STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395746	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carlisle Skilled Nursing and Rehabilitation Center	940 Walnut Bottom Road Carlisle, PA 17013

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility provided documentation, and staff interviews, it was determined that the facility failed to provide notice of a resident's transfer to the Office of the State Long-Term Care Ombudsman for five of 11 residents reviewed for hospital transfers (Residents 27, 48, 79, 81, and 86). Findings include: Review of Resident 27's clinical record revealed diagnoses that included need for assistance with personal care, muscle weakness, and unsteadiness on feet. Review of Resident 27's clinical record revealed he was transferred out of the facility and admitted to the hospital on [DATE] and 19, 2025. Review of select facility documentation provided failed to reveal the representative of the Office of the Long-Term Care Ombudsman was notified of Resident 27's aforementioned hospitalizations. Interview with the Nursing Home Administrator (NHA) on June 26, 2025, at 9:57 AM, revealed he would expect notification of hospitalizations to the representative of the Office of the Long-Term Care Ombudsman, per the regulation. Review of Resident 48's clinical record revealed diagnoses that included hypertension (high blood pressure), obesity, and Type 2 Diabetes Mellitus (disease that occurs when your blood glucose, also called blood sugar, is too high, but does not require the use of insulin). Review of Resident 48's clinical record revealed that she was transferred to the hospital on April 7, 2025. Review of facility provided documentation of April 2025 transfers to the Office of the State Long-Term Care Ombudsman failed to include notice of Resident 48's hospital transfer. Email communication received from the Director of Nursing (DON) on June 25, 2025, at 7:30 PM, indicated that notification of Resident 48's transfer had now been sent to the ombudsman. During staff interview with the NHA and the DON on June 26, 2025, at 9:47 AM, the DON confirmed that she would expect all resident transfers to be reported to ombudsman in a timely manner. (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 79's clinical record revealed diagnoses that included hemophilia (inherited disorder that prevents the blood from clotting properly) and neuromuscular dysfunction of the bladder (when a problem in your brain, spinal cord, or central nervous system makes you lose control of your bladder). Review of Resident 79's clinical record revealed that he had been transferred to the hospital on December 14, 2024; March 9, 2025; April 7, 2025; and May 23, 2025. Review of facility provided documentation of December 2024, March 2025, April 2025, and May 2025 transfers to the Office of the State Long-Term Care Ombudsman failed to include notice of Resident 79's hospital transfers. Email communication received from the DON on June 25, 2025, at 7:30 PM, indicated that notification of Resident 79's transfer had now been sent to the Ombudsman. During staff interview with the NHA and the DON on June 26, 2025, at 9:47 AM, the DON confirmed that she would expect all resident transfers to be reported to ombudsman in a timely manner. Review of Resident 81's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders, personality changes, and impaired reasoning), chronic kidney disease (a condition that results in gradual loss of kidney function), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest in things). Review of Resident 81's clinical record revealed she was transferred out of the facility and admitted to the hospital on [DATE], and February 12, 2025. Review of select facility documentation provided failed to reveal the representative of the Office of the Long-Term Care Ombudsman was notified of Resident 81's aforementioned hospitalizations. Interview with the NHA on June 26, 2025, at 9:57 AM, revealed he would expect notification of hospitalizations to the representative of the Office of the Long-Term Care Ombudsman, per the regulation. Review of Resident 86's clinical record revealed diagnoses that included hypertension and chronic pain syndrome. Review of Resident 86's clinical record revealed that he had been transferred to the hospital on October 18, 2024; and January 14, 2025. Review of facility provided documentation of January 2025 transfers to the Office of the State Long-Term Care Ombudsman failed to include notice of Resident 86's hospital transfer. Email communication received from the DON on June 25, 2025, at 7:30 PM, indicated that notification of Resident 86's transfers had now been sent to the Ombudsman. During a staff interview with the NHA and the DON on June 26, 2025, at 9:53 AM, the DON confirmed that she would expect all resident transfers to be reported to Ombudsman in a timely manner. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a final interview with the NHA and DON on June 26, 2025, at 12:10 PM, the NHA indicated that he had no information to provide for any October 2024 transfers being sent to the Office of the State Long-Term Care Ombudsman. 28 Pa. Code 201.14(a) Responsibility of licensee

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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 clinical record review and staff interviews, it was determined that the facility failed to ensure that resident assessments accurately reflected the resident's status for four of 33 residents reviewed (Residents 48, 79, 86 and 105). Findings include: Review of Resident 48's clinical record revealed diagnoses that included anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), and depression. Review of Resident 48's Medicare 5 Day MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) with the assessment reference date (last day of the assessment period) of October 15, 2024, revealed in Section N. Medications that she was coded as receiving an antianxiety medication and was coded as not receiving anticonvulsant. Review of Resident 48's October 2024 Medication Administration Record (MAR) revealed that she had not received an antianxiety medication, but she had received an anticonvulsant medication. Review of Resident 48's Quarterly MDS with the assessment reference date of April 11, 2025, revealed in Section N. Medications that she was coded as receiving an opioid medication. Review of Resident 48's April 2025 MAR revealed she had not received an opioid medication. Email communication received from the Director of Nursing (DON) on June 25, 2025, at 12:21 PM, indicated that Resident 48's assessments were coded in error and modifications were submitted. During a staff interview with the Nursing Home Administrator (NHA) and the DON on June 26, 2025, at 9:47 AM, the DON confirmed that she would expect the MDS assessments to be completed accurately. Review of Resident 79's clinical record revealed diagnoses that included anxiety (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), post-traumatic stress disorder (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event with triggers that can bring back memories of the trauma accompanied by intense emotional and physical reactions), and hemophilia (inherited disorder that prevents the blood from clotting properly). Review of Resident 79's Annual MDS with the assessment reference date of May 29, 2025, revealed at question A1500. Preadmission Screening and Resident Review (PASRR) he was coded as not being considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Review of Resident 79's clinical record revealed a determination letter from the Pennsylvania Department of Human Services Office of Long-Term Living dated February 27, 2023, which indicated that Resident 79 was determined to have an Other Related Condition. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a staff interview with the NHA and DON on June 25, 2025, at 10:13 AM, the DON confirmed that Resident 79's MDS was coded inaccurately, that a modification would be submitted, and that she would expect a resident's MDS assessment to be coded accurately. Review of Resident 86's clinical record revealed diagnoses that included chronic pain syndrome and stage 4 pressure ulcer (a pressure injury that is deep, reaching into muscle and bone and causing extensive damage) of the sacrum (the part of the spinal column that is directly connected to the pelvis). Review of Resident 86's clinical record revealed that his stage 4 pressure ulcer was present upon his admission to the facility and that he had an order for hospice services, dated December 8, 2024. Review of Resident 86's Quarterly MDS with the assessment reference date of February 23, 2025, revealed in Section M. Skin Conditions that we was not coded at M100A as having a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device, but was coded at question M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage as having one stage 4 pressure ulcer that was present upon admission. Review of Resident 86's Quarterly MDS with the assessment reference date of May 26, 2025, revealed in Section M. Skin Conditions that he was coded at M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage as having one stage 4 pressure ulcer but was not coded as being present upon admission. Email communication received from the DON on June 25, 2025, at 7:30 PM, indicated that Resident 86's MDS were coded in error and that modifications were submitted. During a staff interview with the NHA and DON on June 26, 2025, at 9:53 AM, the DON indicated that she would expect a resident's MDS assessments to be completed accurately. Review of Resident 105's clinical record revealed diagnoses that included schizoaffective disorder (a mental health condition marked by a mix of schizophrenia symptoms, such as hallucinations and delusions), bipolar disorder (a mental health condition characterized by extreme mood swings that include emotional highs and lows), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest in things). Review of Resident 105's physician orders revealed an order for Perphenazine (antipsychotic medication) Oral Tablet 2 mg, give 1 tablet by mouth one time a day for psychosis if behaviors present, document behaviors, with a start date of January 3, 2025. Further review of Resident 105's physician orders revealed an order for Quetiapine Fumarate Oral Tablet, Give 75 mg by mouth at bedtime for bipolar disorder, with a start date of April 15, 2025. Review of Resident 105's clinical record revealed a psychiatry note dated December 30, 2024, that stated, Discussed her current medications and she would like to try to decrease one of her medications. Recommend decreasing perphenazine to 2 mgs daily. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 105's Quarterly MDS with assessment reference date of February 27, 2025, revealed under MDS 3.0 Section N - Medications under Has a gradual dose reduction (GDR- stepwise tapering of a dose of medication) been attempted? it was marked No. Review of Resident 105's clinical record revealed a psychiatry note dated May 8, 2025, that stated, GDR Note: GDR not clinically advisable at this time, after careful consideration. The patient has an extensive psychiatric history and endorses increased anxiety of unknown origin at times. A GDR would be inappropriate at this time as it could lead to further deterioration and escalating behavior patterns. Will reevaluate in the future if a GDR seems appropriate. A GDR of perphenazine was in progress and the dose was decreased in January 2025. Seroquel was decreased from 100 to 75 mg in April 2025. Review of Resident 105's Quarterly MDS assessments with assessment reference dates of May 28, 2025, and June 8, 2025, revealed under MDS 3.0 Section N - Medications under Has a gradual dose reduction (GDR) been attempted? it was marked No. Interview with the DON on June 26, 2025, at 10:04 AM, revealed the aforementioned MDS assessments had been coded in error, and she would expect MDS assessments to be completed accurately. 28 Pa. Code 211.5(f) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure that a baseline care plan that included the minimum healthcare information necessary to properly care for a resident was developed and implemented within 48 hours of admission for one of one residents reviewed (Resident 287); and failed to provide the resident and their representative with a summary of the baseline care plan that includes, but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary for one of one resident's reviewed (Resident 287). Findings include: Review of facility policy, titled OPS416 Person-Centered Care Plan, with a last review date pf May 7, 2025, revealed, in part, 1. A baseline care plan must be developed within 48 hours and include the minimum healthcare information necessary to properly care for a patient including, but not limited to: 1.1 Initial goals based on admission orders; 1.2 Physician orders; 1.3 Dietary orders; 1.4 Therapy services; 1.5 Social services; 1.6 PASRR recommendation, if applicable. 3. The Center must provide the patient and his/her resident representative with a summary of the baseline care plan that includes, but is not limited to: 3.1 Initial goals of the patient; 3.2 Medications and dietary instructions; 3.3 Any services and treatments to be administered by the Center and personnel acting on behalf of the Center; and 3.4 Any updated information based on the details of the comprehensive care plan, as necessary, if the comprehensive care plan is developed within 48 hours. 3.5 The medical record must contain evidence that the summary was given to the patient and resident representative, if applicable. Review of Resident 287's clinical record revealed that she was admitted to the facility on [DATE], with diagnoses that included fracture of the upper end of the right humerus (bone in upper arm) and scalp laceration. Review of Resident 287's clinical record revealed that she was assessed as having pain and urinary incontinence upon admission. Review of Resident 287's care plan failed to include a focus for urinary incontinence or incontinence care. Further review of Resident 287's care plan revealed a focus for pain with a goal of Resident will achieve acceptable level of pain control, as defined by the patient with an initiated date of June 19, 2025. The care plan failed to reveal what Resident 287 had identified as her acceptable level of pain. Review of Resident 287's clinical record progress notes failed to reveal any documentation that Resident 287 or her Representative had been provided with a summary of her baseline care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Email communication received from the Director of Nursing (DON) on June 25, 2025, at 7:30 PM, DON indicated that Resident 287's care plan was updated to reflect urinary incontinence and incontinence care and that her baseline care plan meeting is scheduled for Friday 6/27 [2025]. During a staff interview with the Nursing Home Administrator and the DON on June 26, 2025, at 9:50 AM, the DON confirmed that urinary incontinence and incontinence care should have been included in Resident 287's baseline care plan. She confirmed that was no documentation that Resident 287 had been asked what her acceptable level of pain was and that Resident 287 did not have a baseline care plan meeting nor was provided a summary of her baseline care plan within 48 hours. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, clinical record reviews, as well as staff, resident representative, and resident interviews, it was determined that the facility failed to ensure that the care plan was reviewed and revised to reflect the resident's current status for four of 28 residents reviewed (Residents 48, 77, 94, and 102), and that residents were given the opportunity to participate in the care planning process and failed to ensure care plan meetings were being completed for five of 28 residents reviewed (Residents 25, 26, 47, 59, and 79). Findings Include: Facility policy, titled OPS416 Person-Centered Care Plan, last reviewed May 7, 2025, read in part, 7. Care plans will be: 7.2 Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, and as needed to reflect the response to care and changing needs and goals. 8. Care Plan Meetings: 9. The Center has the responsibility to assist patients to participate by: 9.1 Extending invitations to patient and HCDM sent in advance; 9.3 Facilitating the inclusion of patient/resident representative(s) to attend; 10. Care plan meetings will be documented by use of the Care Plan Meeting note. Review of Resident 25's clinical record revealed diagnoses that included type two diabetes mellitus (condition in which the body cannot use insulin correctly and sugar builds up in the blood) and end stage renal disease (kidneys no longer work to meet the body's needs). During an interview with Resident 25 it was revealed that it had been a long time since she received an invitation to a care plan meeting. Further review of Resident 25's clinical record revealed the last noted care plan meeting was held on July 30, 2024. An email communication from with the Nursing Home Administrator (NHA) received on June 26, 2025, at 9:07 AM, revealed the facility could not provide further documentation that Resident 25 had been invited to a care plan meeting or that a care plan meeting had been held since July 30, 2024. Review of Resident 26's clinical record revealed diagnoses that included dementia - unspecified type (progressive, irreversible degenerative disease of the brain that results in decreased contact with reality and decreased ability to perform activities of daily living) and congestive heart failure (disease process that results in a decreased ability of the heart to effectively pump blood throughout the body). Review of Resident 26's clinical record failed to reveal evidence that care plan meetings were conducted during the duration of the survey review period (July 18, 2024). There was no documentation of care plan meetings being scheduled, nor held, including documentation of attendees or that the Resident and/or Resident Representative were provided notification and opportunity to attend. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a Resident Representative interview on June 26, 2025, Resident 26's Representative stated that she had not been invited to care plan meetings, nor was she aware that the facility was conducting care plan meetings since at least October 2024. During the interview, Resident 26's Representative stated that the facility used to conducted care plan meetings quarterly. Review of Resident 47's clinical record revealed diagnoses that included hypertension (high blood pressure) and hyperlipidemia (high level of fat in the blood). During an interview with Resident 47 it was revealed that it had been a long time since he received an invitation to a care plan meeting. Further review of Resident 47's clinical record revealed the last noted care plan meeting was held on March 28, 2024. An email communication from with the NHA, received on June 26, 2025, at 9:07 AM, revealed the facility could not provide further documentation that Resident 47 had been invited to a care plan meeting or that a care plan meeting had been held since March 28, 2024. Review of Resident 48's clinical record revealed diagnoses that included hypertension (high blood pressure), obesity, and Type 2 Diabetes Mellitus (disease that occurs when your blood glucose, also called blood sugar, is too high, but does not require the use of insulin). Review of Resident 48's care plan revealed a care plan focus for alteration in respiratory function related to acute respiratory failure and pneumonia last revised April 9, 2025, and interventions included administer antibiotic (amoxicillin-potassium clavulanate) and monitor for worsening infection, and guaifenesin-codeine cough syrup, both with an initiated date of April 9, 2025. Review of Resident 48's current physician orders revealed no orders for an antibiotic or cough syrup. Review of Resident 48's order history revealed that the cough syrup was discontinued on April 11, 2025; and the antibiotic was ordered for 10 administrations and was completed on April 13, 2025. Email communication received from the Director of Nursing (DON) on June 25, 2025, at 7:30 PM, indicated the care plan concern had been resolved. During a staff interview with the NHA and DON on June 26, 2025, at 9:47 AM, the DON confirmed that she would expect a resident's care plan to be revised when changes occurred. Review of Resident 59's clinical record revealed diagnoses that included anxiety disorder - unspecified (mental health disorder characterized by excessive worry and/or fear) and adjustment disorder with depressed mood (mental health disorder that is characterized by emotional and/or behavioral changes that are in response to stressful life events and/or changes). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 59's clinical record failed to reveal evidence that care plan meetings were conducted during the duration of the survey review period (July 18, 2024 to June 26, 2025). There was no documentation of care plan meetings being schedule, nor held, including documentation of attendees or that the Resident and/or Resident Representative were provided notification and opportunity attend. Review of Resident 77's clinical record revealed diagnoses of osteomyelitis of left ankle and foot (infectious inflammation of bone marrow) and diabetes. Review of current physician orders for Resident 77 revealed an order for a renal diet (a diet plan designed to support kidney health), starting May 23, 2025. Review of Resident 77's plan of care failed to reveal a care plan regarding Resident 77's need to have a renal diet. Interview with the DON on June 26, 2025, at 2:15 PM, revealed that she would expect the care plan to contain Resident 77's need for a renal diet. Review of Resident 79's clinical record revealed diagnoses that included anxiety (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), post-traumatic stress disorder (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event with triggers that can bring back memories of the trauma accompanied by intense emotional and physical reactions), and hemophilia (inherited disorder that prevents the blood from clotting properly). During a resident interview with Resident 79 on June 23, 2025, at 9:58 AM, he indicated that he had not been invited or attended a care plan meeting in quite a while. Review of Resident 79's clinical record failed to reveal any documentation that he had been invited to attend his care plan or any documentation that a care plan meeting had occurred since February 29, 2024. During a staff interview with the NHA and DON on June 25, 2025, at 10:10 AM, they both confirmed that they had no additional information to provide. The NHA indicated that he would expect there to be documentation of the invite as well as documentation of the care plan meeting and that he felt the best practice would be to document the information in progress notes. Review of Resident 94's clinical record revealed diagnoses of urinary tract infection (an infection that affects any part of your urinary system, including the kidneys, ureters, bladder, and urethra) and acute renal failure (a sudden and rapid loss of kidney function). Review of Resident 94's Minimum Data Set (MDS) assessment, dated June 5, 2025, revealed in Section H-Bladder and Bowel, H0300 Urinary Continence, that Resident 94 is Always Incontinent. Further review of the MDS assessment, dated June 5, 2025, revealed in section V- care area assessment summary, that urinary incontinence was a triggered care area, and the decision was made to care plan urinary incontinence. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 94's care plan failed to reveal any interventions regarding incontinence care or bladder control. Interview with the DON on June 25, 2025, at 2:15 PM, revealed that she would expect Resident 94's care plan to be revised and updated with incontinence care. During an interview with the NHA and DON on June 26, 2025 at 9:45 AM, the NHA stated it was the expectation of the facility that care plan meetings be held and that residents/resident representatives are invited to care plan meetings. Review of Resident 102's clinical record revealed diagnoses that included muscle weakness and hypertension (high blood pressure). Review of Resident 102's care plan revealed a comprehensive care plan for alteration in genitourinary function (organs of the reproductive system and the organs of the urinary system) related to an indwelling foley catheter (a medical device that helps drain urine from your bladder). Review of Resident 102's physician orders revealed a discontinued order for Change Indwelling Catheter - 16Fr 10cc every day shift every 28 day(s), with a discontinued date of August 22, 2025, with a reason to discontinue of catheter discontinued at appointment. Review of Resident 102's clinical record revealed he was documented as being frequently incontinent of bowel. Review of Resident 102's care plan failed to reveal a comprehensive care plan for bowel incontinence. Interview with the DON on June 26, 2025, at 10:08 AM, revealed she would expect Resident 102 to have a comprehensive care plan for bowel incontinence, and that his care plan would have been revised to reflect that he no longer has a foley catheter. 28 Pa. Code 211.12(d)(2)(3)(5) Nursing services

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on facility policy review, clinical record review, observations, and resident and staff interviews, it was determined that the facility failed to provide care and services regarding hygiene and bathing for one of 28 residents reviewed (Resident 48). Findings include: Review of facility policy, titled NSG200 Activities of Daily Living (ADLs), with a last review date of May 7, 2025, revealed, in part, Based on the comprehensive assessment of a patient and consistent with the patient's needs and choices, the Center must provide the necessary care and services to ensure that a patient's activities of daily living (ADL) abilities are maintained . 4.2 A patient who is unable to carry out ADLs will receive the necessary level of ADL assistance to maintain good nutrition, grooming, and personal and oral hygiene. 5. Documentation of ADL care is recorded in the medical record and is reflective of the care provided by nursing staff. ADL care will be documented in real time, as close to the time that care was provided and information obtained as possible. ADL care is documented every shift by the nursing assistant. Review of Resident 48's clinical record revealed diagnoses that included muscle weakness, obesity, and a non-pressure chronic ulcer the left foot. Review of Resident 48's care plan revealed a care plan focus for an alteration in ADL function, dated June 25, 2024, with an intervention for provide resident with modified independence with bathing, dated June 25, 2024. Review of Resident 48's Quarterly MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) with the assessment reference date (last day of the assessment period) of April 11, 2025, revealed that she needed supervision and touching assistance with bathing. During a resident interview with Resident 48 on June 23, 2025, at 1:01 PM, Resident 48 indicated that she does not always get her showers. Review of Resident 48's shower/bath task documentation from May 28, 2025 -June 21, 2025, revealed that her shower/bath days are on Wednesday and Saturday evenings and that she was only documented as receiving a shower/bath on June 21, 2025. Her shower/bath task was documented as non-applicable on May 28 and 31, and June 11, and there was no documentation for June 4, 7, 13, or 18, 2025. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing on June 25, 2025, at 10:08 AM, they both confirmed that they had no additional information to provide. The NHA indicated that he would expect staff to provide showers per a resident's care plan and that he would expect staff to document care when given as well as document when a resident refuses. 28 Pa code 211.12(d)(1)(2)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, and staff interviews, it was determined that the facility failed to ensure care and services are provided in accordance with professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for five of 28 residents (Residents 13, 27, 38, 79, and 102). Findings include: Review of Resident 13's clinical record revealed diagnoses that included cerebrovascular disease (conditions that affect blood flow to your brain) and scoliosis (a condition where the spine curves sideways). Review of Resident 13's clinical record revealed the Resident had a fall on March 27, 2025, at 12:00 PM, where staff were alerted that Resident 13 was seen to be sitting on the floor and trashcan across from toilet. Description of immediate action taken revealed that the medical director provided a new order for urine analysis with culture and sensitivity (UA/C&S) to rule out urinary tract infection (UTI) due to Resident falling three times in the past 24 hours. Review of Resident 13's clinical record revealed a physician's order for UA/C&S one time only for two days, with a start date of March 27, 2025. Review of Resident 13's March 2025 MAR (medication administration record) revealed an order for UA/C&S one time only for two days, with a start date of March 27, 2025. Further review of the MAR revealed the documentation was blank on March 27 and 28, 2025; and on March 29, 2025, it was marked 'NN', which is code for 'No / see nurses notes.' Review of Resident 13's clinical record revealed a nurse's progress note written on March 29, 2025, at 2:29 PM, with text that stated collected UA/C&S one time only for two days. Further review of Resident 13's clinical record revealed no laboratory results found for the UA/C&S or documentation regarding the order not being completed. Interview conducted with the Director of Nursing (DON) on June 25, 2025, at 1:55 PM, revealed the UA/C&S was ordered for Resident 13, however it was never completed, and they do not have any additional information to provide. DON revealed she would have expected Resident 13's UA/C&S to have been completed as ordered. Review of Resident 27's clinical record revealed diagnoses that included need for assistance with personal care, muscle weakness, and unsteadiness on feet. Review of Resident 27's physician orders revealed the following orders: Cadexomer Iodine Gel 0.9 % Apply to Left 3rd Toe topically every day shift for Diabetic Wound for 30 Days Cleanse with NSS, pat dry, apply Iodosorb and Collagen sheet to wound bed then cover with Gauze border dressing, with a start date of April 12, 2025. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Left 3rd Toe: Cleanse w/ NSS, pat dry, apply Collagen sheet to the wound bed then cover with gauze dressing every day shift for Diabetic Wound, with a start date of May 23, 2025. Mupirocin External Ointment 2 %, Apply to Left 3rd Toe topically every day shift for Diabetic Wound for 28 Days, Cleanse w/ NSS, pat dry, apply Mupirocin then cover with gauze dressing, with a start date of May 17, 2025. Santyl External Ointment 250 unit/gram, Apply to Left 3rd toe topically every day shift for Diabetic wound for 30 Days Cleanse with NSS, pat dry, apply Santyl and collagen to the wound bed then cover with gauze, with a start date of May 9, 2025. Review of Resident 27's May 2025 TAR (Treatment Administration Record- documentation for treatments/medication administered or monitored) revealed the Cadexomer order was left blank on May 3 and 8; the order for Left 3rd Toe: Cleanse w/ NSS, pat dry, apply Collagen sheet was left blank on May 24 and 25; the Mupirocin order was left blank on May 22 and 23; and the Santyl order was left blank on May 14. Interview with the DON on June 26, 2025, at 9:59 AM, revealed the wound treatments that were missing on the TAR on May 8 and 22, 2025, were left blank because they were completed during wound rounds. She further revealed she was unable to provide information as to why the other wound treatments were left blank as they should be completed as ordered, and she would expect if the treatments were completed on wound rounds, that would be notated on the TAR, rather than left blank. Further review of Resident 27's physician orders revealed the following orders: Acetaminophen Oral Tablet Give 650 mg by mouth every 8 hours for pain, with a start date of July 29, 2024, and an end date of June 18, 2025. Acetaminophen Tablet 325 mg Give 2 tablet by mouth every 6 hours as needed for Temp 100F or above Notify Physician/Advanced Practice provider. Do not exceed 3g/day and Give 2 tablet by mouth every 6 hours as needed for Mild (1) to moderate (4) pain Do not exceed 3g/day, July 28, 2024, and an end date of June 18, 2025. Acetaminophen Oral Tablet 500 mg Give 2 tablet by mouth every 8 hours for Pain, with a start date of June 16, 2025. Review of Resident 27's clinical record revealed a note written by Employee 16 (Nurse Practitioner) on June 16, 2025, that read, in part, Acute visit for low back pain. Patient reports acute onset of intermittent 10/10 low back pain. Plan: Routine Extra strength Tylenol (Acetaminophen) 1000 mg every 8 hours. Review of Resident 27's June 2025 MAR revealed he was documented as receiving 3300 mg (3.3 g) on June 17, 2025. During an interview with the DON on June 25, 2025, at 10:06 AM, she confirmed Resident 27 received 3.3g of Tylenol in 24 hours on June 17, 2025, which is greater than the recommended dose, and she would have expected the old Tylenol orders to be discontinued when the new Tylenol order was placed on June 16, 2025. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 38's clinical record revealed diagnoses that included type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy) and end stage renal disease (the final, permanent stage of chronic kidney disease where the kidneys are no longer able to function adequately to sustain life). Review of Resident 38's clinical record revealed an active physician's order for hemodialysis every Monday, Wednesday, and Friday, 12:45 PM, have ready by 12:00 PM. Further review of Resident 38's current physician's orders revealed an order for insulin lispro injection solution, inject 3 unit subcutaneously three times a day for type 2 diabetes mellitus, hold is blood sugar is less than 100, monitor for hyper/hypoglycemia, with a start date of April 24, 2024. Review of Resident 38's June 2025 MAR revealed and order for insulin lispro injection solution, inject 3 unit subcutaneously three times a day for type 2 diabetes mellitus, hold is blood sugar is less than 100, monitor for hyper/hypoglycemia, with a start date of April 24, 2024. Further review of Resident 38's June 2025 MAR revealed the insulin was not administered at 12:00 PM on June 2, 4, 6, 9, 11, 13, 16, 18, 20, 23, and 25, 2025, and was marked off as the Resident being away from the center. Review of Resident 38's comprehensive care plan revealed a focus area for diabetes, initiated on September 27, 2023, and last revised on July 27, 2024; with an intervention to administer diabetes medication as ordered by doctor, with an initiated and created date of September 27, 2023. Interview with Employee 3 on June 26, 2025, confirmed that Resident 38 did not receive insulin on the dates above at 12:00 PM, and revealed that the order was changed for Resident 38 to receive insulin two times a day on dialysis days. Employee 3 revealed she would have expected Resident 38 to have received their medications as ordered by the physician. Review of Resident 79's clinical record revealed diagnoses that included anxiety (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), neuromuscular dysfunction of the bladder (when a problem in your brain, spinal cord, or central nervous system makes you lose control of your bladder), and hemophilia (inherited disorder that prevents the blood from clotting properly). Review of Resident 79's physician orders revealed the following orders: In the event of bleeding, please contact the hemophilia treatment center for orders dated May 28, 2025; and Tranexamic acid oral tablet 650 mg (milligrams) Give 2 tablet by mouth every 8 hours as needed for bleeding, dated May 27, 2025. Observations of Resident 79 on June 23, 2025, at 9:57 AM and 11:44 AM, revealed that the urine in his foley catheter (a flexible tube placed through the urethra to the bladder to drain urine) bag was noted to be reddish in color. Review of Resident 79's clinical record progress notes revealed a Registered Nurse's note dated June 23, 2025, at 12:16 PM, which indicated met with resident. Upon meeting, noticed a small amount of blood in foley catheter. The resident stated that was normal for him and that the doctors are aware. Resident denies pain or discomfort at this time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 79's clinical record revealed a Registered Nurse's note dated June 23, 2025, at 11:07 PM, that indicated came onto shift, got in report that resident was having hematuria. On assessment, noted dark red urine in cath[eter] bag; 2nd shift supervisor had spoken to Urology, noted that they had said to monitor. Resident noted to have increased anxiety, requested to go to ED for evaluation. Resident sent to UPMC [NAME] ED per resident request. Review of Resident 79's clinical record progress notes revealed a nurse's note dated June 23, 2025, at 11:43 PM, that indicated he was transferred to the hospital for hematuria (blood in the urine) related to his hemophilia. Review of Resident 79's clinical record progress notes revealed a nurse's note dated June 24, 2025, at 8:00 AM, that he had returned from the hospital, that he had his foley catheter replaced at the hospital, and that he was noted to have a small amount of blood still coming from foley catheter. Review of Resident 79's clinical record progress notes failed to reveal any documentation that the hemophilia center was notified of his bloody urine. Review of Resident 79's June 2025 MAR revealed that he had not received Tranexamic acid oral tablets as ordered for bleeding until June 24, 2025, at 11:45 AM. Email communication received from the DON on June 25, 2025, at 7:30 PM, indicated nursing notes clearly indicate that when [Resident 79] was asked about the blood in his urine, he reported it was normal for him and that his doctors were aware. During a staff interview with the Nursing Home Administrator (NHA) and the DON on June 26, 2025, at 9:49 AM, the DON confirmed that there was no documentation by the nurse who supposedly called the urologist, and that nursing staff should not have just taken Resident 79's word that it was normal and that his doctors were aware. The DON also confirmed that Resident 79 did not receive the ordered medication for bleeding until June 24, 2025, at 11:45 AM, almost 24 hours after the bleeding was originally noted by nursing staff. The DON indicated that she would have expect staff to have at least called the hemophilia clinic for further guidance. She confirmed that based on documentation the Resident requested to go to the emergency room because of anxiety he was having over the hematuria. Review of Resident 102's clinical record revealed he had diagnoses that included muscle weakness and hypertension (high blood pressure). Review of Resident 102's physician orders revealed the following orders: an order for Left Shin: Cleanse w/ NSS, pat dry, apply Xeroform to the wound bed cover w/ kerlix PRN if saturated, soiled, or dislodged. every day shift for Skin tear, with a start date of June 5, 2025. Review of Resident 102's June 2025 TAR revealed the treatment order was left blank for his wound treatment on June 8 and 13, 2025. Interview with the DON on June 26, 2025, at 9:59 AM, revealed she does not have any information provide why the treatments were not documented on the TAR, and she would expect wound treatments to be completed as ordered. 28 Pa. Code 201.18(b) Management (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on clinical record review and resident and staff interviews, it was determined the facility failed to ensure each resident receives proper treatment and services to maintain hearing abilities for one of three residents reviewed for vision and hearing (Resident 42). Findings include: Review of Resident 42's clinical record revealed diagnoses that included stage 3 chronic kidney disease (when your kidneys have mild to moderate damage and are less able to filter waste and fluid out of your blood) and hypothyroidism (when your thyroid gland doesn't make and release enough hormone into your bloodstream). During an interview conducted with Resident 42 on June 23, 2025, at 9:52 AM, revealed that she was having difficulty hearing, and has requested to see a doctor as she has hearing aids but has lost her ability to hear adequately. Review of Resident 42's clinical record revealed a medical practitioner note written on April 11, 2025, at 1:45 PM, that read, in part, Resident 42 was seen for an acute visit for hearing loss, and that they will consult audiology for evaluation. Review of Resident 42's current active physician's orders reveal an order to refer to audiologist related to hearing loss, with an active date of April 11, 2025. During an interview with the Nursing Home Administrator (NHA) on June 25, 2025, at 10:38 AM, revealed that Resident 42 was not placed on the list to be seen by audiology after the order in April 2025, and would have expected Resident 42 to have been placed on the list as ordered. Further interview with the NHA on June 26, 2025, at 9:46 AM, revealed they reached out to their audiology provider who confirmed Resident 42 was not placed on the list to be seen due to needing additional information. NHA provided documentation that Resident 42 has been placed on the list to be seen by audiology as of June 26, 2025, due to complaints of decreased hearing or change in hearing. 28 Pa. Code 211.12 (d) (5) Nursing services

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on review of facility policy, record review, observations, and resident and staff interviews, it was determined that the facility failed ensure the resident received care, consistent with professional standards, to treat and prevent pressure ulcers for two of three residents reviewed (Residents 77 and 106). Findings Include: Review of facility policy, titled NSG236, Revised October 15, 2024, revealed in 6.10. Determine the need for heel off-loading, 6.13 Implement special wound care treatments/techniques, as indicated and ordered, and step 11. Review care plan and revise as indicated. Review of Resident 77's clinical record revealed diagnoses that included osteomyelitis of left ankle and foot (infectious inflammation of bone marrow) and diabetes (a disease that effects how the body utilizes and regulates blood sugar). Observation of Resident 77 on June 23, 2025, at 1:25 PM, revealed him sitting in his wheelchair in his room and two pressure off-loading boots were sitting beside his bed. Interview with Resident 77 at that time revealed that staff occasionally put the pressure off-loading boots on Resident 77 at night when he is in bed. Review of Resident 77's wound team note dated June 3, 2025, revealed a recommendation to off-load wounds. Review of Resident 77's current physician orders failed to reveal a physician order for pressure off-loading boots. Review of Resident 77's care plan revealed a care plan focus area of: Resident at risk for impaired skin integrity, dated May 23, 2025, that failed to contain Resident 77's use of bilateral off-loading boots. Further review or Resident 77's clinical record failed to reveal any documentation of when or if Resident 77's pressure off-loading boots were being utilized. Interview with the Director of Nursing (DON) on June 26, 2025, at 9:51 AM, revealed that Resident 77 was seen by the wound team on June 3, 2025, and the recommendation for the pressure off-loading boots was made at that time. She also revealed that when the recommendation was made, the facility should have received a physician order and revised Resident 77's care plan. Review of Resident 106's clinical record revealed diagnoses that included osteomyelitis of sacral region (infectious inflammation of bone marrow) and pressure ulcer of the sacral region (injuries to the skin and the tissue below the skin that are due to pressure on the skin for a long time). Observation of Resident 106 on June 23, 2025, at 11:34 AM, revealed him lying in bed and two pressure off-loading boots were sitting in the chair beside his bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 106's wound team note dated March 3, 2025, revealed a recommendation to float heels in bed (a technique used to prevent pressure ulcers by relieving pressure on heels). Review of Resident 106's current physician orders failed to reveal a physician order for pressure off-loading boots. Review of Resident 106's care plan revealed a care plan focus area of: Resident at skin breakdown, revised March 19, 2025, that failed to contain Resident 106's use of bilateral heel off-loading boots. Further review or Resident 106's clinical record failed to reveal any documentation of when or if Resident 106's pressure off-loading boots were being utilized. Interview with the DON on June 26, 2025, at 12:15 PM, revealed that Resident 106 was seen by the wound team on March 3, 2025, and the recommendation for the pressure off-loading boots was made at that time. She also revealed that when the recommendation was made the facility should have received a physician order and revised Resident 106's care plan. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on review of clinical records, policy review, observation, and staff interviews, it was determined that the facility failed to provide restorative nursing care for range of motion exercises for two of four residents reviewed for limited range of motion (Residents 5 and 88). Findings include: Review of facility policy, titled Restorative Nursing last revised August 7, 2023, read, in part, Centers may provide restorative nursing programs for patients who: Will benefit from restorative programs in conjunction with formalized rehabilitation therapy. Restorative programs are coordinated by nursing or in collaboration with rehabilitation and are patient specific based on individual patient needs. A licensed nurse must supervise the activities in a restorative nursing program. Document: Daily on Restorative Nursing Record in ADL Point of Care. Review of Resident 5's clinical record revealed diagnoses that included dysphagia (swallowing difficulties) and vascular dementia (a decline in thinking skills caused by conditions that damage blood vessels in the brain, leading to reduced blood flow and oxygen to brain cells). Observation conducted of Resident 5 on June 23, 2025, at 9:49 AM, revealed she was lying in bed with both of her hands contracted. Review of Resident 5's comprehensive care plan revealed a focus area that the Resident has a loss of range of motion related to cerebrovascular accident (stroke - when there is a loss of blood flow of the brain), trigger finger of right 5th digit, contracture of hands, neck and legs, initiated on January 5, 2015, and last revised on July 17, 2024; and an intervention for restorative passive range of motion: bilateral upper and lower extremities with AM and PM care, initiated on May 12, 2015, and last revised on March 17, 2024. Review of Resident 5's Kardex (a quick reference tool that summarizes key patient information to guide daily care), revealed special instructions for the Resident to receive restorative passive range of motion: bilateral upper and lower extremities with AM and PM care. Review of Resident 5's clinical record revealed no documentation found indicating the Resident had been receiving restorative nursing services. During an interview with the Director of Nursing (DON) on June 25, 2025, at 10:32 AM, revealed that Resident 5's restorative was added and that there was a glitch in the system and it was not added as a task for staff to complete. The DON was unable to provide any documentation to support Resident 5 receiving restorative nursing care prior to June 24, 2025. The DON revealed her expectation would be that staff were still completing restorative nursing care on the Resident, however, it was not being documented anywhere. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 88's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders, personality changes, and impaired reasoning), chronic kidney disease (a condition that results in gradual loss of kidney function), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest in things). Review of Resident 88's clinical record revealed an Occupational Therapy note that read, in part, Encourage palm guards at all times except hygiene and meals, active and passive range of motion, restorative nursing program, dated May 20, 2025. Review of Resident 88's nursing tasks revealed a task for Encourage bilateral palm guards at all times except meals and hygiene as resident tolerates. Check skin and provide good hand hygiene daily. Further review of the aforementioned task failed to reveal any documentation captured. Interview with the DON on June 26, 2025, at 10:06 AM, revealed the task was entered incorrectly so documentation was not captured, and she would expect RNP programs to be implemented and documented. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on clinical record review, facility document review, policy review and staff interviews, it was determined that the facility failed to conduct thorough fall investigations for one of six residents reviewed for falls (Resident 81) and failed to ensure that residents who expressed suicidal ideations were provided supervision and safety interventions were put into place to prevent serious bodily injury and/or death. This failure resulted in Resident 59 cutting himself and an immediate jeapordy situation. Findings include: Review of facility policy, titled Procedure: Suicide Precautions, last reviewed May 7, 2025, revealed the facility procedure included the following: 1. Evaluate patients with suicidal behavior or ideation. 2. Notify Physician/advanced practice provider (APP) of patients with suicidal behavior or ideation . 3. For Patients who exhibit suicidal behavior: 3.1 Obtain order for suicide precautions from the physician/APP. Implementation of suicide precautions should not be delayed while awaiting physician order. 3.2 Evaluate immediate safety needs. Remove any potentially dangerous equipment or objects that may be used for self-harm from the patient's room. 3.2.1 Sharp items such as knives, razors, pens, nail clippers, scissors, etc.; .3.2.3. Other items such as electrical cords, straps, belts, plastic bags, and clothing that could be used for self-harm (e.g., shoe laces). 3.3 Provide one-on-one (1:1) supervision of the patient at all times, including when the patient is sleeping or in the bathroom .3.3.2 Designated staff members providing 1:1 supervision: 3.3.2.1. Must have sight of the patient at all times. At no time should the observer leave the patient they are observing unless relieved by an alternate staff member to supervise the patient; .3.3.2.3. Will document patient activities (e.g., sleeping, eating, etc.), behavior (e.g., yelling), and locations (e.g., patient room, bathroom), and applicable interventions/actions taken every 30 minutes on the Continuous 1:1 supervision Flowsheet. 3.4 Verify windows cannot be opened. Notify Maintenance to seal or secure windows, if needed .3.9 Continue suicide precautions every shift until: 3.9.1 Patient is transferred to psychiatric/behavioral health facility; 3.9.2 Consulting psychiatrist/physician discontinues precautions. 3.9.2.1. Do not discontinue 1:1 supervision without a physician's order. 3.10 Document: .3.10.5 Time of initiation of suicide precautions; .3.10.7 Continuous 1:1 Supervision Flowsheet; .3.10.8 Continuation of suicide precautions every shift; 3.10.9 Discontinuation of suicide precautions or transfer out to another facility. Review of Resident 59's clinical record revealed diagnoses that included anxiety disorder - unspecified (mental health disorder characterized by excessive worry and/or fear) and adjustment disorder with depressed mood (mental health disorder that is characterized by emotional and/or behavioral changes that are in response to stressful life events and/or changes). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of an incident report dated April 27, 2025, completed by Employee 10 (Registered Nurse), revealed the incident description read, Approximately [7:30 PM], this writer was called to the unit to speak with [Resident 59]. Upon arrival to the residents room, [Resident 59] was seen sitting quietly in his bedside chair. A [Nurse Aide] reported that the resident had previously asked her if there is an attorney in the building because he needs to speak to one before he kills himself. Staff reported to the charge nurse [Employee 7] who attempted to speak to the resident, however res[ident] refused to speak. Frequent checks initiated, another [Nurse Aide] went to the room to check on the resident and found the res[ident] holding a sharp edged yellow plastic [object] in his left hand with some other pieces of the plastic on the bedside table. [Nurse Aide] stated that she turned res[ident] right-hand and saw blood, at this time, resident asked him how much does he need to go down. Staff immediately notified charge nurse [of injury] . Review of witness statement by Employee 8 (Nurse Aide) revealed, At about 7:15 PM [Resident 59] came to me at the nurses station and asked me if there is a lawyer in this building to talk to. I told him not at this time. I continued to ask him why he wanted a lawyer. He said I want on[e] before [he] kill myself. I told him lets go and talk to the nurse [Employee 7]. We went but he didn't say anything and went back to his room. At about 5 minutes after [another Nurse Aide] went to his room and I saw him trying to cut his arm. We notified the nurse. Review of witness statement by Employee 7 (Licensed Practical Nurse, identified as change nurse), revealed, [Resident 59] had approached [Nurse Aide] in regards of a lawyer. She had brought [Resident 59] to me but he waved his hands in a 'whatever' gesture and walked off. I call his name and he did not reply at that time. Currently I was pulling medication for someone else. One [Nurse Aide] came to get me and one [Nurse Aide] was in the room talking to him. Called the supervisor to the unit at [7:35] PM . Review of witness statement by Employee 9 (Nurse Aide) revealed, Resident [59] came to the desk saying he wanted a lawyer because he was going to slit his throat. I was really worried so I went into his room started to talk to him. As he was talking, I saw blood on his wrist. He has started to cut his wrist. We talked a little while. Then the nurse came in and got the supervisor. They sent him out. At 7:35 PM [Employee 8] notified Employee 10 (Registered Nurse). Employee 10 then performed an assessment on Resident 59 while Resident 59 was in the dining room for supervision. The physician was then notified and emergency medical services were called. During a staff interview on June 25, 2025, at 1:20 PM, Employee 8 stated that on April 27, 2025, Resident 59 approached her with suicidal ideations. At which time she and Resident 59 walked to Employee 7 (LPN) who was performing medication pass. Employee 8 stated that at that time she did not see any cuts, or blood on Resident 59's arms, wrists or hands. During the staff interview, Employee 8 stated that one-to-one observation of Resident 59 was not initiated by Employee 7, though, Employee 8 did keep an eye on Resident 59 from the hallway while Resident 59 was in his room. However, based on review of the statements as identified above, it was determined that Resident 59 was not supervised at the time of the initial self-injury, as it was stated that blood not observed at approximately 7:15 PM, but observed when Employee 9 went into Resident 59's room to speak with him which was at an undetermined time. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the available information revealed that the time Employee 7 was notified of Resident 59's suicidal ideation was approximately 7:15 PM on April 27, 2025. At that time, Employee 7 did not initiate the facility's suicide precautions protocol. Specifically, Employee 7 failed to assess the Resident and initiate one-to-one supervision; failed to immediately notify the registered nurse supervisor (Employee 10); and failed to notified the attending physician. Employee 7 also failed to evaluate the immediate safety needs of Resident 59, including checking his room and removing sharp objects. This failure led to the ability of Resident 59 to self-harm with a sharp piece of plastic. Review of Resident 59's clinical record revealed no order for suicidal precautions or one-to-one supervision were obtained or entered into the electronic health record in response to Resident 59's expressed suicidal ideation on April 27, 2025. On June 25, 2025, at 1:39 PM, the Nursing Home Administrator (NHA) was notified of an Immediate Jeopardy situation in regard to the facility staff failing to implement the facility's suicide precautions protocol. At that time, the NHA was provided with the Immediate Jeopardy template and an Immediate Jeopardy Removal Plan was requested. On June 25, 2025, at 5:17 PM, NHA submitted an Immediate Jeopardy Removal plan. After review, the Immediate Jeopardy Removal plan was accepted on June 25, 2025, at 5:40 PM. The approved removal plan included: 1. A full audit of facility residents to identify any resident(s) actively experiencing suicidal ideation. 2. For any resident identified as having suicidal ideation, the environmental will be evaluation for safety and any items that are unsafe will be removed from the room. Windows will be checked to ensure they are secure and not a risk to resident safety. Staff member will stay with the resident until orders have been given by the provider and interventions are place. 3. A change in condition assessment will be completed as well as provider and resident representative notification. 4. Orders for one-to-one and any other necessary measures will be obtained and entered in the electronic health record until the resident is discharged to an appropriate healthcare center, or the medical provider has assessed and deemed the resident is no longer at risk. 5. If a one-to-one is ordered for a resident, documentation will be completed per policy/procedure until the resident is discharged or the order for one-to-one is discontinued by the medical provider. 6. The facility will educate current staff regarding the facility's suicide precautions protocol. 7. The facility will audit five residents with psychiatric history or depression diagnosis to identify any suicidal ideation for four weeks. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On June 26, 2025, between 8:25 AM and 9:25 AM, review of residents revealed no further residents were experiencing suicidal ideations. Interviews with staff, which included Registered Nurses, Licensed Practical Nurses, and Nurse Aides, revealed staff were educated upon start of shift and were knowledgeable of the facility's suicide precautions protocol and the facility's one-to-one procedure. On June 25, 2025, at 9:30 AM, the Immediate Jeopardy was lifted after implementation of the Removal Plan was verified. During an interview on June 26, 2025, at 10:05 PM, the NHA confirmed that one-to-one observation is considered constant supervision with staff within arms-length of the resident being supervised. During the staff interview, the NHA revealed it was the facility's expectation that the facility's suicide precautions policy would be followed when a resident expresses suicidal ideations. The facility failed to implement the facility's suicide precautions protocol, as identified above, immediately upon being made aware of Resident 59's suicidal ideations on April 27, 2025. This failure placed Resident 59 at high risk for serious injury and/or death and resulted in an Immediate Jeopardy situation for Resident 59. Review of facility policy, titled Falls Management last revised March 15, 2024, read, in part, Patients will be assessed for risk of falling as part of the nursing assessment process. Interventions to reduce risk and minimize injury will be implemented as appropriate. Patients experiencing a fall will receive appropriate care and post-fall interventions will be implemented. In the event a fall occurs, an assessment will be completed to determine possible injury. Review of Resident 81's clinical record revealed diagnoses that included unspecified fracture of lower end of right radius (a fracture that occurs in the lower end of the radius bone near the wrist), repeated falls, and unsteadiness on feet. Review of select facility fall report dated December 25, 2024, detailed a fall sustained by Resident 81. Under the section for Statements it read, No statements found. Review of select facility fall report dated February 11, 2025, detailed a fall sustained by Resident 81. Under the section for Statements it read, No statements found. Interview with the Director of Nursing on June 26, 2025, at 12:16 PM, she revealed she was unable to locate witness statements collected from staff in response to Resident 81's falls on the aforementioned dates, and she would expect thorough fall investigations to be conducted. 28 Pa. code 201.14(a) Responsibility of licensee 28 Pa code 201.18(b)(1) Management 28 Pa code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record reviews, and resident and staff interviews, it was determined that the facility failed to manage or prevent pain consistent with professional standards of practice and the residents' goals and preferences for three of 28 residents reviewed (Residents 13, 27, and 287). Findings include: Review of facility policy, titled NSG 227 Pain Management, with a last review date of May 7, 2025, read, in part, Staff will continually observe and monitor patients for comfort and presence of pain and will implement strategies in accordance with professional standards of practice, the patient-centered plan of care, and the patient's choices related to pain management. Purpose is to design a plan of care to achieve an optimal balance between pain relief and preservation of function, in accordance with patient directed goals and preferences. 7. Center staff will report any observation or communication of pain to the nurse responsible for that patient. 9. Patients receiving interventions for pain will be monitored for the effectiveness and/or side effects/adverse drug reactions (e.g., constipation, sedation). Document: 9.1 Non-pharmacological interventions and effectiveness; 9.2 Effectiveness of PRN [as needed] medications; 9.3 Ineffectiveness of routine or PRN medications including interventions, follow-up, and physician notification. The care plan will be evaluated for effectiveness until satisfactory pain management is achieved. Contact the physician/advanced practice provider to report findings and obtained revised treatment orders, if indicated. Review the non-pharmological approaches for effectiveness. Revise the care plan as indicated. Review of Resident 13's clinical record revealed diagnoses that included cerebrovascular disease (conditions that affect blood flow to your brain) and scoliosis (a condition where the spine curves sideways). Review of Resident 13's clinical record revealed an active physician's order for oxycodone hydrochloric acid (hcl) 5 milligram (mg) tablet, give one tablet orally two time a day for pain, with an active date of March 13, 2025. Review of Resident 13's June 2025 medication administration record (MAR) revealed an order for oxycodone hcl 5 mg tablet, give one tablet orally two times a day for pain, with a start date of March 13, 2025. Further review of the June 2025 MAR revealed that on the following dates and times, the MAR was marked NN, which is code for No / see nurse notes: on 15 and 18 at 9:00 PM; and on 16, 17, and 19 at 8:00 AM and 9:00 PM. Further, on the 20th at 9:00 PM, it was blank, indicating the medication was not administered to the Resident. Review of Resident 13's clinical record revealed progress notes on the dates listed above that said oxycodone hcl 5 mg tablet was not administered due to the medication being unavailable and awaiting delivery from the pharmacy. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview conducted with the Director of Nursing (DON) on June 25, 2025, at 10:20 AM, revealed Resident 13's oxycodone was reordered on June 20, 2025, and a new script was obtained. DON revealed management was not made aware that a refill of the script was needed for oxycodone for Resident 13, and that the expectation would be for the LPN (licensed practical nurse) who was administering Resident 13's medication would see that there was no oxycodone available for the Resident, would reorder and request a script, and use the in house emergency supply until it is delivered. Review of Resident 27's clinical record revealed diagnoses that included need for assistance with personal care, muscle weakness, and unsteadiness on feet. Interview with Resident 27 on June 23, 2025, at 10:57 AM, he revealed he often has pain in his back and the medication he receives doesn't always help relieve his pain. Review of Resident 27's clinical record revealed a note written by Employee 16 (Nurse Practitioner) on June 16, 2025, that read, in part, Acute visit for low back pain. Patient reports acute onset of intermittent 10/10 low back pain. Plan: May apply ice pack PRN. Review of Resident 27's physician orders failed to reveal an order for an ice pack. Review of Resident 27's care plan failed to reveal a comprehensive care plan for pain management. During an interview with the DON on June 25, 2025, at 10:06 AM, she revealed Employee 16 would typically write a physical order for nursing to enter into the electronic health record, but she only put the order in her note, and she may not have known that the ice pack would need a physical order written. She further revealed her expectation that the ice pack should have been ordered and Resident 27 should have had a comprehensive care plan for pain management. Review of Resident 287's clinical record revealed that she was admitted to the facility on [DATE], with diagnoses that included fracture of the upper end of the right humerus (bone in upper arm) and scalp laceration. During a resident interview with Resident 287 on June 23, 2025, at 12:04 PM, she reported that her pain was not being managed to her comfort level. Review of Resident 287's clinical record revealed the following physician orders: Acetaminophen Oral Tablet 500 MG (Acetaminophen) Give two tablets by mouth every 8 hours for mild to moderate pain dated June 19, 2025; (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Aspercreme Lidocaine External Patch 4 % (Lidocaine) apply to right shoulder topically in the morning for right shoulder pain apply at 8:00 AM, remove at bedtime; Aspercreme Lidocaine External Patch 4 % (Lidocaine) apply to right wrist topically in the morning for right wrist pain apply at 8:00 AM, remove at bedtime dated June 19, 2025; Oxycodone hydrochloride tablet 5 mg (milligrams) give one tablet by mouth every 4 hours as needed for moderate to severe pain (4-10) dated June 19, 2025; non-pharmacological intervention(s) used before as needed pain medication. Record non-pharmacological intervention(s) in supplementary documentation. Document effectiveness. If pain continues, follow providers direction which may include pain medication dated June 19, 2025; and Ask resident if they are having pain. Document pain level and new onset Y/N in supplementary documentation and document location of pain in emar PN [electronic medication administration record progress note] every day shift. If new onset complete Einteract Change In Condition and Pain Evaluation, if not new initiate non-pharmacological interventions and document interventions and effectiveness dated June 20, 2025. Review of Resident 287's care plan revealed a care plan focus for alteration in comfort acute pain dated June 19, 2025, with a goal of Resident will achieve acceptable level of pain control as defined by the Resident. Interventions included, but were not limited to, Medicate resident as ordered for pain and monitor for effectiveness and monitor for side effects, report to physician as indicated and Evaluate pain characteristics: quality, severity, location, precipitating/relieving factors. The care plan failed to identify/include Resident 287's specific desired pain goal or acceptable level of pain. Review of Resident 287's June [DATE] revealed that she was not documented as receiving her ordered dose of acetaminophen on June 20, 2025, at 2:00 PM, with no additional supporting documentation provided. It also revealed that she had refused her Aspercreme to her right wrist on June 22-24, 2025, and had refused her Aspercreme to her right shoulder on June 22-23, 2025, with no documentation as to why she refused the medication or that her physician was made aware of the medication refusals. Further review of Resident 287's MAR revealed that her daily pain evaluations were completed June 20-25, 2025, and her pain ranged from 0-5. Further review of Resident 287's June 2025 MAR revealed that she had received her as needed oxycodone as follows: June 19 7:32 PM pain level 10; medication effective; June 20 5:02 AM pain level 7; medication effective; June 20 11:30 PM pain level 10; medication effective; June 21 8:55 AM pain level 6; medication effective; June 21 5:02 PM pain level 5; medication ineffective; June 21 10:01 PM pain level 5; medication effective; June 22 1:29 PM pain level 8; medication effective; June 22 7:27 PM pain level 8; medication effective; (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	June 23 3:15 AM pain level 8; medication effective; June 23 10:27 AM pain level 5; medication effective; June 23 4:44 PM pain level 8; medication effective; June 24 1:13 AM pain level 8; medication effective; June 24 7:06 PM pain level 5; medication effective; June 25 00:15 AM pain level 6; medication effective; and June 25 7:05 PM pain level 7; medication effective. Further review of Resident 287's MAR revealed that there were no non-pharmacological interventions ever documented prior to the aforementioned administrations of her as needed medication. Review of Resident 287's clinical record progress notes revealed a history and physical physician's note dated June 20, 2025, that indicated the plan was to continue current acetaminophen and oxycodone orders and a physiatry consult (a medical specialty that deals with the treatment of people who have a disability, chronic pain, or some other physical problem. The specialty is sometimes called physical medicine and rehabilitation). Resident 287's clinical record progress notes revealed a physician's progress note dated June 22, 2025, that indicated she was being followed by a physiatrist for pain management and therapy. Further review of Resident 287's clinical record failed to reveal any consultations or documentation by the physiatrist. Review of 287's clinical record revealed Resident Concern Form dated June 23, 2025, which indicated that Resident reporting poor pain control with current regimen. Wishes to speak to provider. Response by the nurse practitioner indicated Routine ES [Extra Strength] Tylenol ordered. Review the nurse practitioner's order dated June 23, 2025, revealed an order for Extra Strength Tylenol 1000 mg (milligrams) po [by mouth] tid [three times daily] routine and DC [discontinue] PRN [as needed] Tylenol. However, review of Resident 287's physician orders revealed that this order had been in place since her admission to the facility on June 19, 2025. Review of Resident 287's clinical record progress notes revealed a medical practitioner note by the nurse practitioner dated June 23, 2025, at 12:39 PM, that indicated Resident 287 was awake, alert, oriented, and can make her needs known and follow commands and that Resident 287 reports that she continues to have significant pain in the RUE [right upper extremity-arm]. Will initiate routine E[xtra] S[trength] Tylenol. Reinforced to the patient that she does have PRN [as needed] Oxycodone available Q 4 hours PRN [every four hours as needed] for pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 287's clinical record progress notes revealed a general note written by a Licensed Practical Nurse on June 25, 2025, at 4:37 PM, that indicated it was an interview with Resident 287 for her MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) with the assessment reference date (last day of the assessment period) of June 26, 2025, revealed that Resident 287 has had almost constant pain to her right arm and wrist d/t [due to] fractures. Almost constantly pain affects her sleep. Almost constant pain interferes with therapy activities and day to day activities. Pain intensity is 10 out of 10. There was no documentation noted that Resident 287's assigned nurse, physician, or nurse practitioner was made aware of these findings. Email communication received from DON on June 25, 2025, at 7:30 PM, indicated physiatry team has been added to care team and updated on this resident's pain. Physiatry team does not visit the center daily and has not yet assessed the resident at this time. During a staff interview with the Nursing Home Administrator (NHA) and DON on June 26, 2025, at 9:53 AM, the DON confirmed that she would have expected nursing staff to have followed up with Resident 287's physician regarding her ongoing reports of pain in a timely manner. She confirmed that the nurse practitioner was notified about Resident 287 reporting poor pain control on June 23, 2025, and that the nurse practitioner had visited the Resident and had given an order to initiate routine Acetaminophen (Tylenol), but the DON agreed that order was already in place at the time the nurse practitioner gave the order and, therefore, there was no change in Resident 287's treatment regimen for pain. The DON confirmed that no additional follow up was completed with the nurse practitioner or physician when this was noted. She confirmed that Resident 287 had not had a baseline care plan meeting where her resident specific pain level goal could have been discussed. During a follow-up interview with Resident 287 on June 26, 2025, at 10:30 AM, Resident 287 indicated that she gets no relief from her pain. It is constant. During an interview with Employee 11 (Regional Clinical Support Nurse) on June 26, 2025, at 11:31 AM, revealed that Resident 287 would be seen by the physiatrist today and that Resident 287's physician had deferred her pain management to the physiatrist as the physician did not feel comfortable ordering any additional medications outside of the current ordered regimen. During a final interview with the NHA and DON on June 26, 2025, at 12:15 PM, the DON confirmed that she would have expected nursing staff to have followed up with Resident 287's physician or nurse practitioner in a timely manner to address Resident 287's ongoing pain control concerns. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of grievances, and resident and staff interviews it was determined that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for one out of three nursing units (West wing). Findings Include: During the initial pool process on June 23, 2025, and June 24, 2025, there were 10 residents who expressed concern to the survey team about call bell response time and/or staffing. Review of facility grievances from April, May, and June of 2025 revealed three grievances related to extended wait time for call bells to be answered. Review of Resident Council Meeting minutes for April, May, and June of 2025 revealed that residents present at the meetings complained about extended call bell wait times in April and May of 2025. During an observation on June 23, 2025, at 11:00 AM, in [NAME] wing, B-hall, there were call lights activated for rooms [ROOM NUMBERS]. Further observation revealed that the call bell for room [ROOM NUMBER] was answered at 11:27 AM and the call bell for room [ROOM NUMBER] was answered at 11:32 AM. During an interview with the Nursing Home Administrator on June 25, 2025, at 12:20 PM, she had no further information to provide. 28 Pa code 211.12(d)(1)(4)(5) Nursing services

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on facility document review and staff interview, it was determined that the facility failed to ensure employee performance reviews were completed yearly (at least every 12 months) for five of five employees reviewed (Employees 9, 12, 13, 14, and 15). Findings include: On June 25, 2025, at approximately 9:45 AM, a request for the most recent employee performance reviews for Employees 9, 12, 13, 14, and 15 was made to the Nursing Home Administrator (NHA). During a staff interview on June 26, 2025, at approximately 12:20 PM, the NHA revealed the facility did not have any record that an employee review was conducted within the past year for Employees 9, 12, 13, 14 and 15. During the staff interview, the NHA revealed it was the facility's expectation that employee performance reviews are completed yearly. 28 Pa code 201.18(b)(3)Management 28 Pa code 201.19(2) Personnel policies and procedures

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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. Based on facility policy review, observations, and staff interviews, it was determined that the facility failed to discard expired medications in one of three medication carts observed (B Hall) and in one of two medication rooms observed (West Wing). Findings include: Review of facility policy, titled Storage of Medication, with a last review date of May 7, 2025, revealed Medications and biologicals are stored properly, following manufacturer or provider pharmacy recommendations to keep their integrity and to support safe, effective drug administration. Review of facility policy, appendix Medications with Shortened Expiration Dates, dated 2007, revealed that Novolog insulin should be discarded 28 days after opening and that the beyond use date after initially opening multi-dose injectable vials is 28 days unless otherwise specified by the manufacturer. Observation of the B Hall medication cart on June 24, 2025, at 9:16 AM, revealed a Novolog insulin vial with an open date of May 24, 2025. Observation of the [NAME] Wing medication room on June 24, 2025, at 9:27 AM, revealed two open Afluria influenza vaccine vials. One was dated as being opened December 24, 2024, and the other one was dated as being opened on May 20, 2025. Email communication received from the Director of Nursing (DON) on June 24, 2025, at 10:13 AM, indicated that Per the manufacturer guidelines, the Afluria multi-dose vials are good for 28 days once opened. We've removed vaccines from all the med refrigerators at this time, since we are out of flu season. During a staff interview with the Nursing Home Administrator and the DON on June 24, 2025, at 1:27 PM, the DON confirmed that she would expect medications to be stored and discarded when expired or according to policy and manufacturer guidelines. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(a)(1) Pharmacy services

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on clinical record review and resident and staff interviews, it was determined that the facility failed to ensure dental services were provided to meet resident need for one of one resident reviewed for dental (Resident 14). Findings include: Review of Resident 14's clinical record revealed diagnoses that included anxiety disorder (a group of mental health conditions characterized by excessive, persistent, and disproportionate fear or worry) and dysphagia (swallowing difficulties). During an interview with Resident 14 on June 25, 2025, on 12:18 PM, revealed she had new dentures that do not fit her mouth, which results in her not being able to eat properly. Review of Resident 14's clinical record revealed she was last seen by the facility's dentist on August 16, 2024, with treatment notes that included the Resident is interested in having new dentures fabricated, and that a preauthorization was submitted and will follow up with the Resident following denture approval. Review of Resident 14's clinical record revealed a preauthorization for the Resident's dental claim was submitted and approved on April 18, 2025, and expires on October 15, 2025. Review of Resident 14's clinical record revealed there has not been a follow up appointment scheduled with the dentist after the insurance claim was approved. During an interview with the Nursing Home Administrator on June 26, 2025, at 1:07 PM, revealed he would not have expected dental services to have taken so long for a resident to be scheduled or addressed. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on facility policy reviews, observations, clinical record reviews, review of facility master menu diet guide sheets, and staff interviews, it was determined that the facility failed to provide an altered texture diet, as prescribed by the physician, for six residents (Residents 2, 9, 12, 14, 60, and 101) observed. This failure placed 14 additional residents that had similar diet needs at a high risk for death and resulted in an Immediate Jeopardy situation (Residents 12, 13, 39, 50, 51, 62, 68, 73, 74, 78, 98, 108, 110, and 289). Findings include: Review of facility policy, titled Consistency Alterations and Therapeutic Menus dated May 1, 2023, read, in part, Purpose: To provide diets as ordered by the physician/advanced practice provider. Review of facility policy, titled Dysphagia Management dated May 1, 2023, read, in part, Residents who have swallowing difficulties/dysphagia will receive treatment interventions to promote adequate nutrition and hydration. Review of physician's orders revealed that Residents 2, 9, 12, 14, 60, and 101, were ordered the dysphagia advanced texture diet (special diets for people who have difficulty chewing and/or swallowing- dysphagia). Review of facility master menu diet guide sheets revealed the dysphagia advanced diets should be served chopped carrots as their vegetable at lunch on Wednesday of the Week 1 Menu. Review of facility recipe for sliced carrots, read, in part, the dysphagia advanced diet texture (Soft and Bite Size Level 6) should be served carrots that are cooked, tender, no bigger than ½-inch by ½-inch pieces (1.5 cm x 1.5 cm). Observations during tray line meal service on June 25, 2025, between 11:33 AM and 12:05 PM, revealed Residents 2, 9, 12, 14, 60, and 101 had notation on their meal tickets that they should be served chopped carrots, but they were served round slices of carrots that were larger than bite size pieces. Observations on June 25, 2025, between 12:08 PM and 12:19 PM, revealed Residents 2, 9, 12, 14, 60, and 101, had been served the round slices of carrots. Interview with Employee 1 (Certified Dietary Manager) on June 25, 2025, at 12:20 PM, revealed that the kitchen had in fact served sliced carrots instead of chopped carrots that day at lunch for the dysphagia advanced diet textures, and that the carrot slices served were larger than the guidelines of no bigger than ½-inch by ½-inch pieces (1.5 cm x 1.5 cm). (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with Employee 2 (Speech Language Pathologist) on June 25, 2025, at 2:09 PM, revealed she has not recommended any adjustments to the facility master menu diet guide sheets to change the guidance on what should be served. She further revealed her expectation that food should be served from the kitchen staff at the appropriate textures, including dysphagia advanced diets, which have guidelines for the carrots to be no bigger than ½-inch by ½-inch pieces (1.5 cm x 1.5 cm), consistent with the International Dysphagia Diet Standardization Initiative's recommendations. Review of physician's orders revealed Residents 12, 13, 39, 50, 51, 62, 68, 73, 74, 78, 98, 108, 110, and 289, were also ordered the dysphagia advanced texture diet. Interview with the Nursing Home Administrator (NHA) on June 26, 2025, at 8:47 AM, revealed his expectation that the facility master menu diet guide sheets for mechanically altered diets should be followed. The NHA was notified of the IJ situation on June 25, 2024, at 1:19 PM, and was provided the IJ template. An Immediate Action Plan was requested. The Immediate Action Plan was provided by the NHA on June 25, 2024, at 5:23 PM, and approved at 5:40 PM. The approved plan included: 1. A full audit of facility residents will occur to ensure that facility residents with altered texture diets are identified to ensure all diet orders, meal tracker/tray tickets are accurate. 2. Diet texture education will occur for nursing staff, dietary staff and anyone that assists with meal service. 3. Education will be initiated for facility nursing staff, and any staff who assist in meal service to check resident identifier/diet order/ticket prior to serving meal tray to any resident and if there are any discrepancies, notify his/her direct supervisor and dietary staff to ensure correction is made immediately. 4. Education for dietary staff will be initiated to ensure the meals served match the residents' meal tickets and consistencies are accurate prior to leaving the food line. 5. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Director of Nursing/designee will re-educate current staff regarding proper diet texture identification and proper checks of diet texture per provider order, which includes the process noted above. The Director of Nursing/designee will begin education June 25, 2025. As of June 25, 2025, 100% of available staff have been educated on this policy. 6. Any staff member that has not been educated, will be prior to the start of his/her next shift. Any staff member that has not been scheduled, on leave of absence (FMLA), vacation, or PRN [as needed] staff will be educated prior to returning to his/her next shift. New hires/agency staff are educated on food and fluid textures during orientation. 7. The facility will conduct audits for tray accuracy daily of each meal for one week to ensure the altered texture diets are present. The facility will conduct ongoing audits weekly for four weeks to ensure accuracy of altered texture diets. On June 26, 2025, between 7:39 AM and 8:25 AM, breakfast tray line meal service was observed to ensure all residents received the appropriate texture diet per their physician order. The audit of dinner service on June 25, 2025, as well as they audit of breakfast service on June 26, 2025, were reviewed without concern. Staff interviews revealed the facility had re-educated staff on mechanically altered diets and the master menu diet guide sheet. Interviews were conducted with three registered nurses, three licensed practical nurses, five nursing assistants, four dietary employees, and the dietary manager; all were able to verbalize their role in providing appropriate diet textures. On June 25, 2025, at 9:01 AM, the Immediate Jeopardy was lifted when the action plan implementation was verified. Observations on June 25, 2025, between 11:33 AM and 12:05 PM, revealed that the facility failed to provide food in a form ordered by the physician to meet the individual needs of six residents Resident's 2, 9, 12, 14, 60, and 101. This failure placed 14 additional residents that had similar diet needs at a high risk for death and resulted in an Immediate Jeopardy situation for Residents 12, 13, 39, 50, 51, 62, 68, 73, 74, 78, 98, 108, 110, and 289. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.12(c)(d)(1)(2)(3)(5) Nursing services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of manufacturer guidelines, observation, review of select facility temperature logs, and staff interviews, it was determined that the facility failed to utilize equipment in accordance with professional standards for food service safety in the main kitchen. Findings include: Review of manufacturer guidelines for Cle-Series Dishwashers, dated November 2012, revealed that the minimum temperatures using high-temperature sanitizing for single-tank models, such as CL44e, require a minimum wash temperature of 160 degrees F (Fahrenheit- unit of measure). Observation of the dish machine in the main kitchen on June 23, 2025, at 9:41 AM, revealed the temperature gauge on the machine read 152 degrees F for the wash temperature while in use. During an interview with Employee 1 (Certified Dietary Manager) on June 24, 2025, at 12:37 PM, he revealed the model of the dish machine was CL44e and provided the manufacturer guidelines for review. He further revealed he and the staff were under the impression that the dish machine required a minimum wash temperature of 150 degrees F. Review of the October 2024 dish machine temperature log revealed wash temperatures recorded were below the minimum safe temperature of 160 degrees F on October 3-31 at breakfast; October 1, 3-6, and 9-31 at lunch; and October 1-3, 9, 12, 13, 15, 17, 22 and 26-31. Review of the November 2024 dish machine temperature log revealed wash temperatures recorded were below the minimum safe temperature of 160 degrees F on November 1-30 at breakfast; November 1-11 and 13-30 at lunch; and November 1, 3, 5, 8-10, 13, 15, 18, 20, 21, 23, 24, and 29. Review of the December 2024 dish machine temperature log revealed wash temperatures recorded were below the minimum safe temperature of 160 degrees F on December 1-3, 5-8, and 10-29 at breakfast; December 1-3, 5-8, 10-15 17, 18, 20, 21, 24, and 26-30 at lunch; and December 4, 6, 7, 10, 11, 20-22, 28 and 29 at dinner. Review of the January 2025 dish machine temperature log revealed wash temperatures recorded were below the minimum safe temperature of 160 degrees F on January 2, 4-6, 8-10, 12, 13, 15-29 and 31 at breakfast; January 2, 4-8, 10, 12, 15-27, and 29-31 at lunch; and January 1, 12-16, 18, 21, 24, 25, and 27-31 at dinner. Review of the February 2025 dish machine temperature log revealed wash temperatures recorded were below the minimum safe temperature of 160 degrees F on February 1, 3-6, 8, 9, 11-19, and 21-28 at breakfast; February 1-9, and 11-28 at lunch; and February 1-7 9-21, 24, 25, and 27 at dinner. Review of the March 2025 dish machine temperature log revealed wash temperatures recorded were below the minimum safe temperature of 160 degrees F on March 1-11, and 13-31 at breakfast; March 1-11 and 13-30 at lunch; and March 1-3, 5-10, 12-14, 16-22, 25-28, 30 and 31 at dinner. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the April 2025 dish machine temperature log revealed wash temperatures recorded were below the minimum safe temperature of 160 degrees F on April 1-14, 16-18, 21, 22, 24, 26, and 29 at breakfast; April 1-12, 14, 17, 18 and 24 at lunch; and April 1, 5, 10, 11, 13, 15-17, and 21-29 at dinner. Review of the May 2025 dish machine temperature log revealed wash temperatures recorded were below the minimum safe temperature of 160 degrees F on May 1, 3-8, 10, 12, 15, 17, 19-24, 26-28, 30 and 31 at breakfast; May 1, 3, 4, 6-8, 11, 12, 21, 24, 26, and 29-31 at lunch; and May 1, 3-9, 11, 17, 20-23, 25, 27, 29 and 31, at dinner. Review of the June 2025 dish machine temperature log revealed wash temperatures recorded were below the minimum safe temperature of 160 degrees F on June 1-5, 7-12, 14, 16, 17, 19-21, and 23-25 at breakfast; June 1, 3-5, 8-10, 12, 14, 17, 19, 20, 23 and 24 at lunch; and June 2, 4, 6, 11-14, 16, 18, 19, 23 and 24 at dinner. Interview with Employee 1 on June 25, 2025, at 11:29 AM, revealed a contracted company they work with has installed a temperature recorder on the dish machine that seems to be more accurate than the one on the machine, so he plans to educate staff to record the temperature on the attached gauge. He further revealed he plans to contact the manufacturer of the dish machine to determine if it needs serviced. Interview with the Nursing Home Administrator on June 26, 2025, at 9:55 AM, he revealed he would expect the dish machine to be running at proper temperatures or the proper temperature would be recorded. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.6(f) Dietary services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on review of facility policy, review of medication package insert, observations, and staff interviews, it was determined that the facility failed to maintain an effective infection control program related to the preparation and administration of medications to four of four residents observed (Residents 19, 52, 87, and 109). Findings include: Review of facility policy, titled Medication Administration 7.5 Orals, with a last review date of May 7, 2025, revealed in part avoid touching any of the medication unless wearing gloves. Review of the instruction leaflet for Lantus-Solostar Insulin Pen, with a last revised date of February 23, 2016, revealed the following, in part, Always use a new sterile needle for each injection. A. Wipe the rubber seal with alcohol. B. Remove the protective seal from a new needle. C. Line up the needle with the pen and keep it straight as you attach it (screw or push on, depending on the needle type). Review of facility policy, titled Subcutaneous Insulin, with a last review date of May 7, 2025, failed to reveal any direction to cleanse the rubber seal of an insulin pen before applying a new needle as indicated in manufacturer guidelines. Observation of medication administration on June 24, 2025, between 8:34 AM and 8:49 AM, Employee 4 was observed to cleanse her hands, apply gloves, handle the keys to unlock the medication cart, touch drawer handles of the medication cart, push pills out of the blister pack medication card into her gloved hands that had touched the keys and the drawer handles, place the medications into a medicine cup, and then administered the prepared medications to Resident 19. Employee 4 followed the same process for Resident 52 and Resident 87. During a staff interview with Employee 4 on June 24, 2025, at 8:55 AM, Employee 4 confirmed that she had touched Residents 19, 52, and 87's medications wearing the same gloves that she had touched the keys and drawer handles with during medication preparation. Observation of medication administration on June 24, 2025, at 9:01 AM, Employee 5 was observed applying a new needle to Resident 109's insulin pen without cleansing the rubber seal on the pen prior to applying. During a staff interview with Employee 5 on June 24, 2025, at 9:05 AM, Employee 5 confirmed that she had not cleansed the rubber seal on the insulin pen before applying the new needle. During a staff interview with the Nursing Home Administrator and the Director of Nursing (DON) on June 24, 2025, at 1:27 PM, the DON confirmed that Employee 4 should not have directly touched the medications for Residents 19, 52, and 87 with her gloved hands that had touched unclean items, such as the keys and the medication cart drawer handles. She also confirmed that Employee 5 should have cleansed the rubber stopper on the insulin pen before applying the new needle for Resident 109. 28 Pa. Code 201.18(b)(1) Management (continued on next page)

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