STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395770	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Haven Healthcare Center	590 South Fifth Avenue Lebanon, PA 17042

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 0761 Level of Harm - Immediate jeopardy to resident health or safety 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, observation, and staff interview, it was determined that the facility failed to properly store and label medications on six of 10 nursing units (1C, 1D, 3C, 3D, 3F, 4F) and in the central supply room, to ensure the correct and safe administration of medications for 34 of 43 sampled residents (Residents 9-42). This failure put residents at risk for medication administration errors and resulted in an Immediate Jeopardy situation.Findings include:Review of the facility policy titled, Specific Medication Administration Procedures, last reviewed October 1, 2025, revealed that all medications stored in carts, in medications rooms, or in central supply were to be locked at all times unless in use or under the direct observation of the medication nurse.Review of the facility policy titled, Administering Medications, last reviewed October 1, 2025, revealed that nursing staff were to check the label of all medications three times to verify that the right medication, at the right dose, was being administered at the right time with the right method to the right resident. The expiration date on the medication label was to be checked prior to administration. Opened multi-dose containers were to have the date opened recorded on the container.Review of the facility policy titled, Specific Medication Administration Procedures, last reviewed October 1, 2025, revealed that prior to removing a medication from a container, the nurse administering the medication must check the label against the appropriate order, note applicable supplemental labeling, and follow any relevant directions. The container of any multi-use medications was to be checked for an expiration date before administration.Review of the facility policy titled, Medication Not Available Procedure, last reviewed October 1, 2025, revealed that the Registered Nurse (RN) supervisor was to be contacted if an ordered over-the-counter (OTC) medication was not available in a medication cart at the time of administration to obtain the medication from central supply. Nurse management was to be notified if a system-wide issue was identified. In an interview on February 2, 2026, at 9:57 a.m., the Central Supply Manager stated that OTC medications were stored in central supply and medication carts were stocked as needed by staff. She stated that if no one was working in the supply room to provide access, facility staff had access to the room with a code to the door lock. The Central Supply Manager was not aware of all staff who had access to that code. She reported that in addition to nursing staff, therapists, and nurse aides had collected materials from the central supply after hours. OTC medications in closed, factory-labeled bottles were observed on open shelves in the supply room on February 2, 2026, at 10:05 a.m. The room was accessed via keypad lock.In an interview on February 2, 2026, at 11:53 a.m., Licensed Practical Nurse (LPN) 1, reported that OTC medications had been stored in both medication carts on the 4F nursing unit in open plastic cups with incomplete, handwritten labels. She stated that OTC medications were to be properly stored in their factory-labeled bottles with the lids closed and the date written on the top when the bottles were opened. Observations on units 1C, 1D, 3C, 3D, 3F, and 4F on (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 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	February 2, 2026, from 12:47 p.m. through 3:40 p.m., revealed that OTC medications were stored in open plastic cups with handwritten labels inside the medication carts. Observation of the medication carts on unit 1C revealed that medication cart 1 contained seven cups containing pills with handwritten labels that read: Amea Red (LPN 4 identified this as an eye supplement), Guaifenesin ER 600 mg, Melatonin 5 mg, Cetirizine 10 mg, Iron, B12 100, and Fiber Con. LPN 4 was unable to determine the doses, manufacture dates, expiration dates, or when the original containers of the medications had been opened. Observation of medication cart 2 revealed three cups containing pills with handwritten labels that read: ASA EC, Mucinex, and Ibuprofen 200 mg. There was also a cup labeled: Senna 8.6, which contained a mixture of red, pink, and brown pills. LPN 5 was unable to determine the doses, manufacture dates, expiration dates, or when the original containers of the medications had been opened. She was unable to identify all pills in the cup labeled Senna 8.6. Residents 11, 16, 17, 18, 19, 20, 22, 23, and 24 had medications stored in the medication carts and physician's orders that would correlate with the medications found in clear cups. Observation of the medication carts on unit 1D revealed that medication cart 3 contained seven cups with pills that had handwritten labels that read: Oyster Shell D3, Cranberry 450, Vit D 2000 iu, omep 2D, MVI, cetirizine, and vit D3 2000 iu. LPN 3 was unable to determine the doses, manufacture dates, expiration dates, or when the original containers of the medications had been opened. Residents 10, 25, 26, and 27 had medications stored in medication cart 3 and physician's orders that would correlate with the medications found in the cups. Observation of the medication carts on unit 3C revealed three cups containing pills with handwritten labels that read: Vitamin D3 50,000 iu, Docusate, and Vit C 500 mg, in medication cart 4. LPN 8 was unable to determine the doses, manufacture dates, expiration dates, or when the original containers of the medications had been opened. Residents 9, 28, 29, 30, 31 had medications stored in the medication cart and physician's orders that would correlate with the medications found in the cups. Observation of the medication carts on unit 3D revealed four cups containing pills with handwritten labels that read: Senna 8.6 mg, Vitamin D3 50,000, Multivitamin, and Fiber-lax, in medication cart 5. LPN 9 was unable to determine the manufacture dates, expiration dates, or when the original containers of the medications had been opened. Residents 12, 13, 14,and 15 had medications stored in the medication cart and physician's orders that would correlate with the medications found in the cups. Observation of the medication carts on unit 3F revealed two cups containing pills with handwritten labels that read: Vit D 2,000 iu, and Tylenol 500, in medication cart 6. The cart also contained a cup labeled: Iron 325, which contained white and black pills. LPN 6 was unable to determine the manufacture dates, expiration dates, or when the original containers of the medications had been opened. LPN 6 was unable to identify all pills in the cup labeled Iron 325. Observation of medication cart 7 revealed two cups containing pills with handwritten labels that read: Calcium 600+D 10 mcg, and Iron 325. LPN 7 was unable to determine the manufacture dates, expiration dates, or when the original containers of the medications had been opened. Residents 32 and 33 had medications stored in the medication carts and physician's orders that would correlate with the medications found in the cups. Observation of the medication carts on unit 4F revealed 14 cups containing pills with handwritten labels that read: Docusate Sodium, Ibuprofen, Oyster Calcium, Iron, Multi vitamins, Cranberry, Mag Ox, Aspirin, ASA 81, Docusate, Multivit, Therems, Fe sulp, and Oyster Cple, in medication cart 8. Observation of medication cart 9 revealed two cups containing pills with no labels along with ten cups containing pills with handwritten labels that read: Vit B12, Cranberry, Ibuprofen, Iron, Aspirin, Multivit, Oyster Cal, Thera-M, VitD, and Certizine. LPN 1 was unable to determine the doses, manufacture dates, expiration dates, or when the original containers of the medications had been opened. LPN 1 was unable to (continued on next page)

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F 0761 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	identify the pills contained in the two unlabeled cups. Residents 36, 37, 38, 39, 40, and 41 had medications stored in the medication carts and physician's orders that would correlate with the medications found in the cups. In an interview on February 2, 2026, at 3:43 p.m., the Director of Nursing (DON) confirmed that OTC medications were improperly stored and labeled in open, hand-labeled cups in medication carts. On February 2, 2026, at 5:15 p.m., the Administrator was informed that the failure to properly store and label medications constituted an Immediate Jeopardy situation at F761-K, and the Immediate Jeopardy template was provided. The facility was informed that a corrective action plan was required.The facility implemented the following corrective action plan: 1. All medications that were observed in medication cups/unlabeled cups or any medication that was unable to be identified was to be discarded and destroyed.2. Any medication that was discarded was to be immediately replaced with an unopened, labeled, OTC medication bottle.3. OTC medications would be stored in the original, labeled bottle in the medication carts and administered to residents following the policies relevant to medication administration.4. Procedures for ordering and stocking OTC medications would require that orders be submitted weekly with the Clinical Supply order. In the event that a medication was not sent, backordered, or runs out, needed OTC medications would be purchased from a local pharmacy.5. The Central Supply keylock code would be changed and given only to central supply staff and RN Supervisors.6. All licensed and central supply staff would be trained regarding storage of medications, proper distribution of OTC medications, and the medication not available procedure. Staff on shift at the time of the IJ were trained immediately. All others will be trained during their next shift.7. All medication carts would be audited on each shift for seven days, then once daily for seven days by the Administrator or a designee to ensure no loose or unlabeled medications are stored in any cart.The surveyor validated that the Immediate Jeopardy was removed on February 2, 2026, at 8:55 p.m., through observation, interviews, review of the facility training, and review of facility policies and procedures following the facility's implementation of the corrective action plan for the Immediate Jeopardy. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(3) Management. 28 Pa. Code 211.9(a)(1)(c) Pharmacy services.28 Pa. Code 211.10(c) Resident care policies.28 Pa. Code 211.12 (d)(1)(5) Nursing services.