STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395785	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonebridge Health & Rehabilitation Center	102 Chandra Drive Duncannon, PA 17020

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, clinical record review, review of facility documents, and resident and staff interviews, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards for one of 18 residents reviewed (Resident 11). Findings Include: Review of Resident 11's clinical record revealed diagnoses that included COPD (chronic obstructive pulmonary disease- a progressive, inflammatory lung disease that blocks airflow and makes breathing difficult) and anxiety. During an interview with Resident 11 on June 8, 2026, at 10:34 AM, Resident 11 stated that she was missing her left hearing aid. Observation of Resident 11 at that time revealed she did not have a hearing aid in either ear. Review of facility's grievance log revealed a grievance filed by Resident 11, on January 6, 2026, stating that Resident 11 was missing her hearing aid. The grievance did not specify if it was the right or left hearing aid that was missing. The plan was for the facility to replace the hearing aid. Further review of the grievance form revealed that Resident 11 decided she no longer wanted the hearing aid replaced and stated she didn't wear either hearing aid. Resident 11 signed the grievance resolution on February 9, 2026. During an interview with the Nursing Home Administrator (NHA) on June 9, 2026, at 2:07 PM, he stated he believes it was the left hearing aid that went missing. He stated that Resident 11 still has her other hearing aid but that she doesn't wear it. Review of Resident 11's current physician orders revealed an order, dated June 30, 2025, to assist Resident 11 with left hearing aid placement in the AM and removal in the PM. Review of Resident 11's MARs (medication administration record), dated January, February, March, April, May and June 2026, revealed nursing staff were signing off on each day that they were assisting Resident 11 with left hearing aid placement in the AM and removal in the PM, with the exception of the following dates: January 15, 16 and 17 was documented as the placement being held, and January 15 and 16 was documented as the removal being held. June 6 the removal was documented as other, and June 7 the removal was documented as other and that the Resident claimed she lost them. In a follow up interview with Resident 11 on June 10, 2026, at 11:04 AM, Resident 11 again stated that it was the left hearing aid that was missing. Resident 11 was observed not to be wearing any hearing aid at that time. Resident 11 pulled out her right hearing aid that was located in its case in her top nightstand drawer. Resident 11 stated she doesn't wear the right hearing aid because she was able to hear out of that ear. On June 10, 2026, at 11:07 AM, clinical record review revealed that Employee 5 (Licensed Practical Nurse) had signed off on Resident 11's MAR, on June 10, 2026, day shift, that assistance was provided with placement of the left hearing aid. During a staff interview with Employee 5 on June 10, 2026, at 11:11 AM, the surveyor asked Employee 5 about Resident 11's hearing aid, since Resident 11 was just observed to not be wearing any hearing aids and the left one was missing. Employee 5 stated that she didn't know anything about the resident's hearing aids. Review of Resident 11's MAR, dated June 2026, revealed that in addition to Employee 5 signing off on the left hearing aid on June 10, 2026, Employee 5 also signed off that the left hearing aid was in place six other times in June, prior to June 10. On June 10, 2026, at 11:36 AM, the NHA stated that it has been verified that it was Resident 11's left hearing aid that was missing. In a follow up interview with the NHA on June 10, 2026, at 1:00 PM, he confirmed that since January 2026, staff have continued to sign off on Resident 11's left hearing aid, even though it was reported missing in (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	January and was not replaced. The Director of Nursing stated that the order has been discontinued and the care plan has been updated. In a final interview with the NHA on June 11, 2026, at 11:22 AM, he stated that he would expect staff to not sign off on the MAR that the left hearing aid is in place when it is not. 28 Pa. Code 211.12(d)(1)(2)(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 facility policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure the resident right to receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one of 18 residents reviewed (Resident 1). Findings include: Review of facility policy, titled Cardiopulmonary Resuscitation CPR Policy last reviewed March 16, 2026, read, in part, At admission, facility staff should confirm whether the resident has advance directives and identify the resident/legal representative's preferences regarding CPR (Cardiopulmonary Resuscitation, an emergency procedure used to maintain blood flow and oxygen to vital organs when the heart stops beating). This review may occur as part of the admission assessment. If physician order(s) differ from the resident's wishes or there are no physician orders present: Promptly contact the provider for an appropriate order. Review of Resident 1's clinical record revealed diagnoses that included unspecified severe protein-calorie malnutrition (an imbalance between the nutrients the body needs to function and the nutrients it gets) and gastrostomy status (refers to the presence of an artificial opening in the stomach for feeding patients who cannot ingest food orally). Review of Resident 1's physician orders revealed an order for Code Status: Full Code (a medical order indicating that all life-saving interventions should be attempted if a patient's heart stops or they stop breathing, including CPR) with a start date of May 20, 2026. Review of Resident 1's care plan revealed a focus area Resident has chosen to be a full code with an intervention for Resident's code status will be honored daily through next review, with a start date of May 22, 2026. Review of Resident 1's POLST form (Physician Orders for Life Sustaining Treatment- is a medical order that allows seriously ill or frail individuals to specify the types of medical treatment they want during emergencies), revealed under the CPR section it was marked DNR (Do Not Resuscitate- a medical order indicating that a person does not want CPR or other life-saving measures if their heart or breathing stops). During an interview with the Director of Nursing (DON) on June 9, 2026, at 2:19 PM, she acknowledged there was a discrepancy between the physician order and the POLST form, and she was going to get it clarified immediately. Interview with Employee 2 (Licensed Practical Nurse) on June 9, 2026, at 2:21 PM, she revealed if there was a discrepancy between the physician order for a code status and the POLST form, she would go by the physician's order in the electronic health record. Interview with Employee 3 (Licensed Practical Nurse) on June 9, 2026, at 2:23 PM, she revealed if there was a discrepancy between the physician order for a code status and the POLST form, she would go by the physician's order in the electronic health record. During an interview with Resident 1 on June 9, 2026, at 2:29 PM, he revealed in the event he went unresponsive and needed emergency life sustaining treatment, he would want CPR. Review of Resident 1's clinical record on June 9, 2026, at 2:36 PM, revealed his physician order from full code had switched to DNR, and his chart was flagged with DNR rather than full code. Interview with the DON on June 9, 2026, at 2:41 PM, she revealed she changed his code status order to a DNR while it was getting clarified so it would match the POLST form signed by the Resident. Interview with Employee 4 (ADON- Assistant Director of Nursing) on June 9, 2026, at 2:45 PM, she revealed she just spoke with Resident 1 and he confirmed he would like to be a full code, so she was fixing the orders, updating his POLST, and putting a note into the electronic health record. Review of Resident 1's nursing progress notes revealed a note written on June 9, 2026, at 2:37 PM, that read Reviewed POLST with resident. Resident wishes to be a Full Code. This ADON and DON witnessed resident sign updated POLST indicating he wishes to be a full code. Orders / Facesheet / POLST all now reflect Full Code/ CPR. Phone call placed to Responsible Party to notify. During a follow up interview with the DON on June 10, 2026, at 1:06 PM, she revealed she would expect POLST forms, resident wishes, and physician orders for code status to be consistent across records. 28 Pa. Code 201.29 (a) Resident Rights28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure residents with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility for one of two residents reviewed for limited range of motion (Resident 8).Findings include: Review of facility policy, titled Restorative Nursing Referral Process & Policy last reviewed February 24, 2026, read, in part, Procedure: The referral form is filled out by the referring therapist and given to the Director of Rehab. Residents who could benefit from restorative programs (RNP) include but are not limited to: residents who are ready to finish a program of skilled rehabilitation therapy. Referral to restorative should be generic, not complicated, or should be reconsidered to stay on therapy. Review of Resident 8's clinical record revealed diagnoses that included infection and inflammatory reaction due to internal right hip prosthesis (infection of artificial hip joint that can cause pain and swelling) and generalized osteoarthritis (when protective cartilage that cushions the ends of the bones wears down over time). Review of Resident 8's Physical Therapy Discharge Summary signed on May 28, 2026, read, in part, Discharge Recommendations: Patient is being discharged due to reaching max potential at this time. It is recommended for him to continue working on maintaining progress with RNP for transfers and lower extremity exercises. Review of Resident 8's Restorative Program Referral documents revealed he was recommended to start a program for stand pivot transfers and range of motion on May 28, 2026. During an interview with the Director of Nursing (DON) on June 10, 2026, at 1:39 PM, she revealed the RNP program never got implemented into the medical record to capture documentation related to minutes completed and tolerance to the program, so she does not have any documentation to provide that the RNP program had been implemented. During an interview with Employee 2 (Licensed Practical Nurse) on June 11, 2026, at 9:12 AM, she revealed she typically spends one day a week at the facility updating and integrating restorative programs into the electronic health record once the therapists fill out an order sheet for her, but due to short staffing, she has been responsible for other duties such as being assigned to a medication cart on those days, so she was unable to transcribe Resident 8's RNP program to his chart and care plan. She further revealed she told the Resident to keep track of his RNP exercises, such as what he is doing and how often on his own. During an interview with the DON on June 11, 2026, at 11:39 AM, she revealed she was going to educate the therapy staff that they can come to her to transcribe recommendations for RNP programs into resident health records and care plans, and she would expect RNP programs to be entered into the electronic system and implemented timely. 28 Pa. Code 201.18(b)(1) Management28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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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 observations, facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure staff implement transmission-based precautions to prevent the spread of infection for one of two residents (Resident 36) on transmission-based precautions.Findings Include: Review of facility policy, titled Transmission-Based Precautions and Isolation Policy, revised April 15, 2026, revealed, Contact Precautions - intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the patient or the patient's environment. Review of Resident 36's clinical record revealed diagnoses that included giardia (an infection of the small intestine) and urinary tract infection (UTI- is a bacterial infection in the urinary system [kidneys, bladder, or urethra]). Observation of Resident 36 on June 9, 2026, at 8:50 AM, revealed Resident 36 lying in her bed. Hanging on the wall outside of Resident 36's room was a sign indicating that Resident 36 was on contact precautions and that anyone entering the room was required to put on gloves and a gown, and then remove the gloves and gown before exiting the room. Further observation at that time revealed Employee 1 entering the room without applying any of the required PPE (personal protective equipment) to administer Resident 36's medications. Review of Resident 36's care plan revealed a care plan with a problem area that Resident 36 started on antibiotics for giardia with an intervention of transmission-based precautions as ordered, with a start date of May 28, 2026. Interview with the Nursing Home Administrator on June 10, 2026, at 11:10 AM, revealed that he would expect employees to wear the required PPE. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1) Management