STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395823	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Townview Health and Rehabilitation Center	300 Barr Street Canonsburg, PA 15317

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Findings include: Review of the facility policy, Nursing Documentation dated 3/26/25, indicated, changes in resident condition must be noted and charted and communication with family should be documented as well. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS, periodic assessment of resident care needs) dated 5/2/25, indicated diagnoses of MS multiple sclerosis (long lasting chronic disease of the nervous system), chronic pain, depression, and anxiety. The resident is alert and oriented, is understood, and understands. Review of a nurse progress note dated 1/11/26 indicated Resident R1 was choking and vomiting food, was assessed, the physician was notified, and a chest Xray was ordered. Review of a nurse progress note dated 1/12/26 indicated the X-ray impression was minimal right base atelectasis (blockage in the air sacs of the lung) and Augmentin (an antibiotic) 875/125 mg (milligrams) PO (by mouth) BID (two times a day) times 7 days for pneumonia was ordered. During an interview on 1/18/26 at 9:30 a.m., Resident R1 stated my son was not notified, and I had pneumonia for a week. Review of the progress notes failed to reveal a notification to the resident's family of Resident R1's change in condition. During an interview on 2/18/26, at approximately 3:00 p.m. the Nursing Home Administrator confirmed the facility failed to notify the family of a change in condition for Resident R1. 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 201.29(d) Resident rights. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, facility documents, and staff interview, it was determined that the facility failed to implement policies and procedures to report possible neglect for one of five residents (Resident R1).Findings include: Review of facility policy Abuse Prevention Policy dated 3/26/25, indicated alleged violations involving abuse/neglect are reported immediately to the Administrator, and report results of all investigations to the Administrator and to the PA Department of Health within 5 working days of the incident. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS, periodic assessment of resident care needs) dated 5/2/25, indicated diagnoses of MS multiple sclerosis (long lasting chronic disease of the nervous system), chronic pain, depression, and anxiety. The resident is alert and oriented, is understood, and understands. Resident R1 is dependent on staff for all ADL's (activities of daily living) A review of the facility Electronic Charting System (ECS-identifies resident care needs) indicated Resident R1 is dependent on staff for eating meals. Review of a nurse progress notes dated 1/11/26 indicated at dinner time, Resident R1 was eating and started to cough, felt like food was stuck, and was having a hard time breathing. Further review indicated Resident R1 was choking and vomiting food, was assessed, the physician was notified, and a chest Xray was ordered. Review of a nurse progress note dated 1/12/26 indicated the X-ray impression was minimal right base atelectasis (blockage in the air sacs of the lung) and Augmentin (an antibiotic) 875/125 mg (milligrams) PO (by mouth) BID (two times a day) times 7 days for pneumonia was ordered. During an interview on 2/18/26 at 9:30 a.m., Resident R1 stated Certified Nursing Assistant (CNA) Employee E1 was feeding her meal. I was choking on my food because my head was too flat, I said I couldn't do it, and I got pneumonia. Resident R1 stated that Administration was aware of the incident and interviewed them the following day. The resident was tearful that the incident occurred and did not want to get staff in trouble. During an interview on 2/18/26, at approximately 9:20 a.m. the Director of Nursing was aware of the incident and was asked to provide the investigation documents for Resident R1's choking incident. The Director of Nursing stated no documentation was completed. A review of the facility incident and accident log dated January 2026 did not include a choking incident for Resident R1 on 1/11/26. Review of documentation submitted by the facility to the State Survey Agency failed to include a report of possible neglect to Resident R1. During an interview on 2/18/26, at approximately 12:00 p.m. Medical Director Employee E3 stated that Resident R1's choking incident on 1/11/26 should have been reported per facility policy. During an interview on 11/15/25, at approximately 3:00 p.m. the Nursing Home Administrator confirmed the facility failed to implement policies and procedures to report possible neglect for Resident R1. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 201.18 (b) (1) (e) (1) Management.28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, facility documents, and staff interview, it was determined that the facility failed to implement policies and procedures to investigate a choking incident to rule out possible neglect for one of five residents (Resident R1).Findings include: Review of facility policy Abuse Prevention Policy dated 3/26/25, indicated all alleged violations involving abuse/neglect are promptly and thoroughly investigated. An incident report should be completed by the nurse assigned to the resident. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS, periodic assessment of resident care needs) dated 5/2/25, indicated diagnoses of MS multiple sclerosis (long lasting chronic disease of the nervous system), chronic pain, depression, and anxiety. The resident is alert and oriented, is understood, and understands. Resident R1 is dependent on staff for all ADL's (activities of daily living) A review of the facility Electronic Charting System (ECS-identifies resident care needs) indicated Resident R1 is dependent on staff for eating meals. Review of the nurse progress notes dated 1/11/26 indicated at dinner time, Resident R1 was eating and started to cough, felt like food was stuck, and was having a hard time breathing. Further review indicated Resident R1 was choking and vomiting food, was assessed, the physician was notified, and a chest Xray was ordered. Review of a nurse progress note dated 1/12/26 indicated the X-ray impression was minimal right base atelectasis (blockage in the air sacs of the lung) and Augmentin (an antibiotic) 875/125 mg (milligrams) PO (by mouth) BID (two times a day) times 7 days for pneumonia was ordered. During an interview on 2/18/26 at 9:30 a.m., Resident R1 stated Certified Nursing Assistant (CNA) Employee E1 was feeding the meal. I was choking on my food because my head was too flat, I said I couldn't do it, and I got pneumonia. Resident R1 stated that Administration was aware of the incident and interviewed them the following day. The resident was tearful that the incident occurred and did not want to get staff in trouble. During an interview on 2/18/26, at approximately 9:20 a.m. the Director of Nursing was aware of the incident and was asked to provide the investigation documents and incident report for Resident R1's choking incident. The Director of Nursing stated no documentation was completed. A review of the facility Incident and Accident Log dated January 2026 did not include a choking incident for Resident R1 on 1/11/26. During an interview on 2/18/26, at approximately 12:00 p.m. Medical Director Employee E3 stated that Resident R1's choking incident on 1/11/26 should have been investigated per facility policy. During an interview on 11/15/25, at approximately 3:00 p.m. the Nursing Home Administrator confirmed the facility failed to implement policies and procedures to investigate an incident of possible neglect for Resident R1. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 201.18 (b) (1) (e) (1) Management.28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, facility documents, and staff interviews, it was determined that the facility failed to prevent accidents, which resulted in actual harm, requiring further treatment for aspiration pneumonia for one of six residents (Resident R1). Findings include: Review of the facility Fall and Accident Prevention Program policy dated 3/26/25, indicated the facility will provide a safe environment that is free from hazards and activities that may result in an accident. Review of the facility policy Restorative Nursing-Eating/Swallowing policy dated 3/26/25, indicated activities will be provided to improve or maintain feeding food and fluids that may include providing total assistance for eating to maintain the ability to consume nutrition. Review of Resident R1's face sheet indicated the resident was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 5/2/25, indicated diagnoses of MS multiple sclerosis (long lasting chronic disease of the nervous system), chronic pain, depression, and anxiety. The resident is alert and oriented, is understood, and understands. Resident R1 is dependent on staff for all ADL's (activities of daily living). Review of Resident R1's care plan dated 3/31/25 indicated the resident is dependent on staff for all ADL's and to provide assistance as needed. A review of the facility Electronic Charting System (ECS-identifies resident care needs) dated 9/22/25, indicated Resident R1 is dependent on staff for eating meals. The nurse aide will keep the resident in an upright position, observe for signs and symptoms of aspiration, and provide small bites and sips of food and liquids. Review of the nurse progress notes dated 1/11/26 indicated at dinner time, Resident R1 was eating and started to cough, felt like food was stuck, and was having a hard time breathing. Further review indicated Resident R1 was choking and vomiting food, was assessed, the physician was notified, and a chest Xray was ordered. Review of a nurse progress note dated 1/12/26 indicated the X-ray impression was minimal right base atelectasis (blockage in the air sacs of the lung) and Augmentin (an antibiotic) 875/125 mg (milligrams) PO (by mouth) BID (two times a day) times seven days for pneumonia was ordered. A review of a physician order dated 1/15/26, indicated Unasyn (an antibiotic) 3 grams, intravenous (IV) every six hours for seven days for aspiration pneumonia. A review of physician orders dated 1/14/26 indicated DuoNeb (a medication to open up airways and treat shortness of breath) administer three times a day for pneumonia. Oxygen at 2-4 L (liters) per minute via nasal cannula (a tube that goes into the nose) for shortness of breath as needed. A review of the Medication administration Record (MAR) dated January 2026 indicated Resident R1 received all medications as ordered. During an interview on 2/18/26 at 9:30 a.m., Resident R1 was noted to be in bed with the head elevated at a 45-degree angle. Resident R1 indicated Certified Nursing Assistant (CNA) Employee E1 was feeding the meal on 1/11/26. Resident R1 stated, I was choking on my food because my head was too flat (lower than I am now). I said I couldn't do it. I got pneumonia and was sick, it scared me. It should never happen again. Resident R1 was very upset and tearful, blaming self that the incident occurred, because [Resident R1] did not say anything to the caregiver about being positioned too low and did not want to get staff in trouble. During a telephone interview on 2/18/26, at approximately 12:55 p.m. CNA Employee E1 revealed on 1/11/26, Resident R1 was positioned properly damn near 90 degrees and started to cough due to talking while eating. Employee E1 did not know where to find the resident's care needs for eating, and stated I just know they are a feed A review of Employee E1's personnel file indicated a start date of 11/6/25 and completed training and a satisfactory evaluation for assisting residents unable to feed themselves on 11/18/24. During interviews on 2/18/26, from 10:30 a.m. through 12:00 p.m., CNA Employees E5, E6, E8, and E9 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	confirmed they locate resident's care needs in the ECS system and were able to confirm Resident R1's needs for eating as defined in the care plan. During an interview on 2/18/26, at 3:00 p.m. the Nursing Home Administrator confirmed the facility failed to prevent an accident that resulted in actual harm of aspiration pneumonia for Resident R1. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1)(e)(1) Management.28 Pa. Code 211.10(c)(d) Resident care policies.