

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Carlisle Skilled Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, nurse aide competency review, clinical record review, review of select facility documentation, hospital discharge summary, and staff interviews, it was determined that the facility failed to provide adequate supervision and assistance to prevent accidents for one of 29 residents reviewed (Resident 111), which resulted in actual harm for Resident 111 as evidenced by a femur fracture. Review of facility policy, titled Falls Management last reviewed January 15, 2026, 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. Implement and document patient-centered interventions according to individual risk factors in the patient's plan of care. Educate staff, patient, and/or patient representative(s) as appropriate to increase awareness of 'at risk' patients and to provide possible strategies to minimize risk for falls. Review of checklist, titled Turning and Repositioning not dated, read, in part, Critical elements: Stands on the side of the bed opposite to where caregiver will turn the patient. Moves patient to the side nearest caregiver (moves patient in segments or with a drawsheet). Review of Resident 111's clinical record revealed she had a BIMS (Brief Interview for Mental Status- a quick test that looks at how well you think, learn and remember) score of 9 out of a possible 15, indicating a degree of cognitive impairment, and diagnoses that included history of falling, repeated falls, and displaced fracture of lateral condyle of unspecified femur, initial encounter for closed fracture (fracture of one of the two articular projections at the distal end of the femur). Review of Resident 111's clinical record revealed her transfer ambulation status was full mechanical lift, and her bed mobility status was one assist. Review of Resident 111's comprehensive care plan revealed a focus area of [Resident 111] is at risk for falls last revised June 4, 2026, with an intervention for implement safety precautions, with a created date of May 22, 2026. Review of facility incident report dated July 1, 2026, read, in part, [Employee 4] came out to the nursing station and said that the patient had fallen off the bed. Patient was getting changed so she could go to lunch. Resident stated she was reaching for the side of the bed to roll over and she rolled onto the floor. Nurse Practitioner ordered x-rays of the right femur and hip. The decision was later made to transfer [Resident 111] to the emergency department for further work up. Review of signed statement written by Employee 4 (Nurse Aide) dated July 1, 2026, revealed At 11:30 AM, [Resident 111] had asked me to be changed. I grabbed [Employee 5 (Nurse Aide)] to help me transfer her because she is a Hoyer lift (a medical device designed to safely lift and transfer individuals with limited mobility from one surface to another using a sling and mechanical lifting system). We safely got her into bed. She is a 1 assist in bed so [Employee 5] had left the room. I had rolled her to get the clean brief under her. I grabbed the new brief that was on the bed. When I let go of her hip she had rolled out of bed. I went to put a pillow under her head immediately. I knew the nurse (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0689 Level of Harm - Actual harm Residents Affected - Few	practitioner was next door so I ran and got her then stayed with [Resident 111]. Review of follow-up statement from Employee 4 on July 22, 2026, revealed The resident was up in her wheelchair and asked to get changed. I grabbed another nurse aide, [Employee 5] to help me as [Resident 111] is a Hoyer lift. We positioned her in the bed. She helps with rolling and turning. She is very good about directions and following them. I was standing on the door side of the bed and helped [Resident 111] roll towards the window. As she rolled she was going to the bathroom. I took my hand off her hip to adjust the brief and [Resident 111] scooted herself towards the edge of the bed to hold onto the grab bar and she rolled onto the floor. She was facing away from me. I tried to catch her but couldn't. I immediately yelled for help. Review of facility document, titled On the Spot Education! dated July 1, 2026, revealed Education: Care with residents- roll towards you not away from you. Ask for assistance from another staff member or nurse if needed. The document was signed by Employee 4 on July 1, 2026. Review of Resident 111's Hospital Discharge summary dated [DATE], read, in, part, Discharge Plan: Principal Problem: Closed bicondylar fracture of distal end of right femur. Assessment: Postop day 4 ORIF (Open Reduction and Internal Fixation, a surgical procedure used to repair broken bones by realigning them and securing them with internal hardware) right distal femur with plate and screws and placement of external fixator. Plan: Patient is to be no weightbearing right lower extremity bed to chair transfers only. The external fixator should be in place for 6 weeks. During an interview with the Director of Nursing on July 22, 2026, at 2:18 PM, she revealed she would expect nurse aides to roll residents towards them and not away from them to prevent falls and accidents. The facility failed to provide adequate assistance to prevent accidents, which resulted in actual harm for Resident 111 as evidenced by a femur fracture requiring surgical intervention. 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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record, observations, and resident and staff interviews, it was determined the facility failed to ensure proper monitoring to maintain acceptable parameters of nutritional status, which resulted in actual harm as evidence by weight loss for one of five Residents reviewed (Resident 1). Also, the facility failed to adequately monitor and document fluid restrictions for one of five residents reviewed (Resident 8), and failed to reweigh and notify the physician and dietician of significant weight loss for one of five residents reviewed (Resident 21). Findings include: Review of facility policy, titled Weights and Heights, last reviewed January 15, 2026, revealed the following Based on the patient's comprehensive assessment, the Center will ensure that all patients maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range, unless the patient's clinical condition demonstrates that it is not possible for the patient's preferences to indicate otherwise. Patients are weighed upon admission and/or re-admission, then weekly for four weeks and monthly thereafter. Additional weights may be obtained at the discretion of the interdisciplinary care team. If the body weight of a patient is not as expected, re-weigh the patient. Notify the physician/APP (advanced practice provider) and Dietician of significant weight changes. Notify the patient/patient representative of the weight change. Review of facility policy, titled Enteral Management, revision date July 17, 2026, revealed, . enteral feedings will be provided through a nasogastric (a small, soft tube that goes through the nose, down the throat and into the stomach), gastrostomy (tube placed through the abdomen into the stomach), or jejunostomy tube (tube placed through the skin of the abdomen into the midsection of the small intestine) according to written physician/APP order. Review of Resident 1's clinical record revealed diagnoses that included severe protein-calorie malnutrition (inadequate intake of protein and calories) and malignant neoplasm of the tongue (cancerous growth on the tongue). Review of Resident 1's progress notes revealed a note by the facility dietitian dated June 18, 2026, at 11:23 AM, that read, in part, New order: Administer Jevity 1.5 continuous via Pump 80ml [milliliters] per hour for 20 hours per day or until 1600ml has infused. Flush w/ H2O 58ml per hour while TF infuses. Start time 8pm. This will provide 1600ml total volume, 2400 kcal, 102g protein and 2376ml total fluids (1216ml free water and 1160ml flush). Review of Resident 1's assessment titled dietary screening for malnutrition, at risk for malnutrition, morbid-obesity-ALTRA, dated June 22, 2026, revealed section C. 2. Is the resident at risk for malnutrition was marked yes. Review of Resident 1's comprehensive care plan revealed Resident 1 was at nutritional risk for malnutrition related to tongue cancer, dysphagia, severe protein-calorie malnutrition, the need to tube feed to meet needs, and wound healing. An intervention initiated on June 22, 2026, indicated to assess for signs and symptoms of malnutrition including weights per facility protocol. Resident 1's care plan also revealed that Resident 1 had an enteral feeding tube to meet nutritional needs due to Dysphagia (difficulty swallowing) with an intervention for Jevity 1.5 continuous via pump 80 ml per hour for 20 hours per day or until 1600ml has infused, initiated June 18, 2026. Review of Resident 1's physician orders revealed the following orders: NPO (nothing by mouth) for Dysphagia, enteral feed Jevity 1.5 calories administer via pump 80 ml (milliliters) per hour. Hours per day 20 or until total nutrient delivered, and weight today, dated July 3, 2026. Observation on July 20, 2026, at approximately 1:00 PM, revealed Resident 1's feeding pump was off and the tubing was disconnected from Resident 1's G tube (gastrostomy tube). A one liter bottle of Jevity 1.5 calorie with 200 ml remaining in the bottle was hanging on the dispensing apparatus at Resident 1's bedside. The bottle was dated July 19, 2026, 8:00 PM. Additional (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	observation on July 20, 2026, at 2:30 PM, revealed Resident 1's feeding pump was off and the tubing was disconnected from Resident 1's G tube, with 200 mL (milliliters) of Jevity 1.5 calories remaining in the bottle. Interview with Resident 1 during observation noted above revealed that staff had disconnected the feeding tube earlier that morning. Observation on July 21, 2026, at approximately 9:30 AM, revealed Resident 1's feeding pump was turned off and the tubing was disconnected from Resident 1's G tube (gastrostomy). One liter (1000 milliliters) bottle of Jevity 1.5 cal with 300 ml was remaining in the bottle. The bottle was dated July 20, 2026, 8:00 PM. Interview with Resident 1 at the time of the above observation revealed that staff disconnected his enteral feeding and told him that the enteral feeding was finished. Observation on July 22, 2026, at approximately 9:40 AM, revealed Resident 1's feeding pump was turned off. One liter bottle of Jevity 1.5 cal with 0 ml remaining in the bottle. The bottle was dated July 21, 2026, 8:00 PM. Review of Resident 1's progress notes revealed a note written by the facility dietitian dated July 8, 2026, indicating Enteral Feed: Jevity 1.5 at 80 ml/hr x 20 hours (Provides: 1600 mL, 2400 kcal, 102 g [grams] PRO [protein], 1216 ml free water). Review of Resident 1's current and discontinued physician orders failed to reveal an order for weight monitoring weekly for four weeks and monthly thereafter. Review of Resident 1's vital signs documentation revealed an admission weight of 172.8 pounds, obtained on June 18, 2026. Further review of Resident 1's clinical record failed to reveal documentation of any additional weights or documentation indicating the amount and duration of enteral feedings that Resident 1 received. During an interview on July 22, 2026, at 1:55 PM, with the Nursing Home Administrator (NHA), Director of Nursing (DON), and Employee 1 (Regional Clinical Support Nurse), it was revealed that the facility could not provide additional information relating to why Resident 1's was not being administered the full amount of feeding recommended by the dietitian and why Resident 1's weight had not been obtained. Additional review of Resident 1's clinical record revealed a weight of 160.4 pounds documented on July 23, 2026 (a 12-pound weight loss), indicating that Resident 1 had a 7.18% weight loss in 35 days. During a final interview on July 23, 2026, at 2:01 PM, with the NHA, DON, and Employee 1 it was revealed the facility's expectation is for enteral feedings be fully administered, orders for weight monitoring be in place, and resident weights would be obtained. The facility failed to monitor Resident 1's weight, administer the full amount of enteral feedings, and document the amount and duration of enteral feedings Resident 1 received. Weight obtained during the onsite visit revealed Resident 1 lost 12.4 pounds in 35 days since admission to the facility. Review of Resident 8's clinical record revealed diagnoses that included Chronic Diastolic Congestive Heart Failure (CHF - excessive body/lung fluid caused by a weakened heart muscle) and Ischemic Cardiomyopathy (heart muscled is weakened and struggles to pump blood efficiently because of long-term damage caused by a lack of blood supply). Review of Resident 8's orders revealed she was ordered fluid restrictions of 1800 milliliters per day. Nursing was to provide 720 milliliters per day-360 ml dayshift, 240 ml evening shift and 120 ml night shift. Dietary was to provide 1080 milliliters per day, which was to be 360 milliliters per meal. Review of Resident 8's meal intake documentation revealed that there was no documentation for fluid intake during meals or snacks. Review of Resident 8's medication administration record (MAR) failed to reveal documentation for milliliters of fluid provided by nursing staff from May 21, 2026, evening shift through June 3, 2026, day shift. Review of Resident 8's MAR for June 2026 revealed an order for Fluid restrictions for each shift -360 ml day shift, 240 ml evening shift, and 120 ml night shift. Seven times on day shift, the Resident was provided more than 360 ml of fluid. Two times on evening, Resident 8 was provided more than 240 ml, and four times on night shift she was provided more than 120 ml. There was also eight times where no fluid amount was documented. Review of Resident 8's MAR for July 2026 revealed three times on dayshift that the (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Resident was provided more than 360 ml. There were two times on evening shift that the Resident was provided more than 240 ml, and four times on night shift that more than 120 ml was provided. There was also six times that no fluid amount was documented. During a staff interview with Employee 1 on July 23, 2026, at 11:16 AM, she revealed her expectation would be that nursing staff would be documenting an amount in milliliters if a resident is ordered fluid restrictions and that there would be a task placed in for documentation of milliliters of fluids taken with meals. During an interview with the NHA, DON, and Employee 1 on July 23, 2026, at 1:38 PM, the DON revealed her expectation is for nursing staff to be documenting fluids accurately during the shift and following orders for the correct amount of fluids ordered. Review of Resident 21's clinical record revealed diagnoses that included Dementia (a loss of memory, language, and thinking skills that is severe enough to get in the way of daily life) and Hypothyroidism (a clinical condition where the thyroid gland-a small butterfly-shaped gland in your neck-underproduces essential thyroid hormones). Review of Resident 21's orders revealed a monthly weight was ordered through July 10, 2026, and was ordered weekly starting July 14, 2026. There was a 20-pound weight loss per documentation from July 1 to 3, 2026. A re-weigh was to be completed if there was a significant change, per policy, and there was no re-weigh obtained until July 8, 2026. Review of Resident 21's clinical record revealed a July 4, 2026, at 5:26 PM, notation from the physician indicating that the Resident was overweight. Review of a notation from the nurse practitioner on July 6, 2026, at 1:38 PM, noted the Resident's weight log was reviewed and was stable, and the Resident was overweight. Review of Resident 21's clinical record revealed a Nutritional assessment dated [DATE], in part, noting a significant, unplanned, undesirable 10.2 % weight loss in one month and a 9.3% weight loss in 3 months. Evaluation/nutrition plan recommends liberalizing diet due to significant weight loss and weekly weights for 4 weeks. During a staff interview with Employee 1 on July 22, 2026, at 1:40 PM, she confirmed that the expectation is that residents who have a significant weight change would be reweighed to confirm that the weight is accurate and that the physician and dietician would be made aware if there are significant changes. Further review of Resident 21's vital sign documentation revealed a weight of 172.3 pounds taken on July 21, 2026, via mechanical lift and a weight of 182.4 pounds taken on July 23, 2026, via mechanical lift. During a staff interview with the NHA, DON, and Employee 1 on July 23, 2026, at 1:45 PM, Employee 1 revealed that they would be having maintenance check the scales on the mechanical lifts for accuracy and proper functioning due to significant weight changes noted. 28 Pa Code 201.18(b)(1) Management28 Pa Code 211.2(d)(3) Medical director28 Pa Code 211.12(c)(d)(1)(3)(5) Nursing Services		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on facility policy review, personnel file review, and staff interview, it was determined that the facility failed to ensure that residents were protected from the potential for abuse by failing to perform licensure or registry verifications prior to hire for three of four personnel files reviewed (Employees 7, 8, and 9). Findings include: Review of facility policy, titled OPS300 Abuse Prohibition, with a last review date of November 14, 2025, revealed, in part, The Center will implement an abuse prohibition program through the following: Screening of potential hires. The Center will screen potential employees for a history of abuse, neglect, or mistreating patients, including attempting to obtain information from previous employers and/or current employers, and checking with the appropriate licensing boards and registries. Review of personnel file for Employee 7 (Licensed Practical Nurse) revealed that her date of hire was April 28, 2026. Further review of the personnel file revealed that the facility completed her license verification on July 13, 2026. Review of personnel file for Employee 8 (Nurse Aide) revealed that her date of hire was May 12, 2026. Further review of the personnel file revealed that the facility completed her registry verification on May 13, 2026. Review of personnel file for Employee 9 (Dietician) revealed that his date of hire was July 6, 2026. Further review of the personnel file revealed that the facility completed his license verification on July 9, 2026. During a staff interview with the Nursing Home Administrator (NHA), Director of Nursing, and Employee 1 (Regional Clinical Support Nurse) on July 22, 2026, at 1:44 PM, Employee 1 confirmed that license and registry verification should be completed prior to or upon hire. The NHA indicated that the facility had identified issues in their hiring process and have implemented a Performance Improvement Plan. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.19(3) Personnel policies and procedures.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for three of 29 residents reviewed (Residents 7, 47, and 56). Findings include: Review of Resident 7's clinical record revealed diagnoses that included schizoaffective disorder (mental health condition that includes symptoms of both schizophrenia and mood disorders) and bipolar disorder (unusual shifts in mood, ranging from extreme highs to lows). Review of Resident 7's physician orders revealed the following orders: risperidone (antipsychotic medication) 0.5 mg (milligrams) in the morning for bipolar disorder and bupropion HCL XR (antidepressant medication) 300 mg one time a day for depression, and mirtazapine (antidepressant medication) 7.5 mg at bedtime for antidepressant. Review of Resident 7's significant change minimum data sets (MDS - assessment tool utilized to identify a residents' physical, mental, and psychosocial needs) dated May 15, 2026, indicated a GDR (gradual dose reduction) had not been documented as contraindicated by Resident 7's physician. Review of Resident 7's psychiatry note dated April 16, 2026, revealed a GDR note indicating that on January 21, 2026, a GDR was not clinically advisable due to high risk for relapse of target symptoms related to diagnoses of depression, bipolar disorder, and schizoaffective disorder. During an interview on July 23, 2026, at 2:14 PM, with the Nursing Home Administrator (NHA), the Director of Nursing (DON), and Employee 1, it was revealed that Resident 7's aforementioned MDS was incorrect and it was the expectation of the facility that MDS be coded correctly. Review of Resident 47's clinical record revealed diagnoses that included parkinsonism (a set of movement symptoms - slowness, rigidity, and tremor - that can occur in Parkinson's disease and other conditions), low back pain, and difficulty in walking. Review of Resident 47's admission and 5 Day MDS assessments (Minimum Data Set - an assessment tool to review all care areas specific to the resident's physical, mental or psychosocial needs) with ARD (Assessment Reference Date- last day of the assessment period) revealed it was marked no for Received non-medication intervention for pain? Review of Resident 47's July 2026 MAR (Medication Administration Record- documentation for medication/treatment administered or monitored) revealed she was documented as receiving repositioning as a non-pharmalogical intervention for pain on July 18, 2026. During an interview with Employee 12 (MDS Coordinator) on July 23, 2026, at 11:01 AM, she revealed Resident 47's aforementioned MDS assessments are incorrect, as she should have been marked yes for having non-pharmalogical interventions for pain during the ARD lookback period. During an interview with the DON on July 23, 2026, at 1:02 PM, she revealed she would expect MDS assessments to be coded accurately. Review of Resident 56's clinical record revealed diagnoses that included hypertension (high blood pressure) and dementia (the loss of cognitive functioning that interferes with a person's daily life and activities). Review of Resident 56's physician orders revealed an order for wander guard/wander elopement device due to poor safety awareness, with an original start date of April 18, 2025. Review of Resident 56's care plan revealed the Resident was an elopement risk, with an intervention for a wander guard, which was initiated on April 16, 2025. Review of Resident 56's Quarterly MDS dated [DATE], revealed that Section P0200. Alarms, E. Wander/elopement alarm was marked 0. Not used, signifying that Resident 56 did not have a wander guard in use. During an interview with the NHA on July 23, 2026, at 1:19 PM, she revealed that Resident 56's MDS was incorrect and should have been documented as him having a wander guard used daily. 28 Pa. Code 211.5(f) Medical records. 28 Pa Code 211.12 (d)(3)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, as well as resident, resident representative, and staff interviews, it was determined that the facility failed to ensure the care plan was reviewed and revised for four of 29 residents reviewed (Residents 1, 34, 85, and 130), and failed to ensure that care plan meetings were held, residents were invited, and that the required interdisciplinary team members attended care plan meetings for three of 29 residents reviewed (Residents 6, 34, 106). Findings include: Facility policy, titled Person-Centered Care Plan, revised [DATE], read, in part, The interdisciplinary team, in conjunction with the patient and/or patient representative, as appropriate, will establish the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. 6. Care plans will be: 6.2 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. 7. Care Plan Meetings: 7.1 The physician/advanced practice provider (APP) must participate as part of the interdisciplinary team, and may arrange with the Center alternative methods, other than attendance at care planning conferences, of providing his/her input such as one-on-one discussions, conference calls and/or physician/APP orders. 8. The Center has the responsibility to assist patients to participate by: 8.1 Extending invitations to patient and representative sent in advance; 8.2 Holding care planning meetings at the time of day when the patient is functioning best; 8.3 Facilitating the inclusion of the patient/representative(s) to attend; and 8.4 Incorporating the patient's personal and cultural preferences in developing goals of care. 9. Care plan meetings will be documented by use of the Care Plan Meeting note. Review of Resident 1's clinical record revealed diagnoses that included severe protein-calorie malnutrition (inadequate intake of protein and calories) and malignant neoplasm of the tongue (cancerous growth on the tongue). Review of Resident 1's physician orders revealed an order for DNR (do not resuscitate). Review of Resident 1's POLST revealed a code status of DNR with comfort measures, signed by Resident 1 and the physician on [DATE]. Review of Resident 1's comprehensive plan of care revealed that Resident 1 has an established code status of full code, initiated [DATE]. Review of Resident 1's progress notes revealed a social services care plan meeting note dated [DATE], at 11:38 AM, that indicated advance directives were reviewed and that Resident 1 did not want CPR (cardiopulmonary resuscitation). Interviews with Employee 18 and Employee 19 on [DATE], at approximately 12:30 PM, revealed that they would check the physician's order or the POLST for a resident's code status. An interview on [DATE], at 1:52 PM, with the Nursing Home Administrator (NHA), the Director of Nursing (DON), and Employee 1 (Regional Clinical Support Nurse) revealed that Resident 1 had recently decided to change his code status from full code to DNR. Employee 1 stated that it was the facility's expectation that care plans be revised timely. Review of Resident 6's clinical record revealed diagnoses that included displaced intertrochanteric fracture of the right femur, initial encounter for a closed fracture, muscle weakness, and low back pain. During an interview with Resident 6 on [DATE], at 10:49 AM, she stated she does not have quarterly care plan meetings. Review of Resident 6's clinical record revealed her last care plan meeting was held on [DATE], and was a phone call between the social worker and Resident 6's granddaughter and husband, and her daughter attended in person; it did not reflect that Resident 6 attended or was invited to attend the meeting. During an interview with the DON on [DATE], at 1:03 PM, she revealed she would expect residents to have care (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	plan meetings on a quarterly basis, that residents are invited to their meetings as appropriate, and the meeting would be held with the interdisciplinary team. Review of Resident 34's clinical record revealed diagnoses that included Parkinson's Disease (long term degenerative disorder of the central nervous system that mainly affects the motor system) and cognitive communication deficit (a group of disorders that affect a person's ability to communicate, which can cause difficulty with understanding or producing language and nonverbal communication skills such as gestures and facial expressions). During an interview with Resident 34 on [DATE], at 11:25 AM, Resident 34 indicated that he has not participated in any of his care plan meetings. Review of Resident 34's clinical record revealed that he had attended his care plan meeting on [DATE], along with Social Services and the Nursing Unit Manager. Review of Resident 34's clinical record failed to reveal that a care plan meeting was held after his [DATE], annual assessment was completed. Review of Resident 34's clinical record revealed that he had attended his care plan meeting on [DATE], and [DATE], with Social Services and no other interdisciplinary team members were present. During a staff interview with the NHA, DON, and Employee 1 on [DATE], at 1:35 PM, all confirmed that they would expect residents to be invited to their care plans and that all appropriate interdisciplinary team members would attend the care plan meeting. Employee 1 indicated that the former Social Worker had been placed on a Performance Improvement Plan because of this concern. Employee 1 further indicated that Social Worker was no longer employed at the facility. The NHA indicated that they have implemented a performance improvement plan in place to address this concern. Further review of Resident 34's clinical record revealed that he was seen by an audiologist on [DATE], after he had reported to nursing staff that he was experiencing hearing loss. The audiologist made recommendations for treatment to address Resident 34's hearing loss. Review of Resident 34's clinical record revealed that he has been receiving pain medications specifically for his left shoulder since [DATE]. Review of Resident 34's annual assessment dated [DATE], revealed that he had limited range of motion of an upper extremity on one side. Review of Resident 34's care plan failed to reveal that he had hearing loss, ongoing pain in his left shoulder or contractures to his left hand. During a staff interview with the NHA, DON, and Employee 1 on [DATE], between 1:23 PM and 1:27 PM, the DON confirmed that Resident 34's care plan should have been revised to reflect his left shoulder pain, hearing loss, and hand contracture. Review of Resident 85's clinical record revealed diagnoses that included dementia (a decline in mental ability severe enough to interfere with daily life, commonly involving memory loss, poor judgment, and changes in mood) and demyelinating disease of the central nervous system (multiple sclerosis-a condition that damages the protective sheath covering nerve fibers in the brain and spinal cord). During an interview on [DATE], at 12:22 PM, with Resident 85's Representative, it was revealed that his wife's care plan does not reflect what is being done for her. Review of Resident 85's comprehensive plan of care on [DATE], at 10:41 AM, revealed her comprehensive care plan was not updated from the care plan meeting [DATE]. During an interview on [DATE], at 1:42 PM, with the NHA and the DON revealed their expectation is for the care plan to be updated immediately after a care plan meeting. Review of Resident 106's clinical record revealed diagnoses that included Parkinson's disease (brain disorder causing tremors, muscle stiffness, and slow movement) and chronic kidney disease stage 3A (mild-moderate loss of kidney function). During an interview on [DATE] at 9:48 AM, with Resident 106's Representative, it was revealed that they have not received an invitation to Resident 106's care plan meetings for several months. Review of Resident 106's progress notes revealed a care conference sign in sheet dated [DATE], indicating that nursing, social services, and the Resident Representative attended the meeting. Further review of Resident 106's clinical record failed to reveal documentation that any additional care plan meeting had been held. (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 106's minimum data set assessment (MDS - assessment tool utilized to identify a residents' physical, mental, and psychosocial needs) revealed that Resident 1 had a significant change MDS on [DATE], and quarterly MDSs on February 17, 2026, and [DATE]. During an interview on [DATE], at 1:36 PM, with the NHA, DON, and Employee 1, it was revealed that the facility was unable to provide additional information relating to Resident 106's care plan meetings. The NHA stated that there had been an issue with the previous social worker and care plan meetings were not being held. The social worker had been placed on a performance improvement plan and eventually terminated. The NHA stated that was the facility's expectation that care plan meetings be held, residents and representatives be invited, and that the required members of the interdisciplinary team be present at the meetings. Review of Resident 130's clinical record revealed diagnoses that included paraplegia (partial or complete paralysis of the lower half of the body) and person injured in unspecified motor-vehicle accident, traffic and subsequent encounter. Review of Resident 130's care plan indicated trapeze to use for repositioning in bed. Review of bed safety evaluation dated [DATE], indicated the Resident was dependent for turning and repositioning in bed. During an interview on [DATE], at 12:20 PM, with Employee 1, she confirmed that the care plan should not have trapeze in and that she would be removing it from the care plan. Her expectation is that care plans are kept up to date with resident status and care. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(3)(5) Nursing services.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record reviews, observations, and resident and staff interviews, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards during medication administration for four of six residents observed (Residents 1, 38, and 99) and failed to ensure that a resident who needs respiratory care is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for one of two resident's reviewed for respiratory care (Resident 2). Findings include: Review of facility policy, titled Medication Administration Enteral Tubes, dated [DATE], revealed, in part, Crushed medications are not mixed together. The powder from each medication is mixed with water before administration. The standard of practice is that crushed medications should not be combined and given all at once via feeding tube. Each medication is given separately to avoid interaction and clumping. The enteral tubing is flushed with water between each medication to avoid physical interaction of the medications. Verify tube placement per facility protocol. Check gastric content for residual feeding. Return residual volumes to the stomach. Report any residual above 100 milliliters. Review of facility policy, titled Medication Administration General Guidelines, dated [DATE], revealed, in part, 1. Medications are administered in accordance with written orders of the prescriber. If a dose seems excessive considering the resident's age and condition, or a medication order seems unrelated to the resident's current diagnosis or condition, the nurse calls the provider pharmacy for clarification prior to the administration of the medication. If necessary, the nurse contacts the prescriber for clarification. 8. Check expiration date on package/container. No expired medication shall be administered to a resident. a. Drugs dispensed in the manufacturer's original container will be labeled with the manufacturer's expiration date. Review of facility policy, titled Bi-level Positive Airway Pressure (BiPAP)/Continuous Positive Airway Pressure (CPAP) last revised [DATE], read, in part, Bi-level Positive Airway Pressure (BiPAP) and/or Continuous Positive Airway Pressure (CPAP) is set up and monitored by a licensed nurse or Respiratory Therapist (RT) with a physician's/advanced practice provider's (APP) order. Approved ventilators must be set up and settings maintained by a RT, but may be monitored by a licensed nurse. Review of Resident 1's clinical record revealed diagnoses that included severe protein-calorie malnutrition (a severe nutritional deficiency caused by inadequate or absorption of protein and energy-calories), cancer of the tongue, and presence of a gastrostomy tube (G-tube: a flexible feeding tube placed through the abdominal wall and into the stomach which allows nutrition to be placed directly into the stomach). Review of Resident 1's physician orders revealed orders for Enteral Feed: Check for gastric residual volume (GRV) every shift prior to medication administration via tube. If GRV is greater than 250 milliliters (ml) or over, hold medication, notify physician, and document amount in mL; and Enteral Feed: Flush tube with 30 ml of water before and after each medication pass every shift for enteral feed or 30 ml as ordered. Flush tube with at least 15 ml of water between each medication. Auscultate for presence of Bowel Sounds prior to medication administration via tube, dated [DATE]. During a medication pass observation of Employee 2 (Licensed Practical Nurse) for Resident 1 on [DATE], between 8:50 AM and 9:02 AM, revealed that Employee 2 placed both of Resident 1's ordered morning medications into a single plastic pouch and crushed them and entered his room. She added tap water to the crushed medications in Resident 1's bathroom. Employee 2 then applied gloves without performing hand hygiene. She disconnected the tube feeding bag in preparation to administer medications. She opened and attached a new syringe to Resident 1's g-tube after (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	removing the plunger from the syringe. Employee 2 then poured approximately 20 ml of water into the syringe and then added the plunger back to syringe and pushed the water through. She then disconnected the syringe and removed the plunger. She reconnected the syringe and poured the water containing Resident 1's medications into the tube and allowed the medications to flow through by gravity. She then poured in approximately 20 ml of water and allowed it to flow through by gravity. She then disconnected the syringe and replaced the plunger into the syringe. She removed her gloves and then went into bathroom and rinsed the syringe. She returned to the bedside and placed the syringe in a graduate dated [DATE]. Employee 2 failed to perform hand hygiene prior to donning gloves for medication administration or after medication administration. Employee 2 failed to clean the g-tube port before attaching the syringe to the port. Employee 2 failed to verify placement or check for residual as per Resident 1's physician orders. Employee 2 failed to date the new syringe she was observed to open and, although, she rinsed the syringe after using it, she placed in a graduate sitting on Resident 1's bedside stand dated [DATE]. Review of Resident 1's [DATE] Medication Administration Record revealed that Employee 2 documented that Resident 1's GRV was 45 ml, that she flushed the g-tube with a total amount of 60 ml and that she auscultated Resident 1's bowel sounds prior to medication administration. Review of Resident 38's clinical record revealed diagnoses that included constipation and hypertension (high blood pressure). Review of Resident 38's physician order's revealed an order for MiraLAX 17 grams/one capful every day in 4-8 ounces of water, juice, soda, coffee, or tea for constipation. Directions indicated to stir until dissolved and then administer immediately, dated [DATE]. During a medication pass observation of Employee 2 on [DATE], between 9:03 AM and 9:15 AM, revealed that Employee 2 failed to administer Resident 38 the ordered dose of miraLAX. Employee 2 was observed pouring the powder into the cap and measuring a full dose. She then took a plastic spoon and removed one spoonful. She proceeded to pour the rest of the dose back into the bottle. Employee 2 indicated that she only gives Resident 38 a spoonful of the medication because if she gave her the full dose she would be pooping on herself. Review of Employee 2's documentation of the miraLAX revealed that Resident 38 was documented as receiving her ordered dose. Employee 2 failed to indicate that only a partial dose was administered. During a staff interview with the Nursing Home Administrator (NHA), Director of Nursing (DON), and Employee 1 (Regional Clinical Support Nurse) on [DATE], at 9:30 AM, observations of Employee 2 with Residents 1 and 38 were shared. Employee 1 indicated that Employee 2 would be sent home immediately and that additional education would be provided. Review of Resident 99's clinical record revealed diagnoses that included hypertension and hyperlipidemia (abnormally high levels of fats). Review of Resident 99's physician orders revealed an order for Aspirin tablet chewable 81 milligrams give one tablet one time a day for blood clot prevention, dated [DATE]. During a medication pass observation with Employee 17 (Licensed Practical Nurse) on [DATE], between 9:15 AM and 9:30 AM, for Resident 99, it was noted that a house stock bottle of aspirin 81 milligrams was dated with an open date of [DATE], but the manufacturer expiration date was illegible. Employee 17 confirmed that the date was illegible but administered one tablet from the bottle to Resident 99 and then placed the bottle in his pocket and said he would discard it and get a new bottle for the medication cart later. During a final staff interview with Employee 1 in the presence of the NHA and DON on [DATE], at 1:34 PM, regarding Employees' 1, 13, and 17 actions during medication pass observations, the NHA and DON confirmed that they would expect all nurses to follow physician orders and practice appropriate professional standards. Review of Resident 2's clinical record revealed diagnoses that included chronic obstructive pulmonary disease (COPD an ongoing lung condition caused by damage to the lungs), sleep apnea (a potentially serious condition that causes breathing to stop and start multiple (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	times during sleep), and hypertension. Review of Resident 2's physician orders revealed an order for CPAP (a medical therapy that helps people with sleep apnea breathe more easily during sleep by delivering continuous air pressure through a mask) AUTO: Pressure Settings: Min/Max 8/25, apply at HS (bedtime), remove in AM, with a start date of [DATE]. Review of Resident 2's comprehensive care plan revealed a focus area [Resident 2] has impaired respiratory function related to COPD, sleep apnea, with an intervention for Give oxygen therapy as ordered by the physician, created on February 4, 2024. During an interview with Resident 2 on [DATE], at 9:25 AM, he revealed he wears a CPAP in the evening. Review of Resident 2's [DATE] TAR (Medication Administration Record- documentation for medication/treatment administered or monitored) revealed under the section to document removal of his CPAP in the morning, it was marked NN for Nurses Note on [DATE]-11, 13-15, 17-19, 22, 25, and 27-29, 2026. Review of Resident 2's [DATE] TAR revealed under the section to document removal of his CPAP in the morning, it was marked NN on [DATE], 6-9, 11-13, 15-17, and 20-22, 2026. Review of Nurses' Notes linked to the TAR for the aforementioned CPAP treatments in [DATE] and [DATE] stated either Did not wear overnight or did not use overnight. Review of Resident 2's clinical record revealed no education was noted to be provided to the Resident regarding CPAP use. Review of Resident 2's comprehensive care plan failed to note that he refuses his CPAP or takes it off himself throughout the night. During an interview with the NHA, DON, and Employee 1 on [DATE], at 2:18 PM, Employee 1 revealed the staff are documenting he did not wear it, but it is actually that he wore it and self-removed it at some point throughout the night. She further revealed that the respiratory therapist has provided education on proper CPAP use but she did not document it, and that there should be documented education regarding proper CPAP use and staff should document that he removed it, not that he didn't wear it. 28 Pa. Code 201.14(a)Responsibility of licensee.28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 201.10(c)(d) Resident care policies.28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. Based on clinical record reviews, observation, and resident and staff interviews, it was determined that the facility failed to ensure that residents received proper treatment and assistive devices to maintain hearing abilities for two out of four residents reviewed for hearing (Residents 34 and 115). Findings include: Review of Resident 34's clinical record revealed diagnoses that included Parkinson's Disease (long term degenerative disorder of the central nervous system that mainly affects the motor system) and cognitive communication deficit (a group of disorders that affect a person's ability to communicate, which can cause difficulty with understanding or producing language and nonverbal communication skills such as gestures and facial expressions). During an interview with Resident 34 on July 20, 2026, at 11:25 AM, Resident 34 indicated that he was experiencing hearing loss and was awaiting hearing aids. Review of Resident 34's clinical record revealed an audiology consultation completed on May 28, 2026, after he had reported to nursing staff that he was experiencing hearing loss. The consultation report indicated that Resident 34 had cerumen (wax) in both ears that was occluding his ears and that he had a moderate to severe sensorineural hearing loss in both ears. The consultation report further indicated that the wax was too hard and densely compacted for safe removal. The audiologist indicated that Resident 34 needed a softening agent, such as Debrox, and gave recommendations for the following treatment plan: 1. Have patient rolled over with right ear pointed towards the ceiling. 2. Place 1-3 drops of softening agent in the right ear. 3. Have patient remain in this position for 15 minutes. Softening agent must remain on top of cerumen. 4. Flush ear at end of the day. 5. Repeat in left ear. Complete this process 1x per day for 7 days. This will either completely clear out the patient's ear completely or soften the wax enough to allow for removal by me at the next facility visit. The consultation report failed to reveal that Resident 34's primary physician had reviewed the report or recommendations. Review of Resident 34's clinical record failed to reveal that Resident 34 had received the recommended treatment by the audiologist for his hearing loss. During a staff interview with the Nursing Home Administrator (NHA), Director of Nursing (DON), and Employee 1 (Regional Clinical Support Nurse) on July 23, 2026, at 10:33 AM, Employee 1 confirmed that the recommendation for Debrox for Resident 34 was never implemented. She said that Resident 34's physician had been contacted and that the order had now been implemented. During a final staff interview with the NHA, DON, and Employee 1 on July 23, 2026, at 1:25 PM, the DON confirmed that she would expect the audiologist recommendation for Debrox to have been reviewed by Resident 34's physician and treatment implemented in May when originally recommended for Resident 34's hearing loss. Review of Resident 115's clinical record revealed diagnosis that included hypertension (high blood pressure) and chronic kidney disease (a condition where the kidneys are damaged over time, affecting their ability to perform essential functions). During an interview with Resident 115 on July 20, 2026, at 9:47 AM, she revealed that she was very hard of hearing and had difficulty communicating because of it. Resident 115 revealed that she had hearing aids but left them in the dining room. During an observation of Resident 115 on July 20, 2026, at 9:48 AM, revealed she did not have any hearing aids or amplifiers in her ears during the conversation. Review of Resident 115's Quarterly MDS (Minimum Data Set is part of the federally mandated process for clinical assessment of all Medicare and Medicaid certified nursing homes) dated May 11, 2026, revealed Section B0200. Hearing, ability to hear was marked 3. Highly impaired, and section B0300. Hearing Aid, Hearing aid or other hearing appliance used was marked 1. Yes, indicating the Resident had a hearing device in use. Review of Resident 115's care plan revealed she has impaired communication as evidenced by impaired hearing, with an initiation date of October 21, 2024. Further review of the (continued on next page)		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care plan failed to include any intervention or documentation indicating the use of a hearing device. Review of Resident 115's physician orders failed to include any order for a hearing device. Review of Resident 115's clinical record revealed that she had an audiology consult on May 28, 2026, where the Resident reported she had hearing loss. Further review of the consult revealed the Resident had moderate to severe sensorineural hearing loss (permanent type of hearing loss caused by damage to the inner ear or auditory nerve, affecting the ability to convert sound waves into signals the brain can interpret) and would benefit from hearing aids. During a staff interview with the NHA and Employee 1 on July 23, 2026, at 1:17 PM, revealed that Resident 115 had hearing amplifiers that the nurse puts in and takes out, and that they would expect the Resident to have an order for them as well as them to be care planned. 28 Pa. Code 201.18(b)(1)(3) Management.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure residents with limited mobility receive appropriate services, equipment, and assistance to maintain or improve mobility for four of four residents reviewed for limited range of motion (Residents 6, 7, 11, and 34). Findings include: Review of facility policy, titled NSG232 Restorative Nursing with a last revision date of July 17, 2026, revealed, in part, Restorative Nursing Program refers to nursing intervention that promotes the patient's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. 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. 2. Develop restorative nursing programs appropriate to the patient's identified needs. 3. Develop specific measurable goals and document goals and interventions on the patient's restorative care plan. 4. Implement the restorative nursing program according to the specifics on the care plan. 5. Evaluate program quarterly. 6. Document: 6.1 Daily on Restorative Nursing Record in PointClickCare (PCC) ADL Point of Care (POC); 6.2 Quarterly evaluation by licensed nurse in Care Plan Evaluation progress note. Review of Resident 6's clinical record revealed diagnoses that included displaced intertrochanteric fracture of the right femur, initial encounter for a closed fracture, muscle weakness, and low back pain. During an interview with Resident 6 on July 20, 2026, at 10:39 AM, she revealed she had finished working with therapy, but she was unsure if she had a restorative nursing program (RNP- an individualized, nurse-supervised plan that helps long-term care residents maintain or regain functional abilities such as walking, dressing, eating, mobility, and communication). Review of Resident 6's occupational therapy Discharge summary dated [DATE], revealed Discharge reason: Maximum potential achieved. Referral for RNP. Review of Resident 6's comprehensive care plan revealed a focus area Restorative Ambulation: [Resident 6] demonstrates a deficit in ambulation, recent hospitalization for hip fracture with surgical repair, with interventions including Goal: Patient will walk 150 feet with rolling walker, and Supervision: Provide verbal cueing and walk along with patient, created on April 30, 2026. Review of Resident 6's RNP documentation from May 2026 to present, revealed her program was marked as Not applicable on May 1, 2, 4, 6-8, 10, 13, 14, 16-18, 19, 23, 24, 27, and 31, 2026; June 2, 3, 9, 11, 15-17, 20, 21, and 30, 2026; and July 4, 10, 14, 15, 17, 19, 20 and 21, 2026. During an interview with Employee 1 (Regional Clinical Support Nurse) on July 22, 2026, at 2:11 PM, she revealed she has no information to provide as to why the staff are marking not applicable for Resident 6's RNP program on the aforementioned days, but sometimes she refuses the program, and she plans to do education with staff regarding marking refused instead of marking not applicable for refusals. During an interview with the Director of Nursing (DON) on July 23, 2026, at 1:14 PM, she revealed she would expect RNP programs to be implemented or documented that they were refused if refused. Review of Resident 7's clinical record revealed diagnoses that included osteoarthritis (protective cartilage that cushions the ends of the bones wears down over time) and fibromyalgia (chronic condition that causes widespread pain, fatigue and sleep problems). Review of Resident 7's comprehensive plan of care revealed a focus area for restorative range of motion stating Resident 7 demonstrated loss of range of motion in lower extremities, date initiated February 2, 2026, with an intervention for active and active assisted range of motion. Review of Resident 7's (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	occupational therapy discharge summary signed June 25, 2026, revealed discharge reason maximum potential achieved, referred for RNP/FMP. Further review of Resident 7's clinical record failed to reveal documentation of a restorative range of motion being completed. During an interview on July 23, 2026, at 1:57 PM, with the Nursing Home Administrator, DON, and Employee 1, it was revealed that Resident 7's RNP was missed and never added to the task when the care plan was developed. The DON stated it was the expectation of the facility that restorative programs be completed. Review of Resident 11's clinical record revealed diagnoses that included progressive multiple sclerosis (a disease in which the immune system eats away at the protective covering of the nerves which disrupts communication between the brain and the body), osteoarthritis, and weakness. Review of Resident 11's care plan revealed a care plan focus for self-care deficit related to generalized weakness and multiple sclerosis revised December 6, 2022. Interventions included, but were not limited to, active assisted range of motion to bilateral upper extremities twice a day with activities of daily living with an initiated date of September 15, 2025. Review of Resident 11's range of motion task documentation between June 22, 2026, and July 21, 2026, revealed that on nine occasions (June 22 and 26 [two entries], 2026; July 3, 7, 10 [two entries], 12, and 17, 2026) were documented as Not Applicable. Email communication received from Employee 1 on July 22, 2026, at 11:48 AM, indicated that she cannot justify staff documenting Resident 11's restorative range of motion program as not applicable. During a staff interview with the NHA, DON, and Employee 1 on July 22, 2026, at 1:33 PM, Employee 1 and the DON confirmed that they would expect nursing staff to provide programs as ordered or document accurately as to why the programs were not provided. Review of Resident 34's clinical record revealed diagnoses that included Parkinson's Disease (long term degenerative disorder of the central nervous system that mainly affects the motor system) and cognitive communication deficit (a group of disorders that affect a person's ability to communicate, which can cause difficulty with understanding or producing language and nonverbal communication skills, such as gestures and facial expressions). Review of Resident 34's care plan revealed a care plan focus for self-care deficit related to physical limitations, muscle wasting and atrophy with a revision date of February 18, 2024. Interventions included, but were not limited to, active range of motion to bilateral lower extremities twice a day during activities of daily living dated August 4, 2025. Review of Resident 34's range of motion task documentation between June 23, 2026, and July 22, 2026, revealed that 26 occasions (June 24 [two entries], 25 [two entries], 27, 29 [two entries], and 30, 2026; July 1 [four entries], 2 [two entries], 3, 7, 8, 12 [three entries], 13, 14, 15, and 16 [four entries], 2026) were documented as Not Applicable. During a staff interview with the NHA, DON, and Employee 1 on July 23, 2026, at 1:27 PM, the DON confirmed that she would expect nursing staff to provide programs as ordered or document accurately as to why the programs were not provided. 28 Pa. Code 201.18(b)(1)(3) Management.28 Pa. Code 211.10(c) Resident care policies.28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to maintain complete and accurate records related to dialysis communication and failed to appropriately monitor a resident receiving dialysis services for one of one residents reviewed (Resident 4). Findings include: Review of facility policy, titled NSG253 Dialysis: Hemodialysis (HD) - Communication and Documentation, with a last revision date of June 15, 2022, revealed, in part, Center staff will communicate with the certified dialysis facility regarding the ongoing assessment of the patient's condition by monitoring for complications before and after hemodialysis (HD) treatments received at a certified dialysis facility.1. Prior to a patient leaving the Center for HD, a licensed nurse will complete the top portion of the Hemodialysis Communication Record or the state required form and send with the patient to his/her HD facility visit.2. Following completion of the HD, the dialysis facility nurse should complete and return the form and return it or other communication to the Center with the patient.3. Upon return of the patient to the Center, a licensed nurse will:3.1 Review the certified dialysis facility communication;3.2 Evaluate/observe the patient; and3.3 Complete the post-hemodialysis treatment section on the Hemodialysis Communication Record or state required form. Review of Resident 4's clinical record revealed diagnoses that included end-stage renal disease (ESRD-condition in which a person's kidneys cease functioning on a permanent basis) and dependence on renal dialysis (an artificial process for removing waste products and excess fluids from the body that is needed when the kidneys are not functioning properly). Review of Resident 4's physician orders revealed the following orders: Dialysis Monday, Wednesday, and Friday dated January 14, 2026; Monitor Hemodialysis site for signs/symptoms of complications (e.g. bleeding, swelling, pain, drainage, odor, hardness or redness at site). Notify the physician and dialysis center immediately with any urgent problems dated October 19, 2023, and June 10, 2026; Predialysis- Please obtain VSS, check bruit and thrill and document a nurses note. Fill out dialysis sheet with vital signs and weight and send entire book with Resident to dialysis every Monday, Wednesday, and Friday dated June 10, 2026; and Upon return from dialysis ensure dialysis sheet is filled out in binder. Ensure there is Pre-During-Post Dialysis vital signs and weight in the afternoon every Monday, Wednesday, and Friday dated June 12, 2026. Review of Resident 4's dialysis communication sheets for May 2026 through July 2026 revealed:1) May 1 and 25, 2026, facility dialysis communication sheet was missing;2) May 4, 6, 8, 11, 13, 15, 22, and 27, 2026, facility dialysis communication sheet was not completed upon return to the facility; 3) May 19, 2026, facility dialysis communication sheet was not completed upon return and was attached to the dialysis center report dated May 18, 2026;4) Facility dialysis communication sheet undated was attached to the dialysis center report dated May 20, 2026, and was not completed upon return to the facility;5) Facility dialysis communication sheet dated May 28, 2026, and was attached to the dialysis center report dated May 29, 2026, and was not completed upon return to the facility;6) June 1 and 10, 2026, facility dialysis communication sheet not completed upon return and there was facility dialysis communication sheet that was not dated but was in binder with the dialysis center's report dated June 3, 2026; and7) July 13, 2026, the facility dialysis communication sheet was missing. Review of Resident 4's Medication and Treatment Administration Records for May 2026 revealed the following:1) Monitoring of hemodialysis site was noted to be blank on May 22 and 24, 2026, evening shifts; and 2) Post dialysis weights were not documented on May 15 and 29, 2026, (15 was marked with an X and the 29 said NA). Review of Resident 4's Medication and Treatment Administration Records for June 2026 revealed the following:1) Pre-dialysis weights were recorded as NA on June 15, 17, and 26, 2026;2) Monitoring of hemodialysis shunt thrill and bruit was (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	noted to be recorded as NA June 13 and 14, 2026 evening shift; was blank on June 20, 2026, evening shift and June 26, 2026, day shift; and was recorded as N on June 26, 2026, evening shift; and3) Monitoring of hemodialysis site was blank on June 2, 5, and 20, 2026, evening shift and June 26, 2026, day shift. Review of Resident 4's Medication and Treatment Administration Records for July 2026 revealed the following:1) Pre-dialysis weights were marked NA on July 8, 13, 15, 17, and 20, 2026;2) Monitoring of hemodialysis shunt thrill and bruit was noted to be blank on July 11 and 12, 2026, evening shift and July 13, 2026, day shift; was documented as NA on July 10, 11, 12, 13, 14, and 15, 2026, night shift; July 13, 2026, evening shift; and July 16, 2026, day shift; and was recorded as N on July 14, 2026, day and evening shift, and July 15, 2026, day shift; and3) Monitoring of hemodialysis site was blank on July 11 and 12, 2026, evening shift. During a staff interview with the Nursing Home Administrator (NHA), Director of Nursing, and Employee 1 (Regional Clinical Support Nurse) on July 23, 2026, at 1:22 PM, the NHA confirmed that she would expect Resident 4's dialysis communication sheets be completed thoroughly and would expect her to be monitored appropriately according to physician orders with accurate documentation to reflect monitoring and care provided. Email communication received from Employee 1 on July 23, 2026, at 2:21 PM, indicated that she had no additional information regarding Resident 4's dialysis shunt monitoring and that education will be completed on how to properly document. 28 Pa. Code 201.18(b)(1) Management.28 Pa Code 211.5(f) Medical records.28 Pa. Code 211.10(c) Resident care policies.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 - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on policy review, grievance review, resident council meeting minute review, facility audit review, 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 three out of three nursing units (East, West, and Arcadia). Findings include: Review of the facility policy, titled NSG101 Call Lights with a last review and revised date of July 15, 2026, revealed, Staff will respond to call lights and communication devices promptly. During an interview with Resident 6 on July 20, 2026, at 10:49 AM, revealed the Resident had a concern for long call bell wait times. During an interview with Resident 18 on July 20, 2026, at 11:41 AM, revealed the Resident had a concern for long call bell wait times. During an interview with Resident 138 on July 20, 2026, at 12:36 PM, revealed the Resident had a concern for long call bell wait times and sometimes waits up to 60 minutes for assistance. During an interview with Resident 2 on July 21, 2026, at 9:22 AM, revealed the Resident had a concern for long call bell wait times. Interviews conducted during a group meeting with Resident Council on July 21, 2026, at 1:30 PM, revealed that six out of six residents had concerns with long call bell wait times and staff coming in to turn their call bell off without provided care to them. Review of the facility's grievance log for the past four months revealed there have been grievances filed on April 16, 2026; May 6 and 29, 2026; and June 10, 2026, with concerns for long call bell wait times. Review of call bell audits provided by the facility revealed the following: June 13, 2026, a resident's call light was on for 29 minutes before being answered by staff. June 18, 2026, a resident's call light was on for 39 minutes before being answered by staff, with the resident waiting for someone to assist them to the bathroom. June 24, 2026, a resident's call light was on for 49 minutes until being answered by staff. June 24, 2026, a resident's call light was on for 60 minutes before being answered by staff. The resident turned their call light on at 1:14 PM wanting to get changed before bingo at 2:00 PM, and it was not answered until 2:14 PM. Review of Resident Council Meeting minutes from May 6, 2026, revealed that residents had concerns for long call bell wait times up to 1 1/2 hours. Departmental Response Action included that education will be provided to East and [NAME] Wing clinical staff, dated May 8, 2026. Review of Resident Council Meeting minutes from June 3, 2026, revealed that residents reported continued concerns regarding extended wait times to have call bells answered - from 20 minutes to 1 1/2 hours. Departmental Response Action included nursing leadership will continue to review staffing coverage, perform call bell response time audits, and continue staff education on the importance of prompt responses, dated June 4, 2026. Review of Resident Council Meeting minutes from July 9, 2026, revealed that call light response times continued to be a concern, including being out of reach on the floor and extended wait times. Departmental Response Action included staff education on call bell response times and expectations of answering them, call bell audits to determine pattern continue. Interview conducted with the Nursing Home Administrator on July 23, 2026, at 1:14 PM, revealed that she would expect call bells to be answered timely. 28 Pa. Code 211.12 (a)(c)(d)(4)(5) Nursing Services. 28 Pa. Code 201.18 (e)(1)(2)(3)(6) Management		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on facility policy reviews, clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure that it was free from a medication error rate of five percent or greater based on four medication errors out of 25 opportunities. Findings include: Review of facility policy, titled Medication Administration Enteral Tubes, dated January 2025, revealed, in part, Crushed medications are not mixed together. The powder from each medication is mixed with water before administration. The standard of practice is that crushed medications should not be combined and given all at once via feeding tube. Each medication is given separately to avoid interaction and clumping. The enteral tubing is flushed with water between each medication to avoid physical interaction of the medications. Review of facility policy, titled Medication Administration General Guidelines, dated January 2025, revealed, in part, Medications are administered in accordance with written orders of the prescriber. Observation of Employee 2 (Licensed Practical Nurse) on July 21, 2026, between 8:50 AM and 9:02 AM, revealed that Employee 2 placed both of Resident 1's ordered morning medications into a single plastic pouch, crushed them, and then administered them to Resident 1 utilizing his enteral gastrostomy tube (G-tube: a flexible feeding tube placed through the abdominal wall and into the stomach which allows nutrition to be placed directly into the stomach). Observation of Employee 2 on July 21, 2026, between 9:03 AM and 9:15 AM, revealed that Employee 2 failed to administer Resident 38 the ordered dose of one medication. Resident 38's physician order was to administer MiraLAX 17 grams/one capful every day in 4-8 ounces of water, juice, soda, coffee, or tea for constipation. Directions indicated to stir until dissolved and then administer immediately. Employee 2 was observed pouring the powder into the cap and measuring a full dose. She then took a plastic spoon and removed one spoonful. She proceeded to pour the rest of the dose back into the bottle. Employee 2 indicated that she only gives Resident 38 a spoonful of the medication because if she gave her the full dose she would be pooping on herself. In addition, the solution was observed to be clear when she administered it to Resident 38 instead of cloudy, which would indicate that the powder was not dissolved completely. Observation of Employee 3 (Licensed Practical Nurse) on July 22, 2026, between 8:40 AM and 8:58 AM, revealed that when she administered Resident 67 her morning medications, Resident 67 reported pain in her left arm and hand. Employee 3 returned to the medication cart, reviewed Resident 67's physician orders, and took Resident 38's temperature which was 97.7 Fahrenheit (F). Employee 3 then retrieved Tylenol 325 milligrams two tablets from the medication cart and administered them to Resident 67. Review of Resident 67's physician orders revealed orders for Tylenol Tablet 325 milligrams give two tablets by mouth every four hours as needed for elevated temperature greater than 101 degrees F, not to exceed three grams (3000 milligrams) in 24 hours, dated November 12, 2022; and Tylenol Extra Strength 500 milligrams give two tablets three times a day for arthritis pain (an ordered total of 3 grams per 24-hour period). During a staff interview with Employee 3 on July 23, 2026, at 9:08 AM, she confirmed that she administered the Tylenol to Resident 67 for pain even though the order indicated that it was ordered for a fever. Employee 3 said she must have overlooked that in Resident 67's order since most all residents generally have Tylenol ordered as needed for pain. During medication administration observations there were 4 errors and 25 opportunities, resulting in a medication error rate of 16%. During a staff interview with the Nursing Home Administrator (NHA), Director of Nursing (DON), and Employee 1 (Regional Clinical Support Nurse) on July 23, 2026, at 1:34 PM, the NHA and DON confirmed that they would expect nursing staff to administer medications as ordered and to follow appropriate administration guidelines. 28 Pa. Code 211.9(a)(1) Pharmacy services. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.		

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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, clinical record review, and staff interviews, it was determined that the facility failed to properly label medication vials, failed to dispose of medications upon a resident's discharge, and failed to monitor medication refrigerator temperatures to ensure refrigerated medications are stored at an acceptable temperature in two of two medication rooms observed (West Hall and Arcadia Unit); and failed to discard medications with illegible manufacturer expiration dates in one of three medication carts observed (East Wing D Hall). Findings include: Review of facility policy, titled Medication Administration Enteral Tubes, dated January 2025, revealed, in part, 17. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. No medications are kept on top of the cart. Review of facility policy, titled Storage of Medications, dated February 2026, revealed, in part, Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. 11. Medications requiring 'refrigeration' or 'temperatures between 2 C (36 F) and 8 C (46 F)' are kept in a refrigerator with a thermometer to allow temperature monitoring. Medications requiring storage 'in a cool place' may be refrigerated unless otherwise directed on the label as 'cool' temperatures are those between 8 C (46 F) and 15 C (59 F). A temperature log or tracking mechanism is maintained to verify that temperature has remained within accepted limits. The temperature of any refrigerator that stores vaccines should be monitored and recorded twice daily. 14. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal. During a medication pass observation with Employee 2 on July 21, 2026, between 9:03 AM and 9:15 AM, for Resident 38 revealed that Employee 2 had prepared a dose of miraLAX in a plastic cup and placed other ordered pills into a plastic pill cup when she realized she did not have one of Resident 38's medications. Employee 2 indicated that she needed to go to the medication room to retrieve a new bottle. She placed the cup of pills inside the medication cart and locked the cart. She then took a tissue from the tissue box on her medication cart and placed over the top of the plastic cup containing the miraLAX. She tucked the tissue along the inside of the cup and left it sitting on her cart while she went to the medication room. After retrieving the additional medication for the medication room, she returned to her cart, retrieved the cup of pills from inside the cart, placed the additional medication in the cart, removed the tissue from the top of the miraLAX and proceeded into Resident 38's room and administered the medications. Employee 2 failed to secure medications properly while she was away from her medication cart. Observation of the [NAME] Wing Medication Room on July 21, 2026, at 1:00 PM, with Employee 14 (Licensed Practical Nurse) revealed two boxes of opened vials of octreotide acetate (a man-made protein that is similar to a hormone in the body called somatostatin. Octreotide lowers many substances in the body such as insulin and glucagon [involved in regulating blood sugar], growth hormone, and chemicals that affect digestion) with no opened date indicated. The labeling indicated that the medication was to be discarded 14 days after opening. Employee 14 indicated that the resident the medication was ordered for had been discharged for a while. Review of the clinical record revealed the Resident had been discharged from the facility on April 2, 2026. Employee 14 indicated that she would discard the vials. Observation of the Arcadia Unit Medication Room on July 21, 2026, at 1:23 PM, with Employee 16 (Licensed Practical Nurse) revealed an opened (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bottle of tuberculin skin test solution with no opened date indicated on the vial or box. Employee 16 confirmed that there was no open date indicated on the vial and she was observed discarding the vial into a sharps container. During a medication pass observation with Employee 17 (Licensed Practical Nurse) on July 22, 2026, between 9:15 AM and 9:30 AM, for Resident 99, it was noted that a house stock bottle of aspirin 81 milligrams was dated with an open date of July 17, 2026, but the manufacturer expiration date was illegible. Employee 17 confirmed that the date was illegible but administered one tablet from the bottle to Resident 99 and then placed the bottle in his pocket and said he would discard it and get a new bottle for the medication cart. Review of the Temperature Log for the [NAME] Wing medication refrigerator dated July 2026 in the medication room revealed that temperatures were to be checked and recorded twice a day. The review also revealed that the medication refrigerator temperatures were not recorded at all on July 1, 2, 5, 18, and 19; and on all other dates were only recorded once in the AM slot. Review of the Temperature Log for the [NAME] Wing Medication Room for June 2026, revealed that the medication refrigerator temperatures were not recorded at all on June 2, 6, 7, 12, and 16; and on all other dates temperatures were only recorded once in the AM slot. Review of the Temperature Log for the [NAME] Wing Medication Room for May 2026, revealed that the medication refrigerator temperatures were not recorded at all on May 1, 5, 9, 10, 19, and 29; and on all other dates temperatures were only recorded once in the AM slot. Review of the Temperature Log for the Arcadia Unit Medication Room for July 2026, revealed that the medication refrigerator temperatures were only recorded once on June 5 and 17 in the AM slot and once on June 18 in the PM slot. Review of the Temperature Log for the Arcadia Unit Medication Room for June 2026, revealed that the medication refrigerator temperatures were only recorded once on June 20 in the AM slot and once on June 21 in the PM slot. Review of the Temperature Log for the Arcadia Unit Medication Room for May 2026, revealed that the medication refrigerator temperatures were not recorded at all on May 9 and 24; were recorded once on May 1, 8, 15, 18, and 23 in the AM slot; and recorded once on May 2, 10, and 19 in the PM slot. During a staff interview with the Nursing Home Administrator, Director of Nursing, and Employee 1 (Regional Clinical Support Nurse) on July 22, 2026, at 1:38 PM, Employee 1 and the NHA acknowledged that they would expect medications to be stored and discarded properly. The NHA confirmed that medication refrigerator temperatures should be taken and recorded twice a day. 28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 211.9(a)(1)(j)(1) Pharmacy services.28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on facility policy reviews, clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure staff implemented appropriate infection control guidelines during medication administration for two of six residents observed (Residents 1 and 79), during wound care for one of one resident observed (Resident 1), and failed to implement appropriate infection control precautions per facility policy and physician orders for one of 29 residents reviewed (Resident 65). Findings include: Review of the facility policy, titled Medication Administration General Guidelines, dated January 2025, revealed, in part, Hands are washed with soap and water and gloves applied before administration of .ophthalmic [eye] .enteral [feeding tube] medications. Hands are washed with soap and water again after administration and with any resident contact. Antimicrobial hand sanitizer may be used in place of soap and water as allowed per state nursing regulations and facility policy. Review of facility policy, titled Medication Administration Enteral Tubes, dated January 2025, revealed, in part, 1. Perform hand hygiene. 2. Prepare medications for administration. 4. Put on gloves. 18. Clean feeding syringe and return to bedside stand. Remove gloves perform hand hygiene. Review of the facility policy, titled IC203 Hand Hygiene, with a last review date of March 20, 2026, revealed, in part, The use of gloves does not replace hand hygiene. If a task requires gloves, perform hand hygiene before donning gloves and immediately after removing gloves. 2. Hand hygiene techniques: 2.1 To wash hands with soap and water, 2.2 To decontaminate hands with alcohol-based rub. Review of facility policy, titled Enhanced Barrier Precautions, with a last review date of May 15, 2026, revealed, in part, 1. Post the appropriate Enhanced Barrier Precautions (EBP) sign on the patient's room door. 3. Follow the Centers for Disease Control and Prevention (CDC) Guidance: Enhanced Barrier applies to all patients with any of the following: Infection or colonization with a targeted MDRO when contact precautions do not apply, chronic wounds and/or indwelling medical devices (e.g. central line, urinary catheter, enteral feeding tube. PPE should be used during these high contact patient care activities: dressing; bathing/showering; transferring; providing hygiene; changing linens; changing briefs or assisting with toileting; device care or use central line, urinary catheter, enteral feeding; and wound care-any skin opening requiring a dressing. Required PPE: gown and gloves prior to high contact care activity. 4. Personal Protective Equipment (PPE) should be readily accessible and located outside of the patient's room. Review of Resident 1's clinical record revealed diagnoses that included severe protein-calorie malnutrition (a severe nutritional deficiency caused by inadequate or absorption of protein and energy-calories), cancer of the tongue, and presence of a gastrostomy tube (G-tube: a flexible feeding tube placed through the abdominal wall and into the stomach, which allows nutrition to be placed directly into the stomach). Review of Resident 1's physician orders revealed an order for Enhanced Barrier Precautions related to feeding tube and indwelling urinary catheter dated June 18, 2026. Observation of Resident 1's room on July 21, 2026, at 8:48 AM, revealed that signage was posted beside his door indicating that he was on Enhanced Barrier Precautions. The signage indicated that gown and gloves should be worn when providing high contact care with the specific examples given as were indicated in the facility policy. A cart containing all necessary PPE was also present just to the left of his doorway in the hall directly under the EBP sign. During a medication pass observation of Employee 2 (Licensed Practical Nurse) for Resident 1 on July 21, 2026, between 8:50 AM and 9:02 AM, revealed that Employee 2 failed to perform hand hygiene prior to preparing his medications. Employee 2 was observed to touch the inside of the medication cup with her finger. Employee 2 then placed Resident 1's ordered dose of Tylenol into that cup. Employee 2 realized she did not have Resident 1's other ordered medication available in the cart. She placed the cup with the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Tylenol in the top drawer of the medication cart and went to the nursing station to get assistance with retrieving Resident 1's other medication from the emergency stock. Employee 2 was observed standing at the desk while Employee 14 (Licensed Practical Nurse) was retrieving the medication. Employee 14 then summoned Employee 2 into the medication room to witness the withdrawal. After obtaining Resident 1's medication, she returned to the medication cart. Employee 2 failed to perform any hand hygiene when she returned to the cart. She popped open the medication package and placed the pill into her hand and then dropped it into the cup with the Tylenol. Employee 2 then proceeded to get a plastic pill pouch to crush the medications. Employee 2 was observed to touch the inside of the packet with her fingers to open it and she then placed the medications into the packet and crushed them. Employee 2 then entered Resident 1's room to administer his medications. Employee 2 failed to perform hand hygiene and don gown and gloves prior to entering Resident 1's room. After entering the room, she donned gloves and proceeded to administer Resident 1's medications through his gastrostomy tube. After administering Resident 1's medications, she removed her gloves and went into bathroom and rinsed the syringe. She returned to the bedside and placed the syringe in a graduate dated July 19, 2026. Employee 2 failed to perform any hand hygiene prior to leaving Resident 1's room. Employee 2 proceeded to her medication cart, logged into the computer, and began documenting Resident 1's medication administration. During a medication pass observation with Employee 2 on July 21, 2026, between 9:03 AM and 9:15 AM, for Resident 38 revealed that Employee 2 had prepared a dose of miraLAX in a plastic cup and placed other ordered pills into a plastic pill cup when she realized she did not have one of Resident 38's medications. Employee 2 indicated that she needed to go to the medication room to retrieve a new bottle. Employee 2 placed the cup of pills inside the medication cart and locked the cart. Employee 2 then took a tissue from the tissue box on her medication cart and placed over the top of the plastic cup containing the miraLAX. She tucked the tissue along the inside of the cup and left it sitting on her cart while she went to the medication room. After retrieving the additional medication from the medication room, she returned to her cart, retrieved the cup of pills from inside the cart, placed the additional medication in the cup, and placed the bottle in the drawer. Employee 2 then removed the tissue from the top of the miraLAX and proceeded into Resident 38's room and administered the medications. Employee 2 failed to perform hand hygiene upon returning to her medication cart. Employee 2 unlocked the cart, retrieved the cup of pills, added the additional medication, removed the tissue from the top of the miraLAX and entered Resident 38's room where she was observed to administer Resident 38 her medications. During a hallway observation on July 21, 2026, at 9:38 AM, Employee 2 was observed to administer medications and eye drops to Resident 79 without performing hand hygiene before or after. Employee 2 was also not observed to wear gloves while administering the eye drops. During a staff interview with the Nursing Home Administrator (NHA), Director of Nursing (DON), and Employee 1 (Regional Clinical Support Nurse) on July 21, 2026, at 9:30 AM, observations of Employee 2 were shared. Employee 1 indicated that Employee 2 would be sent home immediately. During a final staff interview with the NHA, DON, and Employee 1 on July 23, 2026, at 1:34 PM, the NHA and DON confirmed that they would expect nurses to follow appropriate infection control practices during medication administration. Further review of Resident 1's clinical record revealed that he had an unstageable pressure ulcer on his left hip (a wound where the true depth cannot be determined because it is covered by slough). Review of Resident 1's physician orders revealed an order to cleanse his left hip pressure ulcer with wound cleanser solution, apply Medihoney, cover with calcium alginate and foam dressing daily and PRN (as needed) dated July 23, 2026. Observation of wound care on Resident 1 on July 23, 2026, at 10:37 AM, revealed Employee 14 (Licensed Practical Nurse) donned and doffed gloves during the treatment and (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	did not perform hand hygiene after every glove changes on four occurrences. During an interview with Employee 14 on July 23, 2026, at 11:24 AM, she confirmed that she had changed her gloves multiple times during the dressing change without performing hand hygiene with every glove change. During a staff interview with the NHA, DON, and Employee 1 on July 23, 2026, at 1:50 PM, Employee 1 revealed their expectation is hand hygiene protocol would be followed. Review of Resident 65's clinical record revealed diagnoses that included diabetes (a chronic condition that occurs when the body cannot effectively use insulin, a hormone that regulates blood sugar levels) and anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome). Observation of Resident 65's room on July 21, 2026, at 10:22 AM, revealed there was no EBP signage posted on or beside her door and there was no PPE equipment outside of her room. Electronic communication received from Employee 1 on July 21, 2026, at 3:21 PM, revealed that Resident 65 was on EBP for a wound infection. Review of Resident 65's care plan revealed that she is at risk for skin breakdown: right lateral foot: diabetic foot ulcer left plantar foot: diabetic foot ulcer; with an intervention for enhanced barrier precaution in place until wound is healed, date initiated on July 7, 2026. Observation of Resident 65's room on July 22, 2026, at 9:54 AM, revealed she has an EBP sign posted beside her door with no PPE observed outside of her room. Review of Resident 65's physician's orders revealed an order for infection precautions - enhances barrier - wound, with an active date of July 21, 2026. During an interview with the NHA and Employee 1 on July 23, 2026, at 1:15 PM, revealed that the PPE for Resident 65's room was located inside her bathroom due to a resident being injured from roaming the hallway with PPE outside of a resident's room previously. The NHA revealed that she would have expected there to be EBP signage outside of Resident 65's room. 28 Pa. Code 201.14(a)Responsibility of licensee.28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 201.10(c)(d) Resident care policies.28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.		

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on facility policy review, review of personnel files, and staff interviews, it was determined the facility failed to ensure abuse training upon hire was completed for two of five employees reviewed (Employees 7 and 13). Findings include: Review of facility policy, titled OPS300 Abuse Prohibition, with a last review date of November 14, 2025, revealed, in part, The Center will implement an abuse prohibition program through the following: Training of employees (both new employees and ongoing training for all employees); Training and reporting obligations will be provided to all employees - through orientation, Code of Conduct training, and a minimum of annually - and will include: 4.1 the Abuse Prohibition policy and 4.8 dementia management and patient abuse prevention. Review of personnel file for Employee 7 (Licensed Practical Nurse) revealed that her date of hire was April 28, 2026. Further review of the personnel file failed to reveal any documentation Employee 7 had completed any new employee orientation to include training on the facility abuse prohibition policy. Review of personnel file for Employee 13 (Nurse Aide) revealed that his date of hire was June 16, 2026. Further review of the personnel file failed to reveal any documentation that Employee 13 had completed any new employee orientation to include training on the facility abuse prohibition policy. During a staff interview with the Nursing Home Administrator (NHA), Director of Nursing, and Employee 1 (Regional Clinical Support Nurse) on July 22, 2026, at 1:44 PM, Employee 1 confirmed that abuse prohibition training should be completed upon hire as part of the facility orientation program and that they had no additional information to provide. The NHA indicated that the facility had identified issues in their hiring process and have implemented a Performance Improvement Plan. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 201.19(6)(7) Personnel policies and procedures. 28 Pa. Code 201.20(a)(b)(d) Staff development.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on facility policy review, clinical record reviews, observations, and staff interview, it was determined that the facility failed to promote an environment that enhances each resident's dignity by storing incontinent briefs in open view for two of 29 residents reviewed (Residents 30 and 34). Findings include: Review of facility policy, titled OPS206 Resident Rights Under Federal Law with a last revised date of February 1, 2023, and a last review date of June 12, 2025, indicated under the section titled Purpose that the facility was to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his/her self-esteem and self-worth. Also, in Section 1 Resident Rights revealed 1.1 The facility to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his/her quality of life, recognizing each resident's individuality. Review of Resident 30's clinical record revealed diagnoses that included anxiety (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities) and adjustment disorder (reaction to a life change or another type of stressor which leads to a subjective, personal experience of mixed anxiety and depression). Observation of Resident 30's room on July 22, 2026, at 9:15 AM, revealed seven incontinent briefs stacked on a stand in the room, visible from the hallway. Review of Resident 34's clinical record revealed diagnoses that included Parkinson's Disease (long term degenerative disorder of the central nervous system that mainly affects the motor system) and cognitive communication deficit (a group of disorders that affect a person's ability to communicate which can cause difficulty with understanding or producing language and nonverbal communication skills such as gestures and facial expressions). Observation of Resident 34's room on July 20, 2026, at 11:25 AM, revealed six incontinent briefs stacked on his heating and air conditioning unit. Observation of Resident 34's room on July 21, 2026, at 1:20 PM, revealed five incontinent briefs stacked on his heating and air conditioning unit. Observation of Resident 34's room on July 22, 2026, at 12:50 PM, revealed four incontinent briefs stacked on his heating and air conditioning unit. During a staff interview with the Nursing Home Administrator (NHA), the Director of Nursing, and the Regional Clinical Support Nurse (RCSN) on July 22, 2026, at 1:33 PM, the RCSN confirmed that she would expect a resident's incontinent briefs to be stored out of sight to maintain resident dignity. The NHA agreed. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.12(d)(1)(2) Nursing services.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on facility policy review, clinical record review, observation, and resident and staff interviews, it was determined that the facility failed to determine a resident's right to self-administer medications was clinically appropriate for one of one resident reviewed (Resident 1). Findings include: Facility policy, titled Medication Administration General Guideline, dated January 2025, read, in part, 15. Residents are allowed to self-administer medications when specifically authorized by the prescriber, the nursing care center's Interdisciplinary Team (IDT), and in accordance with procedures for self-administration of medications and state regulations. Facility policy, titled Medications: Self-administration, last revised October 15, 2024, read, in part, Patients who request to self-administer medications will be evaluated for safe and clinically appropriate capability based on the patient's functionality and health condition. If it is determined that the patient is able to self-administer: A physician/advanced practice provider (APP) order is required. Self-administration and medication self-storage must be care planned. When applicable, patient must be provided with a secure, locked area to maintain medications. Patient must be instructed in self-administration. Evaluation of capability must be performed initially, quarterly, and with any significant change in condition. Review of Resident 1's clinical record revealed diagnoses that included severe protein-calorie malnutrition (inadequate intake of protein and calories) and malignant neoplasm of the tongue (cancerous growth on the tongue). Observation on July 22, 2026, at 2:40 PM, revealed a bottle of saline nasal spray on Resident 1's bedside table. An interview with Resident 1 revealed that staff gave him the bottle of saline nasal spray so that he could use it when he needed it. Review of Resident 1's physician orders revealed an order for ocean nasal spray nasal solution (saline) two times a day for dry nasal passages, order date July 6, 2026. Review of Resident 1's clinical record failed to reveal any assessment of Resident 1's cognitive and physical ability to self-administer the medication. During a staff interview with the Nursing Home Administrator, the Director of Nursing, and Employee 1 on July 23, 2026, at 1:52 PM, it was confirmed that there was no assessment completed to determine Resident 1's cognitive and physical ability to self-administer the medication. Employee 1 stated that it was the facility's expectation that medication not be left at resident's bedsides unless the resident has been evaluated for self-administration of medications. 28 Pa. Code 201.18(b)(1) Management. 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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on policy review and resident and staff interviews, it was determined that the facility failed to ensure the resident has the right to privacy when receiving mail and packages for two of 29 residents reviewed (Residents 4 and 110). Findings include: Review of the facility policy, titled REC214 Patient/Resident Mail Delivery with a last revised and reviewed date of July 17, 2026, revealed Patients/Residents have the right to privacy in written communications, to send and promptly receive unopened mail and other letters, packages, and other materials delivered to the Center/Community, including those delivered through a means other than a postal service, and to have access to stationery, postage, and writing implements at their own expense. Procedure: 1. The Recreation Director or designee will: 1.2 Ensure that mail is delivered to the person unopened or postmarked within 24 hours, including Saturday. During an interview with Resident 4 at the resident council meeting on July 21, 2026, at 1:30 PM, she revealed that staff at the facility have opened her mail thinking it was insurance papers prior to giving it to her, and would deliver it to her opened with a note on it saying that they thought it was for her insurance but it was not so they are returning it to the Resident. Resident 4 revealed she did not give them consent to open her mail. During a resident group meeting on July 21, 2026, at 1:30 PM, it was revealed that staff open Resident 110's packages before giving them to her. During an interview with Resident 110 on July 22, 2026, at 10:01 AM, she revealed that staff would open her Amazon packages without her present and then bring whatever was in the package to her after they went through everything. Resident 110 revealed that her friend orders her snacks, hygiene things, and some clothing from Amazon and can track when it is delivered to the facility, and she will not receive the package until two or three days after it's delivered and sometimes has to go ask for them from the staff. Resident 110 revealed that staff told her they have to make sure she is not ordering knives as they had an issue with a resident ordering them in the past. Resident 110 revealed that she did not give consent for staff to open her packages. Review of Resident 110's clinical record revealed she had a Brief Interview for Mental Status (BIMS) Evaluation completed on April 17, 2026, and scored a 15, which indicates she was cognitively intact. During an interview with an Activities Assistant (Employee 6) on July 22, 2026, at 10:15 AM, she revealed that she did previously open Resident 110's packages without her present before giving them to her because the facility used to have an issue with residents ordering knives in the mail. During an interview with the Nursing Home Administrator (NHA) on July 22, 2026, at 2:00 PM, she revealed that she would expect resident's right to privacy to be honored and that resident packages should not be opened by staff prior to giving them to the resident. 28 Pa. Code 201.29(a) Resident rights.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on facility policy review, observations, and staff interviews, it was determined that the facility failed to ensure the residents' right to a clean, comfortable, and homelike environment, including housekeeping and maintenance services, to maintain a sanitary, orderly and comfortable interior for three of 29 residents reviewed (Residents 6, 34, and 67). Findings include: Review of facility policy, titled OPS200 Safe and Homelike Environment, with a last revised date of November 14, 2025, revealed, in part, The resident/patient has the right to a safe, clean, comfortable, and homelike environment that de-emphasizes the institutional character of the setting. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Observation in Resident 6's room on July 20, 2026, at 10:40 AM; July 21, 2026, at 2:01 PM; and July 22, 2026, at 9:52 AM, revealed her wallpaper was torn and there were two large black scratch marks along the wall. During a staff interview with the Nursing Home Administrator (NHA), the Director of Nursing (DON), and the Employee 1 (Regional Clinical Support Nurse) on July 22, 2026, at 2:09 PM, the NHA revealed the concerns in Resident 6's room would be addressed and she would expect residents to have a clean, comfortable and homelike environment. Observation of Resident 34's room on July 20, 2026, at 11:29 AM, revealed that his trash can had an incontinent brief smeared with a brown substance, and that the trash can was overflowing onto the floor. In addition, there was a potato chip bag visible under his nightstand, an empty juice container on floor, a light brown colored spill stain down the wall at the foot of his bed brown spill stain on wall, a brown colored substance on his bed linens, and his privacy curtain was noted to have brown smears in approximately three different areas. Observation of Resident 34's room on July 20, 2026, at 12:11 PM, revealed a housekeeper exiting his room. Immediate observation of his room revealed food debris particles on the floor, the chip bag was still visible under the nightstand on the floor, and the stains were still present on the wall and the privacy curtain. All his bed linens and been stripped from the bed and the trash can had been emptied. Observation of Resident 34's room on July 21, 2026, at 1:18 PM, revealed the stains were still present on the wall and privacy curtain and that the chip bag was still visible under the nightstand on the floor. In addition, there was a brown smear and a yellow discoloration on his bedspread. Observation of Resident 34's room on July 22, 2026, at 12:51 PM, revealed the stains were still present on the wall and privacy curtain, and that the chip bag was still visible under the nightstand on the floor. During a staff interview with the NHA, the DON, and the Employee 1 on July 22, 2026, at 1:31 PM, Employee 1 confirmed that she would expect resident rooms to be cleaned thoroughly to include walls. Employee 1 also indicated that she would expect staff to change privacy curtains when they are noted to be soiled. Observation of Resident 67's room on July 22, 2026, at 8:40 AM, revealed that Resident 67's mattress was not on the bed correctly. The mattress was noted to have the foot end positioned at the head of the bed. There were four more observations throughout the day on July 22, 2026, at 8:50 AM, 12:45 AM, 12:40 PM and 2:30 PM, that revealed the mattress remained on Resident 67's bed with the foot end at the head of the bed. Observation of Resident 67's room on July 23, 2026, at 8:46 AM, while accompanied by the NHA, revealed the foot end of the mattress was at the head of the bed. During an interview with the NHA on July 23, 2026, at 8:46 AM, she confirmed the foot end of the mattress should be at the foot end of the bed. The NHA revealed there was no reason Resident 67's mattress should be placed on her bed positioned this way. The NHA revealed her expectation is that the staff should note the mattress positioning during bed linen changes and correct the situation at once. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18 (b)(1)(3)(e)(2.1) Management.		

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. Based on clinical record review and staff interviews, it was determined the facility failed to assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months for one of 29 residents reviewed (Resident 6). Findings include: Review of Resident 6's clinical record revealed diagnoses that included displaced intertrochanteric fracture of the right femur, initial encounter for a closed fracture, muscle weakness, and low back pain. Review of Resident 6's clinical record revealed she had a Quarterly MDS (Minimum Data Set-assessment tool utilized to identify residents' physical, mental and psychosocial needs) Assessment on March 10, 2026, and her next assessment was an Annual MDS Assessment completed on July 16, 2026. During an interview with Employee 12 (MDS Coordinator) on July 22, 2026, at 2:41 PM, she revealed Resident 6 should have had an assessment completed every 3 months. During an interview with the Director of Nursing on July 23, 2026, at 1:03 PM, she revealed she would expect MDS assessments to be completed at least quarterly. 28 Pa. Code 211.5(d)(3)(5) Nursing services		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 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 29 residents reviewed (Resident 1). Findings Include: Facility policy, titled OPS416 Person-Centered Care Plan, revision date September 15, 2025, read, in part, 1. Baseline Care Plan . 1.1.7. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the patient and patient representative, if applicable. 1.1. 7.2. Interventions shall be initiated that address the patient's current needs including: 1.1.7.2.1 Any health and safety concerns to prevent decline or injury, such as elopement, fall, or pressure injury risk. 1.1.7.2.3 Any special needs such as for IV therapy, dialysis, or wound care. Review of Resident 1's clinical record revealed diagnoses that included severe protein-calorie malnutrition (inadequate intake of protein and calories) and malignant neoplasm of the tongue (cancerous growth on the tongue). Additional Review of Resident 1's clinical record revealed that he was admitted to the facility from the hospital on June 16, 2026. Review of Resident 1's admission skin assessment dated [DATE], revealed the following skin conditions were noted as present on admission: unstageable left hip pressure ulcer/injury, stage 1 buttocks pressure ulcer/injury, right antecubital skin tear, and a left forearm skin tear. Review of Resident 1's baseline plan of care failed to reveal a focus area or any interventions for skin concerns or treatments. During an interview on July 23, 2026, at 2:29 PM, with the Nursing Home Administrator, the Director of Nursing (DON), and Employee 1, it was confirmed that Resident 1's skin concerns were not included in the baseline care plan and that Resident 1's skin concerns were not added until July 17, 2026. The DON stated it was the expectation of the facility that baseline care plans be completed accurately. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(3)(5) Nursing services		

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NAME OF PROVIDER OR SUPPLIER Carlisle Skilled Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 940 Walnut Bottom Road Carlisle, PA 17013	
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on policy review, clinical record review, resident council interviews, and resident and staff interviews, it was determined that the facility failed to provide necessary services to a resident who is unable to carry out activities of daily living (ADLs) to maintain personal hygiene for three out of five residents reviewed for ADL care (Residents 2, 3, and 28). Findings include: Review of the facility policy, titled NSG200 Activities of Daily Living (ADLs) with a last revised date of May 1, 2023, and a last review date of March 20, 2026, 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 or improved and do not diminish unless circumstances of the patient's clinical condition demonstrate that a change was unavoidable. ADLs include: Hygiene - bathing, dressing, grooming, and oral care. And 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. Review of Resident 2's clinical record revealed diagnoses that included repeated falls and hypertension (persistent high blood pressure). During an interview with Resident 2 on July 21, 2026, at 9:24 AM, he revealed he doesn't always get showers per his preferred schedule. Review of Resident 2's comprehensive care plan revealed a focus area [Resident 2] has ADL self care deficit related to physical limitations, last revised on July 1, 2026, with an intervention for Assist to bathe/shower as needed, last revised March 18, 2024. Further review of Resident 2's comprehensive care plan failed to reveal that he refuses care. Review of Resident 2's shower documentation revealed his preferred shower schedule is Monday and Thursday evening. Further review of Resident 2's shower documentation revealed it was documented not applicable for his shower on July 2, 2026; and documented as receiving a bed/sponge bath on July 20, 2026. During an email correspondence with Employee 1 (Regional Clinical Support Nurse) on July 22, 2026, revealed at times Resident 2 refuses and will accept a bed bath, but she has no information to provide as to why his shower documentation was marked not applicable July 2, 2026. Review of Resident 2's clinical record failed to reveal notation that he refused a shower on July 20, 2026. Review of Resident 3's clinical record revealed diagnoses that included hypertension and dementia (the loss of cognitive functioning that interferes with a person's daily life and activities). Review of Resident 3's bathing/shower task revealed her shower days were on Wednesday and Saturday evenings. Further review of the task revealed there was no documentation completed on July 4, 2026, indicating the Resident did not receive a shower as scheduled. Review of Resident 28's clinical record revealed diagnoses that included hypertension and diabetes (a chronic condition where your body struggles to process blood glucose). Review of Resident 28's bathing/shower task revealed her shower days were on Monday and Thursday evenings. Further review of the task revealed on July 13, 2026, her shower documentation was marked as Response Not Required, indicating the Resident did not receive a shower as scheduled. During an interview conducted with Employee 1 on July 22, 2026, at 11:32 AM, she revealed that she was not sure why staff are documenting that response. During an interview with the Nursing Home Administrator on July 23, 2026, at 1:03 PM, she revealed she would expect residents to receive their showers as scheduled. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 clinical record review, observation, and staff interviews, it was determined that the facility failed to ensure that treatments were provided as ordered for two of 29 residents reviewed (Residents 99 and 106); failed to ensure catheter orders were complete for one of two residents reviewed for catheters (Resident 1); and failed to ensure consultation appointments were scheduled in a timely manner to meet each resident's physical, mental, and psychosocial needs for one of 29 residents reviewed (Resident 99). Findings include: Review of Resident 1's clinical record revealed diagnoses that included obstructive and reflux uropathy (blockage urine flow making it difficult or impossible to urinate) and benign prostatic hyperplasia with lower urinary tract symptoms (non-cancerous enlargement of the prostate gland causing trouble with urination). Review of Resident 1's comprehensive plan of care revealed that Resident 1 required an indwelling foley catheter 16 FR/10ml balloon due to neurogenic bladder. Review Resident 1's physician orders revealed the following order: indwelling catheter ____ FR (French) with ____ cc [NAME] to beside straight drainage for diagnosis/Hx of need _____. During an interview on July 23, 2026, at 2:29 PM, with the NHA, DON, and Employee 1, it was confirmed that Resident 1's foley catheter order was incomplete and that it was the facility's expectation that physician orders be accurate and complete. Review of Resident 99's clinical record revealed diagnoses that included dermatitis (itchy rash caused by direct contact with a substance or an allergic reaction to it) and seborrheic dermatitis (a common skin condition that mainly affects your scalp; it causes scaly patches, inflamed skin and stubborn dandruff and usually affects oily areas of the body, such as the face, sides of the nose, eyebrows, ears, eyelids and chest). Observation of Resident 99 on July 20, 2026, at 10:19 AM, revealed that he had a red rash to his face with multiple opened and scabbed areas noted. Resident 99 indicated that his face was itchy. Review of Resident 99's clinical record revealed a dermatology (skin specialist) consultation report dated August 12, 2025, which indicated that Resident 99 was to be seen for a follow-up appointment in eight months. Further review of Resident 99's clinical record failed to reveal any other dermatology consultation appointments after August 12, 2025. Review of Resident 99's clinical record revealed the following orders to treat his dermatitis:1) Ammonium Lactate Lotion 12 % Apply to bilateral lower extremities and bilateral palms of hands topically every day and evening shift dated August 4, 2022;2) Cetaphil Moisturizing External Cream (Emollient) Apply to bilateral lower extremities topically everyevening shift for moisturize date December 21, 2022;3) Clobetasol Propionate External Cream 0.05 % Apply to left lower leg topically two times a day on for fourteen then off for seven days repeatedly dated February 22, 2022;4) Hibiclens External Liquid 4 % (Chlorhexidine Gluconate) Apply to Lower legs topically every day shift every Tuesday and Friday. Use wash on shower days dated September 1, 2023;5) Ketoconazole Shampoo 2 % Apply to damp scalp and down face topically every evening shift every Monday, Wednesday, and Friday dated June 28, 2023; and6) Tacrolimus External Ointment 0.1 % Apply to left lower leg topically two times a day every 1 month(s) starting on the 15th for 7 day(s) for 1-2 grams dated February 15, 2025. Review of Resident 99's Treatment Administration Record (TAR) for May 2026 revealed the following:1) his Ammonium Lactate administration was blank on the 22 and 24 evening shift and 29 day shift;2) his Cetaphil administration was blank on the 22 and 24 evening shift;3) his Clobetasol administration was blank on the 22 evening shift;4) his Hibiclens administration was blank on the 29 day shift; and5) his Ketoconazole administration was blank on the 22 evening shift. Review of Resident 99's TAR for June 2026 revealed the following:1) his Ammonium Lactate administration was blank on the 2, 5, 11, and 20 evening shift and 26 day shift;2) his Cetaphil (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration was blank on the 2, 5, 11, and 20 evening shift;3) his Clobetasol administration was blank on the 2, 5, 11, and 20 evening shift and 26 day shift;4) his Hibiclens administration was blank on the 26 day shift;5) his Ketoconazole administration was blank on the 5 evening shift; and6) his Tacrolimus administration was blank on the 20 evening shift. Review of Resident 99's TAR for July 2026 revealed the following:1) his Ammonium Lactate administration was blank on the 12 evening shift and 13 day shift;2) his Cetaphil administration was blank on the 12 evening shift; and3) his Clobetasol administration was blank on the 12 evening shift and 13 day shift. Email communication received from Employee 1 (Regional Clinical Support Nurse) on July 22, 2026, at 11:48 AM, indicated We cannot justify the holes in the TARS. During a staff interview with the Nursing Home Administrator (NHA), Director of Nursing (DON), and Employee 1 on July 22, 2026, at 1:36 PM, Employee 1 indicated she would expect Resident 99's treatments to have been provided as ordered or documentation be present to reflect why they were not provided. During a staff interview with the NHA, DON, and Employee 1 on July 23, 2026, at 1:31 PM, the NHA confirmed that she would have expected Resident 99's dermatology appointment to have been scheduled as recommended by the dermatologist. Review of Resident 106's clinical record revealed diagnoses that included Parkinson's disease (brain disorder causing tremors, muscle stiffness, and slow movement) and chronic kidney disease stage 3A (mild-moderate loss of kidney function). Review of Resident 106's physician orders revealed an order for weight monthly in the morning every one month starting on the first for five days, start date May 1, 2026. Further review of Resident 106's clinical record failed to reveal any weight documented for July 2026. During an interview on July 23, 2026, at 2:00 PM, with the NHA, DON, and Employee 1, it was confirmed that Resident 106's weight had not been obtained as ordered and that it was the expectation of the facility that physician orders be followed. 28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on facility policy review, observations, resident and staff interviews, and clinical record reviews, it was determined that the facility failed to ensure that a resident receiving wound care was consistent with infection control standards of practice regarding aseptic field at the bedside and hand hygiene for one of four residents reviewed (Resident 1); and failed to ensure that residents receive necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent of a pressure ulcers for one of four residents reviewed (Resident 122). Findings Include: Review of the facility policy, titled Procedure: Wound Dressings, Aseptic last reviewed February 24, 2025, revealed, in part, the following steps: 3. Prepare a clean, uncluttered, disinfected surface. 4. Create an aseptic field at bedside and place clean barrier on over-bed table. Place supplies on barrier. Review of the facility policy, titled IC203 Hand Hygiene last reviewed March 20, 2026, read, in part, If a task requires gloves, perform hand hygiene before donning gloves and immediately after removing gloves. 2. Hand hygiene techniques: 2.1 To wash hands with soap and water, 2.2 To decontaminate hands with alcohol based rub. A review of the clinical record for Resident 1 on July 23, 2026, revealed diagnoses that included difficulty in walking and severe protein-calorie malnutrition (a severe nutritional deficiency caused by inadequate or absorption of protein and energy-calories). A review of the clinical record for Resident 1 on July 23, 2026, also revealed that he had an unstageable pressure ulcer on his left hip (a wound where the true depth cannot be determined because it is covered by slough). A review of Resident 1's physician orders dated July 2026, included an order for a treatment to left hip pressure ulcer with wound cleanser solution, Medihoney, covered with Calcium alginate and foam dressing to be done daily and PRN (as needed). Observation of wound care on Resident 1 on July 23, 2026, at 10:37 AM, revealed Employee 14 (Licensed Practical Nurse) and Employee 15 (Licensed Practical Nurse) setting up for the aseptic wound dressing change. The aseptic field was set up on the Resident's bed beside him. The surface was not disinfected and the clean barrier was not placed on an over-bed table per facility policy. A red biohazard bag and a clear garbage bag were placed on the foot end of the bed and were touching the towel that was to be the clean field. Employee 14 doffed and donned gloves four times during the treatment and did not perform hand hygiene with every glove change. During an interview with Employee 14 on July 23, 2026, at 11:20 AM, she confirmed that the dirty bag should not be on the same surface and touching the clean field. During an interview with Employee 14 on July 23, 2026, at 11:24 AM, she confirmed that she had changed her gloves multiple times during the dressing change without performing hand hygiene. During an interview with Nursing Home Administrator (NHA), Director of Nursing (DON) and Employee 1 on July 23, 2026, at 1:50 PM, Employee 1 revealed their expectation is that policy for dressing changes and hand hygiene protocol is to be followed. Review of Resident 122's clinical record revealed diagnoses that included osteoporosis (disease which makes bones weak and fragile) and bilateral osteoarthritis of the hip (joint cartilage breaks down causing pain). Review of Resident 122's physician orders revealed an order a pressure-redistribution mattress to the bed with a start date April 17, 2026. During an interview with Resident 122 on July 20, 2026 at 10:37 AM, Resident 122 revealed that she recently changed rooms and her air mattress was not moved with her. Observations on July 20, 2026, at 10:37 AM, and July 21, 2026, at 1:21 PM, revealed a regular mattress on Resident 122's bed. Review of census information revealed Resident 122 changed rooms on July 16, 2026. Review of Resident 122's comprehensive plan of care revealed a focus area indicating that Resident 122 was at risk for skin breakdown related to advanced age, decreased activity, frail fragile skin, and history of pressure ulcer, with an intervention for pressure redistribution surface on bed/chair. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 122's tasks for the past 30 days revealed that Resident 122 was documented yes, indicating preventative skin care pressure redistributing mattress was in place on July 17 at 4:13 AM, 10:59 PM, and 11:57 PM; July 18 at 2:59 PM and 9:48 PM; July 19 at 12:10 AM and 4:04 PM; and July 21 at 2:42 AM and 3:58 AM. During an interview on July 23, 2026, at 9:39 AM, with the NHA, DON, and Employee 1 revealed staff forgot to take the air mattress with Resident 122 when the rooms change occurred and that maintenance moved the mattress to Resident 122's new room on July 22, 2026 before breakfast. The NHA stated that it was the expectation of the facility that physician orders be followed. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 211.12 (d)(1)(2)(5) Nursing Services		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that a resident admitted with an indwelling foley catheter was accurately assessed for the removal of the catheter for one of one resident reviewed (Resident 1). Findings include: Review of Resident 1's clinical record revealed diagnoses that included severe protein-calorie malnutrition (a severe nutritional deficiency caused by inadequate or absorption of protein and energy-calories), cancer of the tongue, and obstructive (functional blockage of urine flow which causes damage to the kidneys) and reflux (urine flows backward into the kidneys) uropathy (any condition affecting that affects the urinary system). Observation of Resident 1 on July 21, 2026, at 9:00 AM, revealed the presence of an indwelling foley catheter (a flexible tube placed through the urethra to the bladder to drain urine). Review of Resident 1's physician orders revealed an order for a voiding trial to start June 30, 2026. Bladder scan every eight hours. May insert a straight catheter (a flexible tube placed through the urethra into the bladder to drain urine, which is removed immediately after the bladder has been emptied) for a post voided residual (amount if urine remaining in the bladder after urinating) greater than 400 milliliters. Reinsert indwelling foley catheter if required three straight catheter insertions in 24, dated June 29, 2026. Review of Resident 1's physician services provider notes revealed a note dated July 1, 2026, at 1:59 PM, which indicated Resident 1 had history of urinary retention (inability to fully empty the bladder) with an indwelling foley. The note further indicated staff were currently attempting voiding trial and that he required straight catheter that afternoon. Further review of Resident 1's nursing progress notes and treatment records failed to reveal any documentation as to the implementation or findings of the voiding trial by nursing staff. During a staff interview with the Nursing Home Administrator, the Director of Nursing, and Employee 1 (Regional Clinical Support Nurse) on July 23, 2026, at 3:07 PM, Employee 1 indicated that the facility could not provide any documentation regarding specifics of the voiding trial outside of the provider note on July 1, 2026. Employee 1 further indicated that the order was put in wrong and therefore documentation was lacking. 28 Pa. Code 211.11(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. Based on facility policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure that pain management is provided to residents who require such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two of five residents reviewed for pain management (Residents 47 and 122). Findings include: Review of facility policy, titled Pain Management last revised March 24, 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: To maintain the highest possible level of comfort for patients by providing a system to identify, assess, treat, and evaluate pain. An individualized, interdisciplinary, person-centered care plan will be developed and include: Non-pharmacological and pharmacological approaches. PRN (as needed) pain medications will: Be documented in the Medication Administration Record (MAR), have defined parameters for use, have reasons for PRN medication requests documented, and effectiveness and/or side effects/adverse drug reactions will be assessed and documented. Review of Resident 47's clinical record revealed diagnoses that included parkinsonism (a set of movement symptoms - slowness, rigidity, and tremor - that can occur in Parkinson's disease and other conditions), low back pain, and difficulty in walking. Review of Resident 47's physician orders revealed the following orders: oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) Give 1 tablet by mouth every 6 hours as needed for severe pain, with a start date of July 11, 2026. Non-Pharmacological Intervention(s) document every shift. Record Non-Pharm intervention in Supplementary Documentation. Document Effectiveness. If having pain follow providers direction which may include pain medication, every shift for pain management, with a start date of July 11, 2026. Review of Resident 47's comprehensive care plan revealed a focus area Resident exhibits or is at risk for alterations in comfort related to chronic pain with an intervention for Utilize pain scale with a created date of July 12, 2026. Further review of Resident 47's comprehensive care plan revealed a focus area Resident/patient has impaired in cognitive function or impaired thought processes related to Parkinsons disease with an intervention for Monitor for pain. Attempt non-pharmacologic interventions to alleviate pain and document effectiveness, with a created date of July 12, 2026. During an interview with Resident 47 on July 20, 2026, at 11:41 AM, she revealed she was in a lot of pain all night the night before, and her pain was not always managed. Review of Resident 47's July 2026 Medication Administration Record (MAR) revealed her PRN oxycodone was administered on July 12-17, and 19, 2026, without a numeric pain scale noted in her record consistent with severe pain. Further review of the oxycodone order failed to reveal a numeric pain scale associated with when to administer the medication. Review of Resident 47's order for non-pharmalogical interventions for pain, revealed non-pharmalogical pain interventions were not attempted prior to the administration of PRN pain medication on July 12-17, 2026. During an interview with the Director of Nursing (DON) on July 23, 2026, at 1:14 PM, she revealed she would expect PRN oxycodone to have a numeric pain scale and only be administered with an appropriate pain level, and for non-pharmalogical pain interventions to be implemented as appropriate. Review of Resident 122's clinical record revealed diagnoses that included osteoporosis (disease which makes bones weak and fragile) and bilateral osteoarthritis of the hip (joint cartilage breaks down causing pain). Review of Resident 122's physician orders revealed an order for buprenorphine (butrans) patch (narcotic pain medication) weekly 5 micrograms/hour, one patch transdermally one time every seven days for pain management. Review of Resident 122's MAR (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for April 2026 - July 2026 revealed the following: Buprenorphine patch apply at 9:00 AM was marked NN indicating no/see nurse notes on April 17 and 24; marked HD indicating hold/see nurse notes on May 29; andBuprenorphine patch removal at 8:59 AM was marked NN indicating no/see nurse notes on April 24, May 1 and 29, and June 5; and marked HD indicating hold/see nurse notes on July 3. Review of Resident 122's nursing progress notes for April 2026 - July 2026 revealed the following: April 17 and 24 notes indicating that Resident 122's butrans patch was not available and they were awaiting a delivery from the pharmacy. No notes on May 1 or May 29 relating to Resident 122's butrans patch removal. A note on May 29 indicated patches were not available and call was placed to pharmacy to obtain patches. June 5th removal note indicated that Resident 122 did not have a patch in place to be removed. Further review of Resident 122's nursing progress notes failed to revealed any notes relating to Resident 122's butrans patch removal on May 1 and 29, and July 3. During an interview with the Nursing Home Administrator, DON, and Employee 1 it was revealed that Resident 122's butrans patch was unavailable for approximately four days after being ordered in April 2026, and that no additional information could be provided relating to the aforementioned documentation concerns. The DON stated that it was the expectation of the facility that the physician be notified when medication is not available and that documentation be correct. 28 Pa. Code 211.9(a)(1) Pharmacy services28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on policy review, clinical record review, and staff interviews, it was determined that the facility failed to provide the licensed pharmacist's report of a medication irregularity for two of five residents reviewed (Residents 3 and 112). Findings include: Review of the facility policy, titled Medication Monitoring Medication Regimen Review and Reporting with a last policy review date of March 10, 2026, revealed, 6. Resident-specific MRR recommendations and findings are documented and acted upon by the nursing care center and/or physician. 7. A record of the consultant pharmacist's observations and recommendations is made available in an easily retrievable format to nurses, physicians and the care planning team within 48 hours of MRR completion. Review of Resident 3's clinical record revealed diagnoses that included hypertension (high blood pressure) and dementia (the loss of cognitive functioning that interferes with a person's daily life and activities). Review of Resident 3's clinical record revealed that on January 11, 2026, a Medication Regimen Review (MRR) was performed and the Pharmacist made comments/recommendations for the physician to act upon. Further review of Resident 3's clinical record failed to include what the Pharmacy recommendations were on January 11, 2026, or any evidence that the physician was aware of or responded to this pharmacy recommendation. During an interview conducted with the Regional Clinical Support Nurse (RCSN) and Nursing Home Administrator (NHA) on July 22, 2026, at 1:22 PM, revealed that they were not able to provide the pharmacy recommendation written by the pharmacist on January 11, 2026. Review of Resident 112's clinical record revealed diagnoses that included diabetes (a chronic condition that occurs when the body cannot effectively use insulin, a hormone that regulates blood sugar levels) and anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome). Review of Resident 112's clinical record revealed that on April 20, 2026, a MRR had been performed and the Pharmacist made comments/recommendations for the physician to act upon. Further review of Resident 112's clinical record failed to include what the Pharmacy recommendations were on April 20, 2026, or any evidence that the physician was aware of or responded to this pharmacy recommendation. During an interview conducted with the RCSN and NHA on July 22, 2026, at 1:22 PM, revealed that they were not able to provide the pharmacy recommendation written by the pharmacist on April 20, 2026. 42 CFR 483.45 Drug Regimen Review.28 Pa. Code 211.9 (a)(1) Pharmacy services.28 Pa. Code 211.12 (d)(1) Nursing services.28 Pa. Code 211.12(d)(3) Nursing services.28 Pa. Code 211.12 (d)(5) Nursing services.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395746	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Carlisle Skilled Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on nurse aide job description review, employee file reviews, and staff interview, it was determined that the facility failed to ensure required in-service training for nurse aides sufficient to ensure the continuing competence of nurse aides no less than 12 hours per year and/or include resident abuse prevention training for two of five nurse aide files reviewed for annual education requirements (Employees 10 and 11). Findings include: Review of facility document, titled Job Description: Nursing Assistant last revised November 23, 2020, read, in part, Must attend a minimum of 12 hours continuing education programs provided by the center in order to maintain certification. Review of Employee 10's annual education hours revealed she had only completed 2.38 hours of annual education and had not completed any abuse prevention training. Review of Employee 11's annual education hours revealed she had not completed any abuse prevention training. During an interview with the Director of Nursing on July 22, 2026, at 2:09 PM, she revealed she would expect nurse aides to complete at least 12 hours of required in-service training per year and include resident abuse prevention training. 28 Pa. Code 201.14(a) Responsibility of licensee.		