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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395784	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/23/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on clinical record reviews, facility provided documents, and staff interviews, it was determined that the facility displayed past-non-compliance in its failure to prevent a significant medication error for one of three residents reviewed (Resident 1).Findings include: Review of Resident 1's clinical record revealed diagnoses that included chronic embolism and thrombosis of unspecified deep veins (presence of blood clots in the deep veins, typically in the legs, which can lead to serious complications if not managed properly) of the left lower extremity 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 order history revealed an order entered by Employee 4 dated February 24, 2026, to recheck PT/INR (blood test used to determine blood clotting time to assist in managing warfarin dosing) on March 11, 2026. Review of Resident 1's physician order history revealed an order entered by Employee 4 dated February 24, 2026, which indicated warfarin 2.5 milligrams give one tablet at bedtime and recheck PT/INR in two weeks (March 11, 2026), to start on February 25, 2026. Review of Resident 1's Medication Administration Record for March 2026 revealed that she received her ordered dose of warfarin from February 25, 2026, through March 10, 2026. Further review revealed that she received no warfarin on March 11 through March 17, 2026. Further review of the clinical record revealed no evidence that the PT/INR was completed as ordered on March 11, 2026. Review of Resident 1's clinical record revealed a progress note dated March 18, 2026, at 7:51 AM, by Employee 5 (Registered Nurse) that indicated she had discussed concerns regarding Resident 1's PT/INR and warfarin doses with night shift and that Resident 1's physician was present at the facility and was made aware of concern regarding medication. The note further indicated that Resident 1's physician provided a new order to obtain a stat (immediate) PT/INR that morning and then he would provide further orders on warfarin dosage. Review of Resident 1's clinical record revealed a physician's progress note dated March 18, 2026, at 4:06 PM, that indicated Resident 1 missed a few days of warfarin noted by staff and an order for PT/INR was given. The note indicated that Resident 1's physician restarted her on her previous dose of warfarin and gave an order to recheck the PT/INR in a week. Resident 1 had no adverse effects noted from the missing doses of warfarin. Review of Resident 1's Medication Administration Record for March 2026 revealed that she has been receiving her ordered dose of warfarin since March 18, 2026. Review of Resident 1's Treatment Administration Record for March 2026 revealed that she was scheduled for a PT/INR lab draw on March 24, 2026. During a staff interview with Employee 2 (Regional Director of Clinical Services) on March 23, 2026, at 2:44 PM, she confirmed that Employee 4 signed off on the order and, therefore, it did not populate on Resident 1's record to complete the lab test. Employee 2 confirmed that the medication order was also set to stop on the date the lab was ordered and, therefore, the Resident did not get lab drawn or medication. Continued interview with Employee 2 revealed that the facility initiated a plan of correction. Employee 4 was placed on the Do Not Return list. Employee 2 indicated that when Employee 5 discovered the issue with Resident 1 on March 18, 2026, Employee 5 immediately followed up with Resident 1's provider to report the concern and to obtain additional orders. In addition, Employee 5 reviewed all other residents on warfarin on March 18, 2026, to ensure that all other potentially affected residents had received their medication and lab (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tests as ordered and found no other concerns. On March 18, 2026, Employee 5 reinstated a warfarin log that the facility used in the past to track labs and warfarin doses for each resident receiving warfarin. Education was provided to all Registered Nurse Supervisors on March 18, 2026, as they will be the staff to manage this log. Facility provided written documentation to support all immediate action steps taken on March 18, 2026. Review of the plan of correction documents, review of clinical records and interviews with staff revealed no concerns with residents not received medications and associated labs. During a final staff interview with the Nursing Home Administrator (NHA), Director of Nursing, and Employee 2 (Regional Director of Clinical Services) on March 23, 2026, at 4:00 PM, the NHA confirmed that he would expect staff to enter orders appropriately to prevent significant medication errors. The NHA indicated that the facility was in compliance as of March 18, 2026, the same date the concern was identified. He indicated that the audits would start this week and that audits will be reviewed at the next Quality Assurance Performance Improvement Committee Meeting. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 211.10(c) Resident care policies.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.