety, and depression. Resident R59's clinical record revealed a physician progress note dated 3/6/26, and then again on 4/14/26. The clinical record lacked evidence of any physician progress notes being completed since the 4/14/26, visit which is greater than the required 90 days following and admission. Resident R76's clinical record revealed an admission date of 10/9/25, with diagnoses that included hypothyroidism (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(thyroid does not produce enough hormones for the body), dysphagia, and dementia. Resident R76's clinical record revealed a physician progress note dated 11/21/25, and then again on 3/10/26. The clinical record lacked evidence of any physician progress notes being completed upon admission at least once within the first 30 days, at 60 days, at 90 days, and since the 3/10/26, visit which is greater than the required 60 days (70 days including the 10-day grace period). Resident R85's clinical record revealed an admission date of 9/1/22, with diagnoses that included COPD, osteoporosis, and schizoaffective disorder. Resident R85's clinical record revealed a physician progress note dated 9/26/25, and then not again until 3/10/26. The clinical record lacked evidence of any physician progress notes being completed between 9/26/25, and 3/10/26, a span of 165 days. During an interview on 5/29/26, at 11:40 a.m. the Director of Nursing confirmed that Residents R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R12, R13, R14, R18, R20, R23, R26, R36, R49, R59, R76, and R85 clinical records lacked evidence of the required physician visit progress notes. He/she also confirmed that physician progress notes should be completed at every required visit. 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.2 (d)(8) Medical director 28 Pa. Code 211.5 (f)(ii)(iv) Medical records

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide a written summary of the baseline care plan and order summary to the resident and/or representative for one of 26 residents reviewed (Resident R1). Findings include: Review of facility policy entitled Care Plans - Baseline dated 5/13/26, revealed The resident and/or representative are provided a written summary of the baseline care plan (in a language that the resident/representative can understand) that includes, but is not limited to the following:The stated goals and objectives of the resident. A summary of the resident's medications and dietary instructions.Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. Review of Resident R1's clinical record revealed an admission date of 10/7/25, with diagnoses that included Asthma (a long-term lung disease that causes the airways to narrow and make it difficult to breath), hypothyroidism (a condition when the thyroid produces low amounts of thyroid hormones), and hypertension (high blood pressure). Resident R1's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R1 and/or his/her representative. During an interview on 5/28/26, at 3:11 p.m. the Nursing Home Administrator confirmed there was no evidence that a written summary of the baseline care plan and order summary were provided to Resident R1 and/or their representative. 28 Pa. Code 211.10(c) Resident care policies 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 facility policy and clinical records, and staff interview, it was determined that the facility failed to review and revise comprehensive care plans to reflect the current care and services for two of 26 residents reviewed (Residents R6 and R85).Findings include: Facility policy entitled Care Plans, Comprehensive Person-Centered dated 5/13/26, revealed Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. Resident R6's clinical record revealed an admission date of 12/21/12, with diagnoses that included hydronephrosis with renal and ureteral calculous obstruction (a condition where urine cannot properly drain from the kidney due to blockage), diabetes (a health condition that is caused by the body's inability to produce enough insulin), and hypertension (high blood pressure). Resident R6's progress notes revealed a note dated 2/12/26, indicated that his/her urinary catheter was removed. Resident R6's Care Plan for altered genitourinary system dated 12/16/25, revealed interventions to change urinary catheter as ordered, check tubing for kinks each shift, flush urinary catheter as ordered, catheter to continuous drainage, irrigate catheter, and secure catheter. Resident R6's Minimum Data Set (MDS-periodic assessment of resident care needs) dated 5/11/26, Section H Bladder and Bowel revealed under H0100 Appliances indwelling catheter was answered no. Review of Resident R6's current physician orders revealed no current order for a urinary catheter. During an interview on 5/28/26, at 12:45 the Nursing Home Administrator confirmed that Resident R6's altered genitourinary system care plan was not reviewed/revised to reflect current resident care and services regarding the catheter. He/she also confirmed that care plans should be reviewed and revised as necessary. Resident R85's clinical record revealed an admission date of 9/1/22, with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), Osteoporosis (a condition where bone strength weakens and is susceptible to breaking) , and Schizoaffective Disorder (a mental health condition that can be a mix of symptoms such as hallucinations [seeing things or hearing voices that other don't], delusions [believing things that are not real or true], and depression [persistent feeling of sadness loss of interest in activities once enjoyed]). Resident R85's Care Plan for elopement risk related to history of attempts to leave facility unattended initiated 5/25/23, with target date of 6/30/26, revealed an intervention for Wanderguard Bracelet Check every shift for proper functioning initiated 5/25/23, with a last revision date of 6/2/25. Resident R85's MDS's with Assessment Reference Dates (7 day look-back period of time) of 7/31/25, 10/25/25, 1/23/26, and 4/1/26, Section P0220 Alarms Subsection E Wander / Elopement Alarms was coded as No for being used in the last. Resident R85's physician orders revealed an order dated 1/24/24, to discontinue wanderguard to right wrist. During an interview on 5/28/26, at 12:45 p.m. Licensed Practical Nurse Assessment Coordinator confirmed that Resident R85's wanderguard was discontinued on 1/24/24, and his/her care plan was not updated to accurately reflect that his/her wanderguard was discontinued and it should have been. 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and manufacturer's guidelines, observation, and staff interview, it was determined that the facility failed to appropriately discard outdated medications for one of two medications rooms (West) and one of four medication carts (West One). Findings include: Facility policy entitled Medication Labeling and Storage dated 5/13/26, revealed Multi-dose [NAME] that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. Review of manufacturer's guidelines revealed that an open vial of Tubersol (a solution used for tuberculosis testing upon admission and employment) should be discarded within 30-days after opening. Review of manufacturer's guidelines revealed that and open vial of Insulin Glargine (also known as Lantus - medication used to treat diabetes) should be discarded within 28-days after opening. Observation of drug storage on 5/26/26, at 1:52 p.m. on the [NAME] Unit medication storage room refrigerator revealed an open vial of Tubersol with an open date of 3/23/26 making the discard date 4/22/26. During an interview at the time of observation, Licensed Practical Nurse (LPN) Employee E1 confirmed that the open vial of Tubersol was past 30 days and should have been discarded. Observation of drug storage on 5/26/26, at 1:55 p.m. of [NAME] One medication cart revealed an open vial of Insulin Glargine with an open date of 4/26/26 and discard date of 5/24/26. During an interview at the time of observation, LPN Employee E1 confirmed that the open vial of Insulin Glargine was past 28 days and should have been discarded. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1) Nursing services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to ensure food was prepared in a safe and sanitary manner in the dishwashing area of the main kitchen.Findings include: A facility policy entitled, Sanitization dated 5/13/26, revealed The food service area is maintained in a clean and sanitary manner .All utensils, counters, shelves, and equipment are kept clean. Observations conducted on 5/26/26, at approximately 10:40 a.m. of the main kitchen revealed one fan over the meal prep area and one fan in the dishwashing area with a thick layer of dust and a fuzzy substance. Interview conducted with the Kitchen Manager at that time confirmed that the one fan over the meal prep area and the one fan in the dishwashing area had a thick layer of dust and a fuzzy substance. 28 Pa. Code 211.6(f) Dietary services 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to dispose of trash in the garbage dumpster and failed to dispose of boxes in the recycling dumpster properly for two dumpsters observed outside of the building.Findings include:Facility policy entitled Sanitization dated 5/13/26, indicated Garbage and refuse containers are in good condition, without leaks, and waste is properly contained in dumpster/compactors with lids.Observations on 5/26/26, at approximately 12:30 p.m. of the garbage dumpster revealed several bags of trash heaping out of the container and the lid could not be closed and the recycling dumpster revealed several boxes heaping out of the container and the lid could not be closed.During an interview on 5/26/26, at approximately 12:40 p.m. the Nursing Home Administrator confirmed that the garbage dumpster had several bags of trash heaping out of the container and the recycling container had several boxes heaping out of the container, and that both containers lids could not be closed. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management