STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395784	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Letort Spring Nursing and Rehab LLC	801 N. Hanover Street 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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on facility policy review, clinical record review, facility documentation review, and staff interviews, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for three of three residents reviewed (Residents 1, 2, and 3) which resulted in actual harm as evidenced by two hospital transfers for seizure activity for one of three residents reviewed (Resident 1).Findings include: Review of facility policy, titled IIA2. Medication Administration-General Guidelines, undated, revealed, in part, Medications are administered in accordance with written orders of the attending physician. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR (Medication Administration Record) to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off duty without first recording the administration of any medications. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (e.g. the resident is not in the facility at scheduled dose time, or a starter dose of antibiotic is needed), the space provided on the MAR for that dosage administration is initialed and coded appropriately. An explanatory note is entered in the record. If two consecutive doses of a vital medication are withheld or refused, the physician is notified. Review of facility policy, titled IC4: Ordering and Receiving Controlled Medications, undated, revealed, in part, Schedule II controlled medications prescribed for a specific resident are delivered to the facility only if a faxed or original written prescription has been received by the pharmacy. Schedule III, IV and V may also be dispensed pursuant to a verbal order from the physician. In addition, if medication is needed prior to the next delivery, the pharmacist may authorize a nurse at the facility to remove a supply of the medication from the emergency supply in the facility according to policy IC5. In an emergency situation, the provider pharmacy can accept a telephone order for a schedule II medication. The DEA defines emergency to mean that the immediate administration of the drug is necessary for the proper treatment of the intended individual, that no alternative is available and that it is not possible for the prescriber to provide a prescription for the drug at that time. In no situations will an emergency dispensing exceed a 7-day supply. An individual resident's controlled substance record is prepared by the pharmacy or the facility for each controlled substance medication prescribed for a resident. The following information is completed: 1) Name of resident 2) Prescription number 3) Drug name, strength (if designated), and dosage form of medication 4) Date received 5) Quantity received and 6) Name of person receiving the medication supply. Schedule II controlled substance medications are reordered when a seven-day supply remains to allow for transmittal of the prescription to the pharmacist. Review of Resident 1's clinical record revealed diagnoses that included epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures) and dementia (a (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Actual harm Residents Affected - Few	chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning). Review of Resident 1's physician orders revealed orders for lacosamide (a medication used to manage seizure activity) 100 milligrams give one tablet by mouth every 12 hours. Review of Resident 1's past Controlled Substance Record's for her ordered lacosamide revealed that 30 tablets were received at the facility on December 29, 2025, and nursing staff began administering the medication from this package on January 1, 2026, at 9:10 AM. Further review of this record revealed that the last dose was administered to Resident 1 on January 15, 2026, at 8:00 PM. Review of Resident 1's January 2026 MAR revealed that she was administered a dose of lacosamide on January 16, 2026, at 8:00 AM, by Employee 1 (Licensed Practical Nurse [LPN]), despite that all available doses of Resident 1's lacosamide had been administered as of January 15, 2026, at 8:00 PM. Review of a written statement from Employee 1 on January 28, 2026, revealed that Employee 1 called the pharmacy on January 16, 2026, to inform them that Resident 1 was out of her lacosamide and it was needed. The statement indicated that the medication had already been ordered days prior and that the pharmacy indicated that the medication would be on the next pharmacy delivery. Employee 1 further indicated that she had erroneously charted administering Resident 1 her January 16, 2026, 8:00 AM dose of lacosamide and was going to correct the documentation. Further review of Resident 1's January 2026 MAR revealed that her lacosamide was documented as 16 Hold/See Nurses Note for her January 16, 2026, 8:00 PM dose administration, and her January 17, 2026, 8:00 AM and 8:00 PM dose administrations. Review of Resident 1's clinical record revealed a Medication Administration Note dated January 16, 2026, at 8:12 PM, that indicated Resident 1's lacosamide was on order from the pharmacy. Review of Resident 1's clinical record revealed a Medication Administration Note dated January 17, 2026, at 1:26 PM, that indicated Resident 1's lacosamide was on back order and pharmacy was notified. Review of Resident 1's clinical record revealed a Medication Administration Note dated January 17, 2026, at 10:26 PM, that indicated Resident 1's lacosamide was not available, pharmacy was called, and that the medication was on order. Review of Resident 1's clinical record progress notes revealed a nurse's note written by Employee 2 (LPN) dated January 17, 2026, at 10:40 PM, which indicated that Resident 1 was noted to be having a seizure which lasted from 10:20 PM to 10:26 PM. The note further indicated a call had been placed to the pharmacy earlier in the day regarding Resident 1's lacosamide and that the pharmacy indicated that the drug would be sent. The note also indicated that when Employee 2 called the pharmacy again to confirm that the lacosamide would be in the next pharmacy delivery run (night of January 17, 2026), the pharmacy indicated a script would be needed to dispense Resident 1's lacosamide. The note indicated that Employee 3 (Registered Nurse [RN]) reached out to the physician and requested that Resident 1 be sent out to the ER for further evaluation. Review of Resident 1's clinical record progress notes revealed a nurse's note written by Employee 3 (RN) dated January 17, 2026, at 11:20 PM, which indicated that Resident 1 had a seizure that lasted approximately 20-25 minutes. The note further indicated that Resident 1's physician was made aware of Resident 1's seizure, that her ordered lacosamide was not available, and that Resident 1's physician provided a new order to send Resident 1 to the hospital for evaluation and treatment. Based on review of Resident 1's progress notes for January 17, 2026, at 10:40 PM and 11:20 PM, it was unclear how long her seizure lasted.Review of Resident 1's clinical record progress notes failed to reveal any documentation that Resident 1's physician was made aware that the facility did not have Resident 1's ordered lacosamide to administer on January 16 or 17, 2026, (a total of four doses missed) until after Resident 1 suffered a seizure on January 17, 2026, at 10:00 PM, requiring a transfer to the hospital for evaluation and treatment. Review of Resident 1's hospital records for her transfer on January 17, 2026, (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	revealed no seizure medications were administered while she was at the hospital. Review of Resident 1's clinical record revealed that she returned to the facility on January 18, 2026, at 3:16 AM. At that time, the facility still did not have the required lacosamide medication. Resident 1's lacosamide was ordered to be administered on January 18, 2026, at 8:00 AM. Review of Resident 1's clinical record progress notes revealed a physician's progress note dated January 18, 2026, at 8:41 AM, which indicated that he was made aware last evening about Resident 1's lacosamide concern and seizure activity. The note further indicated that there was a concern that Resident 1 may have not gotten the lacosamide since January 11, 2026, and that the physician had issues getting a new script faxed to the pharmacy on the evening of January 17, 2026, that the facility had no acute medications to administer for seizure and he gave an order to transfer Resident 1 to the hospital for evaluation and treatment. Further review of Resident 1's clinical record progress notes revealed a physician's progress note dated January 18, 2026, at 8:43 AM, which indicated that he was called again because Resident 1 had another seizure lasting approximately 20 minutes, that there were no acute medications available at the facility to stop seizure activity, that it was still unclear if Resident 1 had been receiving her lacosamide or if the pharmacy had delivered it on January 11, 2026, and that he ordered for Resident 1 to be sent to the emergency room again for evaluation and treatment. Review of Resident 1's clinical record progress notes revealed a nurses note written by Employee 4 (RN) dated January 18, 2026, at 9:00 AM, which indicated that Resident 1 experienced another seizure from approximately 7:06 AM to 7:23 AM, and that Resident 1's physician was made aware of her seizure activity, that concerns regarding the Resident's medications were reviewed with Resident 1's physician, and that Resident 1's physician provided a new order for Ativan 1 milligram intramuscular every 12 hours as needed for seizure activity and was in agreement to send Resident 1 to emergency room again for evaluation and treatment. The note further indicated that concerns regarding Resident 1's lacosamide were discussed with emergency medical services staff at time of transfer to the hospital at approximately 7:40 AM. The note indicated that the pharmacy was contacted at approximately 8:40 AM regarding Resident 1's medication concern and a voicemail indicated the pharmacy was closed, but that an urgent message was left for the on-call pharmacist at 8:44 AM. Review of Resident 1's clinical record revealed that she returned to the facility on January 18, 2026, at 10:48 AM, and that she received her morning doses of lacosamide while in the emergency room. Review of facility provided documentation revealed that Resident 1's January 18, 2026, 8:00 PM dose of lacosamide was retrieved from the facility's emergency medication supply. Review of Resident 1's current Controlled Substance Record for her lacosamide revealed that 60 tablets were received at the facility on January 19, 2026, and the first dose was administered on January 19, 2026, at 8:00 AM. Further review of Resident 1's clinical record revealed that she had no seizure activity between August 3, 2025, and January 17, 2026, while receiving her medications and suffered two seizures, resulting in two hospital transfers when the lacosamide was not administered as ordered. During a staff interview with Employee 9 (Regional Director of Clinical Services) on January 28, 2026, at 1:25 PM, she confirmed that Employee 1 had erroneously documented administering Resident 1's lacosamide. She further indicated she had spoken to the pharmacy to get some clarification as to what occurred. Employee 9 indicated that the pharmacy said that the facility had ordered Resident 1's lacosamide on January 12, 2026, and that the pharmacy did have an active script for the medication, but it must have been overlooked by pharmacy staff and was not filled. Employee 9 also confirmed that there was no documentation in Resident 1's chart that her physician was notified about the Resident not being able to receive her lacosamide until after Resident 1 experienced her first seizure on January 17, 2026. During a staff interview with the Nursing Home (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Administrator (NHA), Director of Nursing (DON), and Employee 9 on January 29, 2026, at 3:50 PM, the DON indicated that she would expect nursing staff to administer a resident's medications as ordered by their physicians or to notify a resident's physician promptly for further guidance when a medication was not available to administer. The DON confirmed that facility nursing staff reordered Resident 1's lacosamide on January 12, 2026, (three days before Resident 1's supply exhausted), and that she would have expected nursing staff to follow-up with the pharmacy when the medication was not delivered when ordered. She confirmed that there was no documentation of any notifications to or from pharmacy between January 12 and 17, 2026, regarding Resident 1's lacosamide supply. The DON indicated that the facility does have lacosamide in their locked electronic emergency medication supply but nursing staff were unable to utilize this for Resident 1 between January 16 and 18, 2026, because the pharmacy said that they did not have a current script for the lacosamide and, therefore, would not supply an authorization code to retrieve the medication from the locked emergency supply. The DON further confirmed that the pharmacy indicated on January 18, 2026, after a new prescription was provided by Resident 1's physician, that the pharmacy already had a current prescription for Resident 1's lacosamide and that it was overlooked and, therefore, the mediation was not refilled when initially ordered on January 12, 2026. The DON indicated that she would expect nursing staff to reorder a medication when they are down to a five-day supply. The DON confirmed that she would expect the pharmacy to dispense and deliver medications timely or to notify the facility immediately if there was an issue with filling a medication order. Review of Resident 2's clinical record revealed diagnoses that included dementia and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Review of Resident 2's physician orders revealed orders for buspirone (medication to treat anxiety) 10 milligrams give one tablet every 8 hours, dated January 7, 2026; Tylenol Extra Strength 500 milligrams give two tablets three times a day, dated May 18, 2025; and Xanax (medication used to treat anxiety) 0.5 milligrams give one tablet every 8 hours, dated December 22, 2025. Review of Resident 2's January 2026 MAR revealed that on January 11, 2026, her 2:00 PM doses of her buspirone, Tylenol Extra Strength, and her Xanax were blank. Review of Resident 2's Controlled Substance Record revealed that on January 11, 2026, her 2:00 PM dose of Xanax was signed out as being administered by Employee 10 (RN). Review of Resident 2's January 2026 MAR revealed that on January 17, 2026, her 2:00 PM dose of Xanax was documented as 16 Hold/See Nurses Note. Review of Resident 2's Controlled Substance Record revealed that on January 17, 2026, her 2:00 PM dose of Xanax was signed out as being administered by Employee 6 (RN). Review Resident 2's clinical record progress notes revealed a Medication Administration Note written by Employee 6 dated January 17, 2026, at 2:52 PM, that indicated her ordered Xanax was not needed. Review of Resident 2's clinical record progress notes revealed a nurses note written by Employee 7 (LPN) dated January 17, 2026, at 8:27 PM, which indicated Resident had calling out behaviors and agitation. Resident listening to other staff and resident conversations and responding to them with agitation and yelling. Resident assisted to her room with snacks, fluids and calming music playing. Resident assisted herself with her snacks and was able to stop yelling. Resident approached by this nurse sitting in her room awake drinking her water. Resident in a pleasant mood. Resident continued to sit inside her room as this was effective for her behaviors. Review of Resident 2's January 2026 MAR revealed that on January 21, 2026, her 2:00 PM doses of her buspirone, Tylenol Extra Strength, and her Xanax were blank. Review of Resident 2's Controlled Substance Record revealed that on January 21, 2026, her 2:00 PM dose of Xanax was signed out as being administered by Employee 1. Review of Resident 2's clinical record progress notes failed to reveal any documentation as to why her (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	ordered doses of buspirone, Tylenol Extra Strength, and her Xanax were not administered as ordered on January 11 and 21, 2026. Review of Resident 2's January 2026 MAR revealed that on January 26, 2026, her 6:00 AM and 2:00 PM doses of Xanax were documented as 16 Hold/See Nurses Note. Review of Resident 2's clinical record progress notes revealed a Medication Administration Note written by Employee 8 (LPN) dated January 26, 2026, at 8:45 AM, that indicated Resident 2's Xanax was not administered and awaiting pharmacy delivery. Review of Resident 2's clinical record progress notes revealed a nurses note written by Employee 4 dated January 26, 2026, at 3:34 PM, that indicated Employee 4 contacted the pharmacy about retrieving Resident 2's Xanax from the emergency medication supply. Employee 4 questioned why they could not administer Xanax 0.25 milligrams two tablets to equal Resident 4's ordered dose of 5 milligrams, but that the pharmacy indicated that medications must be dispensed as written. The note further indicated that Employee 4 contacted Resident 2's physician for further orders and that the pharmacy indicated that the medication would be on the next pharmacy delivery to the facility. Review of Resident 2's clinical record progress notes revealed a nurses note written by Employee 4 dated January 26, 2026, at 4:27 PM, that indicated Resident 2's physician gave a one-time order for Xanax 0.25 milligrams give two tablets now. Review of Resident 2's current Controlled Substance Record revealed that the pharmacy filled the Xanax prescription on January 25, 2026, but the Receipt Verification section of the form was blank. According to the record, the first dose was administered from the package on January 26, 2026, at 6:30 PM. During a staff interview with the NHA, DON, and Employee 9 on January 29, 2026, between 3:48 PM and 4:00 PM, the DON indicated that she would expect nursing staff to administer a resident's medications as ordered by their physicians and complete documentation appropriately. The NHA indicated that Resident 2's medication packets were audited and that there were no pill pouches still in the cart dated for January 11 and 21, 2026, and, therefore, the Tylenol and buspirone medications must have been administered and that the nurses must have failed to complete all the administration documentation of Resident 2's medications on those dates. The DON indicated that she would expect nursing staff to reorder a medication when they are down to a five-day supply. The DON confirmed that she would expect the pharmacy to dispense and deliver medications timely or to notify the facility immediately if there was an issue with filling a medication order. The DON confirmed that she would expect staff to complete the Receipt Verification on a resident's Controlled Substance Record. At the interview, no additional information was provided regarding the conflicting documentation of Resident 2's January 17, 2026, 2:00 PM, dose of Xanax or information as to when nursing staff reordered Resident 2's Xanax from the pharmacy. Review of Resident 3's clinical record revealed diagnoses that included dementia, hypertension (high blood pressure), and unspecified cough. Review of Resident 3' s physician orders revealed orders for albuterol sulfate nebulization solution 2.5 milligrams/ 3 milliliters 0.083% administer 3 milliliters orally via nebulizer every four hours, dated October 31, 2025; geri-tussin oral syrup 100 milligrams/5 milliliters give 10 milliliters every four hours, dated October 31, 2025; and Protonix delayed release 40 milligrams in the morning, dated October 30, 2025. Review of Resident 3's November 2025 MAR revealed that on November 1, 2025, his 4:00 AM doses of albuterol and geri-tussin as well as his 6:00 AM dose of Protonix were blank. Review of Resident 3's clinical record progress notes failed to reveal any documentation as to why these medications were not administered as ordered. During a staff interview with the NHA, DON, and Employee 9 on January 29, 2026, between 3:48 PM and 4:00 PM, the DON indicated that she would expect nursing staff to administer a resident's medications as ordered by their physicians and to complete all documentation appropriately. She indicated that she had a call out to the nurse to determine if Resident 3 received his medications. 28 Pa. Code 201.14(a) Responsibility of (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	licensee28 Pa. Code 201.18(b)(1) Management28 Pa. Code 211.9(a)(1) Pharmacy services28 Pa. Code 211.10(c) Resident care policies28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services

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F 0755 Level of Harm - Actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on facility policy review, clinical record reviews, and staff interviews, it was determined that the facility failed to provide pharmaceutical services to accurately acquire, receive, dispense, and administer drugs to meet the needs of each resident for two of three residents reviewed (Residents 1 and 2), which resulted in actual harm as evidenced by two hospital transfers for seizure activity for one of three residents reviewed (Resident 1).Findings include:Review of facility policy, titled IC4: Ordering and Receiving Controlled Medications, undated, revealed, in part, Schedule II controlled medications prescribed for a specific resident are delivered to the facility only if a faxed or original written prescription has been received by the pharmacy. Schedule III, IV and V may also be dispensed pursuant to a verbal order from the physician. In addition, if medication is needed prior to the next delivery, the pharmacist may authorize a nurse at the facility to remove a supply of the medication from the emergency supply in the facility according to policy IC5. In an emergency situation, the provider pharmacy can accept a telephone order for a schedule II medication. The DEA defines emergency to mean that the immediate administration of the drug is necessary for the proper treatment of the intended individual, that no alternative is available and that it is not possible for the prescriber to provide a prescription for the drug at that time. In no situations will an emergency dispensing exceed a 7-day supply. An individual resident's controlled substance record is prepared by the pharmacy or the facility for each controlled substance medication prescribed for a resident. The following information is completed: 1) Name of resident 2) Prescription number 3) Drug name, strength (if designated), and dosage form of medication 4) Date received 5) Quantity received and 6) Name of person receiving the medication supply. Schedule II controlled substance medications are reordered when a seven-day supply remains to allow for transmittal of the prescription to the pharmacist. Review of Resident 1's clinical record revealed diagnoses that included epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures) and dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning). Review of Resident 1's physician orders revealed orders for lacosamide (a medication used to manage seizure activity) 100 milligrams give one tablet by mouth every 12 hours. Review of Resident 1's Controlled Substance Record (document for signing out and tracking medications) for her ordered lacosamide revealed that 30 tablets were received at the facility on December 29, 2025, and nursing staff began administering the medication from this package on January 1, 2026, at 9:10 AM. Further review of this record revealed that the last dose was administered to Resident 1 on January 15, 2026, at 8:00 PM. Further review of Resident 1's January 2026 Medication Administration Record (MAR) revealed that her lacosamide was documented as 16 Hold/See Nurses Note for her January 16, 2026, 8:00 PM dose administration and her January 17, 2026, 8:00 AM and 8:00 PM dose administrations. Review of Resident 1's clinical record revealed a Medication Administration Note dated January 16, 2026, at 8:12 PM, that indicated Resident 1's lacosamide was on order from the pharmacy. Review of Resident 1's clinical record revealed a Medication Administration Note dated January 17, 2026, at 1:26 PM, that indicated Resident 1's lacosamide was on back order and pharmacy was notified. Review of Resident 1's clinical record revealed a Medication Administration Note dated January 17, 2026, at 10:26 PM, that indicated Resident 1's lacosamide was not available, pharmacy was called, and that the medication was on order. Review of Resident 1's clinical record progress notes revealed a nurse's note written by Employee 2 (Licensed Practical Nurse [LPN]) dated January 17, 2026, at 10:40 PM, which indicated that Resident 1 was noted to be having a seizure which lasted from 10:20 PM to 10:26 PM. The note further indicated a call had been placed to (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	the pharmacy earlier in the day regarding Resident 1's lacosamide and that the pharmacy indicated that the drug would be sent. The note also indicated that when Employee 2 called the pharmacy again to confirm that the lacosamide would be in the next pharmacy delivery run (night of January 17, 2026), the pharmacy indicated a script would be needed to dispense Resident 1's lacosamide. The note indicated that Employee 3 (Registered Nurse [RN]) reached out to the physician and requested that Resident 1 be sent out for further evaluation. Review of Resident 1's clinical record progress notes revealed a nurse's note written by Employee 3 (RN) dated January 17, 2026, at 11:20 PM, which indicated that Resident 1 had a seizure that lasted approximately 20-25 minutes. The note further indicated that Resident 1's physician was made aware of Resident 1's seizure, that her ordered lacosamide was not available, and that Resident 1's physician provided a new order to send Resident 1 to the hospital for evaluation and treatment. Based on review of Resident 1's progress notes for January 17, 2026, at 10:40 PM and 11:20 PM, it was unclear how long her seizure lasted. Review of the written statement from Employee 1 (LPN) on January 28, 2026, revealed that Employee 1 called the pharmacy on January 16, 2026, to inform them that Resident 1 was out of her lacosamide and it was needed. The statement indicated that the medication had already been ordered days prior and that the pharmacy indicated that the medication would be on the next pharmacy delivery. Review of Resident 1's clinical record progress notes revealed a nurses note written by Employee 4 (RN) dated January 18, 2026, at 9:00 AM, which indicated that Resident 1 experienced another seizure from approximately 7:06 AM to 7:23 AM, and that Resident 1's physician was made aware of her seizure activity, that concerns regarding the Resident's medications were reviewed with Resident 1's physician, and that Resident 1's physician provided a new order for Ativan (an antianxiety medication that can be used to treat seizures) 1 milligram intramuscular every 12 hours as needed for seizure activity and was in agreement to send Resident 1 to emergency room again for evaluation and treatment. The note further indicated that concerns regarding Resident 1's lacosamide were discussed with emergency medical services staff at time of transfer to the hospital at approximately 7:40 AM. The note indicated that the pharmacy was contacted at approximately 8:40 AM regarding Resident 1's medication concern and a voicemail indicated the pharmacy was closed, but that an urgent message was left for the on-call pharmacist at 8:44 AM. Review of Resident 1's clinical record progress notes revealed a nurse's note written by Employee 3 dated January 18, 2026, at 9:42 AM, which indicated that prescriptions for Resident 1's lacosamide and Ativan were signed by Resident 1's physician and faxed to the pharmacy at 8:51 AM. Review of Resident 1's clinical record progress notes revealed a nurses note written by Employee 3 dated January 18, 2026, at 9:43 AM, which indicated that the pharmacy had called the facility and discussed concerns with Resident 1's lacosamide. The note further indicated that the pharmacist determined that the last delivery date of Resident 1's lacosamide was on December 28, 2025, with a 15-day supply. The pharmacist indicated that the pharmacy already had a script for the lacosamide and confirmed that Resident 1's lacosamide and Ativan would be included in the next pharmacy delivery to the facility (night of January 18, 2026). Review of Resident 1's January 2026 MAR revealed that she was administered a dose of lacosamide on January 18, 2026, at 8:00 PM, by Employee 5 (LPN). The dose of lacosamide was retrieved from the facility's emergency medication supply. Review of Resident 1's current Controlled Substance Record for her lacosamide revealed that 60 tablets were received at the facility on January 19, 2026, and the first dose was administered on January 19, 2026, at 8:00 AM. Further review of Resident 1's clinical record revealed that she had no seizure activity between August 3, 2025, and January 17, 2026, while receiving her medications and suffered two seizures resulting in two hospital transfers when her lacosamide was not administered as ordered as a result of the pharmacy failing to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395784	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Letort Spring Nursing and Rehab LLC	801 N. Hanover Street Carlisle, PA 17013

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F 0755 Level of Harm - Actual harm Residents Affected - Few	provide Resident 1's ordered medication or communication to the facility in a timely manner as to why medication could not be supplied when initially ordered. During a staff interview with Employee 9 (Regional Director of Clinical Services) on January 28, 2026, at 1:25 PM, she confirmed that Employee 1 had erroneously documented administering Resident 1's lacosamide. She further indicated she had spoken to the pharmacy to get some clarification as to what occurred. Employee 9 indicated that the pharmacy said that the facility had ordered Resident 1's lacosamide on January 12, 2026, and that the pharmacy did have an active script for the medication, but the pharmacy indicated that it must have been overlooked by pharmacy staff and was not filled as requested. During a staff interview with the Nursing Home Administrator (NHA), Director of Nursing (DON), and Employee 9 on January 29, 2026, between 3:48 PM and 4:00 PM, the DON confirmed that facility nursing staff reordered Resident 1's lacosamide on January 12, 2026, (three days before Resident 1's supply exhausted), and that she would have expected nursing staff to follow-up with the pharmacy when the medication was not delivered when ordered. She confirmed that there was no documentation of any notifications to or from pharmacy between January 12 and 17, 2026, at 1:26 PM regarding Resident 1's lacosamide supply. The DON indicated that she would expect nursing staff to reorder a medication when they are down to a five-day supply. The DON further indicated that the facility does have lacosamide in their locked electronic emergency medication supply, but nursing staff were unable to utilize this for Resident 1 between January 16 and 18, 2026, because the pharmacy said that they did not have a current script for the lacosamide and, therefore, would not supply an authorization code to retrieve the medication from the locked emergency supply. The DON further confirmed that the pharmacy indicated on January 18, 2026, after a new prescription was provided by Resident 1's physician, that the pharmacy already had a current prescription for Resident 1's lacosamide and that it was overlooked by pharmacy staff and, therefore, the medication was not refilled when initially ordered on January 12, 2026. The DON confirmed that she would expect the pharmacy to dispense and deliver medications timely or to notify the facility immediately if there was an issue with filling a medication order. Review of Resident 2's clinical record revealed diagnoses that included dementia and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Review of Resident 2's physician orders revealed an order for Xanax (medication used to treat anxiety) 0.5 milligrams give one tablet every 8 hours, dated December 22, 2025. Review of Resident 2's clinical record progress notes revealed a Medication Administration Note written by Employee 8 (LPN) dated January 26, 2026, at 8:45 AM, that indicated Resident 2's Xanax was not administered and awaiting pharmacy delivery. Review of Resident 2's clinical record progress notes revealed a nurses note written by Employee 4 (RN) dated January 26, 2026, at 3:34 PM, that indicated Employee 4 contacted the pharmacy about retrieving Resident 2's Xanax from the emergency medication supply. Employee 4 questioned why they could not administer Xanax 0.25 milligrams two tablets to equal Resident 4's ordered dose of 5 milligrams, but that the pharmacy indicated that medications must be dispensed as written. The note further indicated that Employee 4 contacted Resident 2's physician for further orders and that the pharmacy indicated that the medication would be on the next pharmacy delivery to the facility. Review of Resident 2's clinical record progress notes revealed a nurses note written by Employee 4 dated January 26, 2026, at 4:27 PM, that indicated Resident 2's physician gave a one-time order for Xanax 0.25 milligrams give two tablets now. Review of Resident 2's current Controlled Substance Record revealed that the pharmacy filled the Xanax prescription on January 25, 2026, but the Receipt Verification section of the form was blank. According to the record, the first dose was administered from the package on January 26, 2026, at 6:30 PM. During a staff interview with the (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	NHA, DON, and Employee 9 on January 29, 2026, between 3:48 PM and 4:00 PM, the DON indicated that she would expect nursing staff to reorder a medication when they are down to a five-day supply. The DON confirmed that she would expect the pharmacy to dispense and deliver medications timely or to notify the facility immediately if there was an issue with filling a medication order. The DON confirmed that she would expect staff to complete the Receipt Verification on a resident's Controlled Substance Record. At time of interview, no additional information was provided regarding when nursing staff reordered Resident 2's Xanax from the pharmacy or why there was a delay in delivery from the pharmacy. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1) Management28 Pa. Code 211.9(a)(1) Pharmacy services28 Pa. Code 211.10(c) Resident care policies28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services