STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395778	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Communities at Indian Haven,	1675 Saltsburg Avenue Indiana, PA 15701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to notify the ombudsman of the transfer to the hospital, for three of 32 residents reviewed (Residents 1, 4, 7). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated January 9, 2026, indicated that the resident was cognitively impaired, required assistance from staff for her daily care needs and had diagnoses that included heart failure and renal failure. A nursing note, dated September 26, 2025, at 2:45 a.m. revealed that Resident 1 had a decline in condition, had a fever of 101 degrees Fahrenheit (F), was sweating through her clothing, had crackles (lung sounds that indicate the presence of fluids or secretions in the airways) and occasional moist cough, and her oxygen saturation (percentage of oxygen in blood) dropped to into the 70's with 2 liters of oxygen on. The physician was notified and an order was received to transfer the resident to the emergency room for evaluation. She was admitted to the hospital with a diagnoses of pneumonia. There was no documented evidence that the ombudsman was notified of Resident 1's transfer to the hospital as required. A quarterly MDS assessment for Resident 4, dated December 19, 2025, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included sepsis (serious condition in which the body responds improperly to an infection). Physician's note for Resident 4 dated September 1, 2025, at 1:28 p.m. revealed that the resident was seen by the physician and had an elevated temperature and heart rate. The physician gave orders to send the resident to the hospital emergency room for evaluation. A nurse's note dated September 1, 2025, at 5:56 p.m. revealed that the resident was admitted to the hospital with a diagnosis of urinary tract infection and heart failure. A nurse's note for Resident 4 dated October 22, 2025, at 5:24 p.m. revealed that the resident's daughter was in the facility to visit the resident and requested that the resident be sent to the hospital emergency room for evaluation. The physician was agreeable and the resident was transferred to the hospital. A nurse's note dated October 23, 2025, at 5:57 a.m. revealed that the resident was admitted to the hospital with a diagnosis of sepsis. There was no documented evidence that the ombudsman was notified of Resident 4's transfers to the hospital as required. A quarterly MDS assessment for Resident 7, dated July 9, 2025, indicated that the resident was cognitively intact and required assistance from staff for her daily care needs. A nursing note, dated July 16, 2025, at 9:25 a.m., revealed that Resident 7's right hip incision had more swelling and was causing increased pain. At 7:06 p.m. a physician's order was received to send the resident to the emergency room for evaluation of her right hip abscess. The resident was admitted to the hospital and was awaiting a general surgery consult. Interview with the Nursing Home Administrator on January 30, 2026, at 11:51 a.m. confirmed that there was no documented evidence that the ombudsman was notified regarding the hospitalizations for Residents 1, 4, and 7. 28 Pa. Code 201.29(j) Resident Rights.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on review of the Resident Assessment Instrument User's Manual and clinical records and staff interviews, it was determined that the facility failed to ensure that the Care Area Assessment Process of comprehensive Minimum Data Set assessments and comprehensive assessments were completed in the required time frame for two of 32 residents reviewed (Residents 12, 68). Findings include:The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2025, indicated that for admission MDS assessments, the assessment completion date, and the Care Area Assessment (CAA - the process of completing an in-depth assessment of triggered, potentially problematic care areas) completion date (Item V0200B2) were to be no later than the resident's admission date plus 13 calendar days and there must be an MDS every 92 days. A comprehensive MDS assessment for Resident 12 revealed that the ARD was September 30, 2025, however, there was no prior MDS assessment in the last 366 days.A comprehensive MDS assessment for Resident 68 revealed that the ARD was November 19, 2025, however, there was no prior MDS assessment in the last 366 days.Interview with the Registered Nurse Assessment Coordinator (RNAC - a registered nurse who is responsible for the completion of MDS assessments) on January 30, 2026 at 10:19 a.m. confirmed that the above referenced MDS assessments were not completed in the required time frames.28 Pa. Code 211.5(f) Clinical records.

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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 review of the Resident Assessment Instrument Manual and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that quarterly Minimum Data Set assessments were completed within the required time frame for 2 of 32 residents reviewed (Residents 37, 40). Findings include:The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2025, indicated that the assessment reference date (ARD - the last day of the assessment's look-back period) of a quarterly MDS assessment must be no more than 92 days after the ARD of the most recent assessment of any type, and the assessment was to have a completion date (Section Z0500B) that was no later than the ARD plus 14 calendar days. A quarterly MDS assessment for Resident 37 had an ARD of October 31, 2025, which was more than 92 days after the last assessment. A quarterly MDS assessment for Resident 40 had an ARD of October 30, 2025, which was more than 92 days after the last assessment.Interview with the Registered Nurse Assessment Coordinator Consultant (RNAC - a registered nurse who is responsible for the completion of MDS assessments) on January 30, 2026 at 10:19 a.m. confirmed that the above comprehensive MDS assessments were not completed in the required time frames.28 Pa. Code 211.5(f) Clinical records.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set (MDS) assessments for six of 32 residents reviewed (Residents 1, 11, 12, 13, 16, 38). Findings include:The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (required assessments of a resident's abilities and care needs), dated October 2025, revealed that Section N0415E1 Anticoagulant was to be checked if the resident took the medication during the seven-day look-back period.Physician's orders for Resident 1, dated October 3, 2025, included an order for the resident to receive 15 milligram (mg) of Rivaroxaban (anticoagulant) at bedtime for chronic atrial fibrillation (irregular heart rhythm).Review of the Medication Administration Record (MAR) for Resident 1, dated January 2026, revealed that staff administered the 15 mg of Rivaroxaban at bedtime every morning from January 1 through 29, 2026. However, a quarterly MDS assessment for Resident 1, dated, January 9, 2026, revealed that Section NO415E1 was not checked, indicating that the resident did not receive an anticoagulant medication during the seven-day look-back assessment period.The RAI User's Manual, dated October 2025, revealed that Section N0415A1 Antipsychotic was to be checked if the resident took the medication during the seven-day look-back period and Section N0450A Antipsychotic Medication Review was to be coded (1) Yes, if the resident took an antipsychotic medication routinely since admission/entry or re-entry or the prior OBRA assessment, whichever was most recent. If the resident took an antipsychotic routinely, then Section N0450B, has a gradual dose reduction been attempted?, was to be coded (0) for no, and (1) yes, and if (1) yes was coded, then staff were to include the date that the gradual dose was attempted.A psychiatry note for Resident 11, dated November 20, 2025, indicated that the resident was doing well with the decrease in Zyprexa (antipsychotic) and to decrease the Zyprexa from 10 mg at bedtime to 5 mg at bedtime. Physician's orders, dated November 20, 2025, included an order for the resident's Zyprexa be decreased from 10 mg at bedtime to 5mg at bedtime.Review of the Medication Administration Record (MAR) for Resident 11, dated November 2025, revealed that staff administered the 5 mg of Zyprexa at bedtime starting November 20, 2025. A quarterly MDS assessment for Resident 11, dated, December 16, 2025, revealed that Section NO415A1 was checked to indicate that the resident received an antipsychotic medication during the seven day look back period and Section N0450A was coded (1) yes, to indicate that the resident received an antipsychotic medication routinely since admission/entry or re-entry or the prior OBRA assessment; however Section 0450B was coded (0) No, indicating that the resident did not receive a gradual dose reduction.Physician's orders for Resident 12, dated September 1, 2024, included an order for the resident to receive 80 mg of Ziprasidone (antipsychotic) one time a day for schizoaffective disorder (mental health condition characterized by the combination of schizophrenia symptoms, including hallucinations, delusions, and disorganized speech, and a mood disorder).Review of the MAR for Resident 12, dated December 2025, revealed that staff administered 80 mg of Ziprasidone one time a day during the month of December 2025. A quarterly MDS assessment for Resident 12, dated December 30, 2025, revealed that Section NO415A1 was checked, indicating that the resident received an antipsychotic medication during the seven-day look-back period; however, Section N0450A was coded (0) No, indicating that the resident did not receive an antipsychotic medication routinely since admission/entry or re-entry or the prior OBRA assessment.Physician's orders for Resident 13, dated September 9, 2024, included an order for the resident to receive 5 mg of Aripiprazole (antipsychotic) one time a day and 10 mg of Aripiprazole at bedtime for bipolar disorder (chronic mental health condition that causes significant fluctuations in mood, energy, activity levels, and the ability to think clearly).Review of the MAR for Resident 13, dated November 2025, revealed that staff administered 5 mg of Aripiprazole one time a day and 10 mg of Aripiprazole at bedtime (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	November 1 through 20, 2025. A quarterly MDS assessment for Resident 13, dated, November 27, 2025, revealed that Section NO415A1 was checked, indicating that the resident received an antipsychotic medication during the seven day look back period; however Section N0450A was coded (0) No, indicating that the resident did not receive an antipsychotic medication routinely since admission/entry or re-entry or the prior OBRA assessment.Interview with the Nursing Home Administrator on January 30, 2026, at 3:23 p.m. confirmed that the MDS assessments for Residents 1, 11, 12, and 13 were coded incorrectly.The RAI User's Manual, dated October 2025, revealed that Section J0100A was to be marked yes if the resident received scheduled pain medication regimen at any time in the last 5 days of the look-back period. Physician's orders for Resident 16 dated May 21, 2026, included that the resident receive 15 mg of oxycodone (pain medication) three times a day for chronic pain. Review of the MAR for Resident 16 dated November 2025 revealed that the resident received 15 mg of oxycodone three times of day every day during the period of November 1-13, 2025. However, a quarterly MDS for Resident 16 dated November 13, 2025, revealed that Section J0100A was checked not to indicate that resident was not on a scheduled pain medication regimen. The RAI User's Manual, dated October 2025, revealed that Section O0110K1B was to be marked yes if the resident was receiving hospice services during the seven-day look-back period. Nurse's note for Resident 38 dated November 29, 2025, revealed that the resident was admitted to hospice services. However, a significant change MDS assessment dated [DATE], revealed that Section O0110K1B was coded no, indicating that the resident was not receiving hospice services. Interview with the Nursing Home Administrator on January 30, 2026, at 11:51 a.m. confirmed that MDS assessments for Residents 16 and 38 were coded incorrectly. 28 Pa. Code 211.5(f) Medical records

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on review of policies and clinical records reviews, as well as observations and staff interviews, it was determined that the facility failed to develop comprehensive care plans that included specific and individualized interventions to address the care needs of one of 32 residents reviewed (Residents 3, 4, 16, 18, 47, 75, 84, 85). Findings include:The facility's policy regarding care plans, dated April 15, 2025, indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develop and implement a comprehensive, person-centered care plan for each resident.A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3 dated November 24, 2025, indicated the resident was cognitively impaired, required assistance from staff for daily care needs and had diagnosis that included respiratory failure.Nurse's note for Resident 3 dated January 19, 2026, at 2:54 p.m. revealed that the resident tested positive for covid infection. The resident's daughter was aware and agreeable to the resident receiving Paxlovid for seven days. A nurse's note dated January 23, 2026, revealed the resident was readmitted from the hospital with a diagnosis of covid, pneumonia and sepsis.Observations on January 28, 2026, at 9:26 a.m. revealed the resident was in her room with the door closed and a sign was posted outside her door indicating that droplet precautions (infection control measures used in healthcare settings to prevent the spread of pathogens like influenza and COVID-19, transmitted through large respiratory droplets) were in place.There was no documented evidence that a care plan was developed to address Resident 3's specific and individualized care needs related to being positive of Covid 19.Interview with the Director of Nursing on January 29, 2026, at 11:54 a.m. confirmed that an individualized care plan and interventions were not developed related to Resident 3 being positive for Covid 19.A quarterly MDS assessment for Resident 4 dated December 19, 2025, indicated that the resident was cognitively intact, required assistance from staff for daily care needs and had diagnosis that included depression. Review of the Medication Administration Record (MAR) for resident 4 dated January 2026, revealed that the resident received two tablets of five milligrams (mg) of escitalopram (an antidepressant) every day for depression from January 1 through January 29, 2026.There was no documented evidence that a care plan was developed to address Resident 4's specific and individualized care needs related to receiving antidepressant medications.Interview with the Director of Nursing on January 29, 2026, at 11:54 a.m. confirmed that an individualized care plan and interventions were not developed related to Resident 4's antidepressant medication use.A quarterly MDS assessment for Resident 16 dated November 13, 2025, indicated that the resident was cognitively intact, required assistance from staff for daily care needs and had the presence of pain.A physician's order for Resident 16 dated January 24, 2026, included for the resident to receive 10 mg of oxycodone (pain medication) every six hours as needed pain. Interview with Resident 16 on January 28, 2026, at 11:56 a.m. revealed that the resident stated he has frequent back pain and asks for pain medication frequently when he needs it.There was no documented evidence that a care plan was developed to address Resident 16's specific and individualized care needs related to the presence of back pain and receiving pain medications.Interview with the Director of Nursing on January 30, 2026, at 11:51 a.m. confirmed that an individualized care plan and interventions were not developed related to Resident 16's presence of back pain and receiving pain medications.A quarterly MDS assessment for Resident 18 dated November 26, 2025, indicated that the resident was cognitively intact, was independent with most daily care needs and had diagnosis that included depression and atrial fibrillation (an irregular and often very rapid heart rhythm).A physician's order for Resident 18 dated August 9, 2025, included for the resident to receive 20 mg of paroxetine (antidepressant) one time a day for depression.A (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician's order for Resident 18 dated August 9, 2025, included for the resident to receive 15 mg of Xarelto (anticoagulant medication to prevent blood clots) one time a day at bedtime for atrial fibrillation.There was no documented evidence that a care plan was developed to address Resident 18's specific and individualized care needs related to the use of antidepressant and anticoagulant medication use.Interview with the Director of Nursing on January 30, 2026, at 11:51 a.m. confirmed that an individualized care plan and interventions were not developed related to Resident 18's use of antidepressant and anticoagulant medication use.An admission MDS assessment for Resident 47, dated January 12, 2026, indicated that the resident was cognitively intact and received an antibiotic. A physician's order, dated January 20, 2026, included orders for the resident to receive 2 grams of Cefepime HCL Solution (antibiotic) intravenously (IV) two times a day until February 3, 2026 for sepsis (condition in which the body responds improperly to an infection).Observations on January 28, 2026, at 9:45 a.m. revealed Resident 47 was in bed and an IV medications were hanging on an IV pole. There was no documented evidence that a care plan was developed to address Resident 47's specific and individualized care needs related to receiving IV antibiotics. Interview with the Director of Nursing on January 29, 2026, at 11:49 a.m. confirmed that an individualized care plan and interventions were not developed related to Resident 47's IV use. A quarterly MDS assessment for Resident 75 dated December 1, 2025, indicated that the resident had moderate cognitive impairment, was always incontinent of bowel and bladder, and had diagnosis that included dementia. Review of nurse aide care documentation dated January 2026 indicated that the resident was incontinent of urine daily, and all bowel movements were documented as incontinent.There was no documented evidence that a care plan was developed to address Resident 75's specific and individualized care needs related to incontinence of bowel and bladder.Interview with the Director of Nursing on January 30, 2026, at 11:51 a.m. confirmed that an individualized care plan and interventions were not developed related to Resident 75's incontinence of bowel and bladder. A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 84, dated January 28, 2026, indicated that the resident was cognitively intact, required assistance for daily care, and that he medicated with an anticoagulant (blood thinner). Physician's order for Resident 84 dated January 29, 2026 was for the resident to receive 2.5 milligrams (mg) Eliquis (blood thinner) two times per day. The resident's care plan, dated January 29, 2026, did not include the resident's anticoagulant.An interview with the Director of Nursing on January 29, 2026 at 11:50 a.m. revealed that there was no care plan in place regarding Resident 84's anticoagulant and that it should have. A nursing note, dated January 22, 2026, at 10:08 p.m. revealed that Resident 85 had an occasional non-productive cough with nasal congestion, hoarse voice, diminished lung sounds, and a temperature of 101.1 degrees Fahrenheit. A Covid test revealed the resident was positive for Covid. The physician was notified and Paxlovid (antiviral medication used to treat Covid) and Tessalon pearls (used to relieve coughing) were ordered. A physician's order, dated January 22, 2026, included orders for Droplet based precautions due to being positive for Covid 19.Observations on January 28, 2026, at 9:45 a.m. revealed that Resident 85 was in her room with the door closed and a sign was posted outside her door indicating that droplet precautions were in place.There was no documented evidence that a care plan was developed to address Resident 85's specific and individualized care needs related to being positive of Covid 19.Interview with the Director of Nursing on January 29, 2026, at 11:49 a.m. confirmed that an individualized care plan and interventions were not developed related to Resident 85 being positive for Covid 19.28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for two of 32 residents reviewed (Residents 44, and 53).Findings include: The facility's policy regarding plans of care, dated April 15, 2025, indicated that resident assessments were ongoing and care plans were revised as information about the resident and their condition changed. The interdisciplinary team reviews and updates the care plan when there has been a significant change in the resident's condition; when the desired outcome is not met; when the resident has been readmitted to the facility from a hospital stay; and at least quarterly, in conjunction with the required quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs). A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 44, dated December 24, 2025, revealed that the resident was cognitively impaired, required staff assistance with daily care needs, was frequently incontinent of bowel and bladder, was at risk for developing pressure ulcers, and had no unhealed pressure ulcers.Physician's orders, dated February 12, 2025, included orders for the resident to have an alternating pressure mattress (mattress that utilizes a system of air cells to redistribute pressure across the body). A nursing note, dated August 13, 2025, revealed that the alternating pressure mattress was discontinued due to low risk and no current pressure injuries. The resident's current care plan included that an alternating pressure mattress was being used.Observations of Resident 44 on January 30, 2026, at 8:16 a.m. revealed the resident was sitting on the side of his bed eating breakfast and there was no alternating pressure mattress in place. Interview with the Director of Nursing on January 30, 2026, at 3:50 p.m. confirmed that Resident 44's care plan was not revised to reflect that the alternating pressure mattress was discontinued on August 13, 2025.A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 53, dated October 28, 2025, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnosis that included obstructive neuropathy (functional or structural blockage of the urinary tract that prevents normal urine flow). Care plan for resident 53 dated December 5, 2024, indicated that the resident was receiving anti-anxiety medication for anxiety disorder.Review of the Medication Administration Record (MAR) for Resident 53 dated January 2026 revealed that the resident did not receive any anti-anxiety medication during the month of January.Interview with the Nursing Home Administrator on January 30, 2026, at11:51 a.m. confirmed that Resident 53's care plan was not revised to reflect that she was not receiving an anti-anxiety medication and it should have been. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on review of Pennsylvania's Nursing Practice Act and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a professional (registered) nurse assessed a resident after a change in condition for one of 32 residents reviewed (Resident 90). Findings include:The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals.The facility's policy regarding change in condition, dated April 15, 2025, indicated that the resident would be assessed following a change in condition. A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 90, dated December 26, 2025, revealed that the resident was cognitively intact and required assistance from staff for daily care needs.A nursing note, dated December 28, 2025, revealed that the resident was experiencing auditory and visual hallucinations, was seeing and having conversations with her father in law who passed away several years ago, and knowing that these conversations are not real. There was no documented history of hallucinations in the resident's clinical chart.There was no documented evidence in the clinical record to indicate that Resident 90 was assessed by a registered nurse when she began having auditory and visual hallucinations.Interview with the Nursing Home Administrator on January 30, 2026 at 12:03 p.m. confirmed there was no documented evidence of a registered nurse assessment at the time of Resident 90's new hallucinations, and there should have been.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 review of facility policies, clinical records, and shower schedules, as well as staff interviews, it was determined that the facility failed to ensure that residents were provided with showers as scheduled for one of 32 residents reviewed (Resident 75).Findings include:The facility policy for the procedure for bathing a resident in a tub or shower dated April 15, 2025, indicated that the purpose of the procedure was to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Documentation after a tub or shower should include the date and time the shower/tub was performed, the name of the individual who assisted with the bath, how the resident tolerated the shower/tub bath, and if the resident refused the shower/tub, the reason why and the intervention taken. Staff should notify the supervisor if the resident refuses the shower/tub bath. A quarterly MDS assessment for Resident 75, dated December 1, 2026, revealed that the resident had moderate cognitive impairment, was dependent on staff for bathing or showering, and had diagnosis that included stroke and dementia. Care plan for Resident 75 dated August 27, 2025, indicated that that the resident had a self-care deficit because of a right sided hemiplegia (paralysis affecting one side of the body,) after a stroke, and identified her preferred bathing type as a shower. A review of the nurse aide bathing documentation for Resident 75 dated January 2026, revealed that the Resident received a sponge bath and did not receive a shower from January 6-28, 2026, a total of 23 days. An interview with Nurse Aide 1 on January 30, 2026, at 1:13 p.m. revealed that there is no reason why Resident 75 could not get a shower and to her knowledge, she was supposed to receive showers. Interview with the Nursing Home Administrator on January 30, 2026, at 11:51 p.m. revealed there was no documented evidence that Resident 75 was showered according to her care planned preference during the 23 days of January 6- 28, 2026. 28 Pa. Code 211.12(d)(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. Based on review of facility policy and clinical record reviews, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders regarding medication administration were followed for one of eight residents reviewed (Resident 4).Findings include: The facility policy for administering medication dated April 15, 2025, included that medications must be administered in accordance with the orders, including any required time frame. The individual administering the medication must initial the resident's Medication Administration Record (MAR) on the appropriate area after giving each medication.A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated December 19, 2025, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included heart failure and diabetes. Physician's orders for Resident 4, dated September 6, 2025, included an order for the resident to receive two grams of Ceftriaxone (an antibiotic) intravenously (way of giving a medication through a needle or tube inserted into a vein) every 24 hours for a urinary tract infection.Review of the MAR for Resident 4, dated September 2025, revealed that two grams of Ceftriaxone was documented as U-SA on September 6 and September 7, 2025. Two grams of Ceftriaxone was documented as administered on September 8-12, 2025. Interview with the Director of Nursing on January 29, 2026, at 11:54 a.m. revealed that U-SA was an abbreviation meaning unknown-self-administered, and he was unsure why the medication was documented as U-SA on September 6 and September 7 or if the medication was administered on those two days. Interview with the Nursing Home Administrator on January 30, 2026, revealed there was no documented evidence that the resident received two grams of Ceftriaxone for seven days as ordered by the physician. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on a review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that weights were obtained per the facility policy and that the physician was notified of significant weight loss for two of 32 residents reviewed (Residents 53 and 75). Findings include: A facility policy for weight assessment and intervention dated April 15, 2025, included that any weight change of greater than five pounds for residents weighing 100 pounds or more within 30 days will be retaken within 24 hours A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 53, dated October 28, 2025, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, had diagnosis that included senile degeneration of the brain (a decline in an individual's memory, behavior, and cognitive abilities), and had unplanned weight loss. Care plan for Resident 53 dated December 12, 2024, indicated that the resident had the potential for a nutritional problem and that staff were to monitor, record, and report to the physician any signs or symptoms of malnutrition that include significant weight loss of three pounds in one week, greater than 5 percent in one month, greater than seven and a half percent in three months or greater than ten percent in six months. Review of a weight change note for Resident 53 dated January 5, 2026, at 11:34 a.m. revealed that the resident had a significant weight loss of 20 pounds which was 10.2 percent in 180 days (six months). There was no documented evidence that the physician was notified of the resident's significant weight loss per her care planReview of Resident 53's weight records revealed that on November 1, 2025, the resident weighed 181.6 pounds. On December 6, 2025, the resident weighed 176.4 pounds, a weight loss of 5 pounds 2 ounces. There was no documented evidence that residents was reweighed in 24 hours for a weight change of greater than five pounds for residents weighing 100 pounds or more per facility policy.A quarterly MDS assessment for Resident 75, dated December 1, 2026, revealed that the resident had moderate cognitive impairment, required assistance from staff for daily care needs, had diagnosis that included dementia, and had unplanned weight loss. Care plan for Resident 75 dated August 27, 2025, indicated that the resident had the potential for a nutritional problem and that staff were to monitor, record, and report to the physician any signs or symptoms of malnutrition that include significant weight loss of three pounds in one week, greater than 5 percent in one month, greater than seven and a half percent in three months or greater than ten percent in six months.Review of a weight change note for Resident 75 dated December 8, 2025, at11:36 a.m. revealed that the resident had a significant weight loss of 15 pounds, which was 10.7 percent in 180 days (6 months). A weight change note dated December 15, 2025, at 2:28 p.m. revealed that the resident had a significant weight loss of six pounds, which was 5.1 percent in 30 days. A weight change note dated January 5, 2026, at 12:24 p.m. revealed that the resident had a significant weight loss of 12.8 pounds, which was 9.3 percent in 90 days (3 months). There was no documented evidence that the physician was notified of the resident's significant weight loss when it was identified, according to her care plan. Review of Resident 75's weight record revealed that on November 11, 2025, the resident weighed 138.2 pounds. On December 1, 2025, the resident weighed 129.6 pounds, a weight loss of 8.6 pounds. There was no documented evidence that residents was reweighed in 24 hours for a weight change of greater than five pounds for residents weighing 100 pounds or more per facility policy. The resident's weight on December 9, 2025, was 131.4 pounds, the resident's weight on January 2, 2026, was 125.4 pounds, a weight loss of six pounds. As of January 29, 2026, there was no evidence the resident was reweighed after a weight change of greater than five pounds for residents weighing 100 pounds or more per facility policy.Interview with the Nursing Home Administrator on January 30, 2026, at11:51 a.m. revealed that there was no documented evidence that the physician was notified of Resident 53 and Resident 75's significant weight loss, per their care plans. Interview with the Nursing Home Administrator on January 30, 2026, at 1:18 p.m. revealed that there was no documented evidence that Resident 53 and Resident 75 were reweighed (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after a weight loss of greater than five pounds in one month per the facility policy on the above-mentioned dates. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, and staff interviews, it was determined that the facility failed to ensure that medications were properly stored for one of 32 residents reviewed (Resident 4).Findings include:A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated December 19, 2025, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, received an antidepressant medication, anticoagulant medication, and anti-convulsant medication. Resident 4 had diagnoses that included heart failure and diabetes. Observation of Resident 4 on January 28, 2026, at 9:53 a.m. revealed the resident was sitting in her wheelchair beside her bed and an unsupervised medicine cup containing 7 unlabeled clean and dry pills was sitting on her overbed table. Interview with Resident 4 at that time revealed that they were her morning medications that the nurse left for her to take.Interview with Licensed Practical Nurse 2 on January 28, 2026, at 9:57 a.m. revealed that she believed that Resident 4 had taken her morning medications when she was in the room administering them, and that Resident 4's medications should not have been left unlabeled and unsupervised on her bedside table. An interview with the Nursing Home Administrator on January 28, 2026, at 4:52 p.m. confirmed that Resident 4 medications should not have been left unsupervised and unlabeled at the bedside.28 Pa. Code 211.9(a)(1) Pharmacy Services.28 Pa. Code 211.12(d)(1) Nursing Services.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include:The facility's deficiencies and plan of corrections for an annual survey ending February 5, 2025, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending January 30, 2026, identified repeated deficiencies related to a failure to accurately complete MDS assessments, failure to create individualized care plans, quality of care, and infection control.The facility's plan of correction for a deficiency regarding accurate MDS assessments, cited during the survey ending February 5, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F641, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that resident's MDS assessments were completed accurately.The facility's plan of correction for a deficiency regarding development of care plans, cited during the survey ending February 5, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F656, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that resident's care plans were developed/implemented timely.The facility's plan of correction for a deficiency regarding quality of care, cited during the survey ending February 5, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that quality care was provided.The facility's plan of correction for a deficiency regarding infection control, cited during the survey ending February 5, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F880, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that there was appropriate infection control.Refer to F641, F656, F684, F880.28 Pa. Code 201.14(a) Responsibility of Licensee.28 Pa. Code 201.18(e)(1) Management.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that proper infection control practices were followed during the administration of a treatment for one of 38 residents reviewed (Residents 48). Findings include:The facility policy regarding nephrostomy tubes dated April 15, 2025, indicated that the steps in completing nephrostomy tube dressing changes and irrigation include to wash and dry your hands, open a sterile (completely free from germs/microorganisms (like bacteria)) drape and create a sterile field (a designated, microorganism-free area prepared to prevent contamination during procedures), open several packages of gauze pads, open several packages of povidone-iodine swabs, and open the disposable waste bag and place it away from the sterile field. The steps for the dressing change include to position resident on their side opposite of the tube, place a pad under the resident, wash your hands and put on clean gloves, careful remove the wet or soiled dressing, discard the dressing in the disposable waste bag, wash and dry hands, put on sterile gloves, with iodine , or a four inch by four inch gauze dipped in Normal Saline Solution (NSS-sterile saltwater), cleanse the nephrostomy tube site in outward circles form the insertion site. Discard the swabs or gauze in the disposable waste bag, place one to two sterile drain dressings on the nephrostomy tube site and secure with tape. Remove your gloves and wash your hands. The procedure for irrigation includes to open gauze pads, iodine or alcohol swabs, and pre-filled syringe, wash your hands and put on sterile gloves before performing the procedure. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 53, dated October 28, 2025, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, had an indwelling catheter (or nephrostomy tube), and diagnosis that included obstructive neuropathy (functional or structural blockage of the urinary tract that prevents normal urine flow). Physician orders for Resident 53 dated June 13, 2025, included for staff to cleanse the nephrostomy tube site with NSS and dry well, apply silicone tape (a skin-friendly, flexible adhesive) under the tubing to prevent it from touching skin, apply OPTILOCK dressing (brand of super-absorbent wound dressing), secure with silicone tape, and assure STAT lock (device to secure tubing in place) is in place every day shift every Monday, Wednesday, and Friday. Physician's orders dated January 13, 2026, include to flush the resident's nephrostomy with 10 ml of normal saline every shift. Observations of a nephrostomy tube dressing change and flush for Resident 53 on January 30, 2026, at 1:28 p.m. revealed that Licensed Practical Nurse 3 assembled all the supplies she needed for the procedure and placed them on the resident's bedside table and on the resident's bed without pacing a clean or sterile field. After removing the resident's soiled nephrostomy dressing and discarding it into a waste bag, she proceeded to open a bag of gauze that was laying on the resident's bed, pour NSS onto the nephrostomy site area and wipe the exposed nephrostomy tube site area with gauze without removing her soiled gloves, performing hand hygiene and applying sterile gloves. Licensed Practical Nurse 3 then removed the tape that was on the nephrostomy tubing and applied new tape. At that time, she removed her gloves and completed hand hygiene. She applied sterile gloves and then proceeded to open a package of sterile gauze that was lying on the resident bed, touching the packaging which contaminated her sterile gloves, and wiped the nephrostomy tube insertion site area, she then opened the Optilock dressing that was laying on the resident's bed and applied it to the nephrostomy site and applied tape to secure it. She then proceeded to flush the resident's nephrostomy tube with the same sterile gloves she applied the nephrostomy dressing with. She did not remove her gloves, perform hand hygiene and apply clean sterile gloves after completing the dressing change and before flushing the nephrostomy tube. Interview with Licensed Practical Nurse 3 on January 30, 2026, at 1:57 p.m. confirmed that she did not maintain a sterile field while providing a nephrostomy tube dressing change and while flushing the nephrostomy, stating she was not sure if it was supposed to be a sterile procedure, but she used sterile gloves because she likes to use sterile gloves when she applies clean (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dressings to any wound or other treatments. An interview with the Nursing Home Administrator on January 30, 2026, at 3:24 p.m. confirmed that Licensed Practical Nurse 3 should have completed Resident 53's nephrostomy site dressing change and flush using sterile procedures. 28 Pa. Code 211.12(d)(1)(5) Nursing services.