STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395825	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Watsontown Rehabilitation and Nursing Center	245 East Eighth Street Watsontown, PA 17777

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to develop person-centered care plans related to safe positioning during meals for 19 of 32 residents (Residents R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, and R20).Findings include: Review of the facility, Comprehensive Care Plan Policy dated 6/4/25, indicated the comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs dated 3/2/26, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), brain cancer, and dysphagia (difficulty swallowing). Review of Resident R2's Speech Therapy Discharge summary dated [DATE], included the discharge recommendation of, out of bed for meals. During an interview on 3/13/26, at 10:48 a.m. the Director of Rehabilitation Employee E1 confirmed that Resident R2 needed to be out of bed and/or seated upright to consume meals safely. Review of Resident R2's care plan for nutritional problems reviewed 3/12/26, indicated to monitor for signs and symptoms of dysphagia but failed to include interventions related to safe positioning for meals. Review of Resident R2's Kardex failed to include directions for assisting the resident out of bed for meals. Review of a list of residents, provided by the Director of Rehabilitation, on 3/13/26, included 32 residents that required staff to ensure they are out of bed during meals for swallowing safety. Of those 32 residents, the following was noted: Review of Resident R3's care plan for dysphagia reviewed 1/6/26, failed to include interventions related to safe positioning for meals. Review of Resident R3's Kardex (document that outlines the patients' activities of daily living [ADLs], continence levels, and behaviors, as well as physician, advanced directives, diet, and allergies utilized by nurse aide staff) failed to include directions for assisting the resident out of bed for meals. Review of Resident R4's care plan for nutritional risk related to therapeutic diet with thickened liquids reviewed 3/10/26, failed to include interventions related to safe positioning for meals. Review of Resident R4's Kardex failed to include directions for assisting the resident out of bed for meals. Review of Resident R5's care plan for nutritional problem related to history of difficulty chewing related to poor dentition with need for texture modified diet reviewed 2/3/26, indicated to monitor for signs and symptoms of dysphagia but failed to include interventions related to safe positioning for meals. Review of Resident R5's Kardex failed to include directions for assisting the resident out of bed for meals. Review of Resident R6's care plan for dysphagia reviewed 1/29/26, indicated Speech Therapy to address deficits through active treatment plan but failed to any further information on interventions included in that treatment plan and failed to include interventions related to safe positioning for meals. Review of Resident R6's Kardex failed to include directions for assisting the resident out of bed for meals. Review of Resident R7's care plan for nutritional risk related to therapeutic and mechanically altered diet reviewed 1/20/26, indicated to monitor for signs and symptoms of dysphagia but failed to include interventions related to safe positioning for meals. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R7's Kardex failed to include directions for assisting the resident out of bed for meals. Review of Resident R8's care plan for biting/chewing difficulty reviewed 2/10/26, indicated to monitor for signs and symptoms of dysphagia but failed to include interventions related to safe positioning for meals. Review of Resident R8's Kardex failed to include directions for assisting the resident out of bed for meals. Review of Resident R9's care plan for inadequate oral intake reviewed 1/27/26, indicated to monitor for signs and symptoms of dysphagia but failed to include interventions related to safe positioning for meals. Review of Resident R9's Kardex failed to include directions for assisting the resident out of bed for meals. Review of Resident R10's care plan for limited food acceptance reviewed 2/26/26, indicated to monitor for signs and symptoms of dysphagia but failed to include interventions related to safe positioning for meals. Review of Resident R10's Kardex failed to include directions for assisting the resident out of bed for meals. Review of Resident R11's care plan for swallowing problem related to dysphagia reviewed 2/26/26, failed to include interventions related to safe positioning for meals. Review of Resident R11's Kardex failed to include directions for assisting the resident out of bed for meals. Review of Resident R12's care plan for inadequate oral intake and the need for altered textured diet reviewed 3/10/26, indicated to monitor for signs and symptoms of dysphagia but failed to include interventions related to safe positioning for meals. Review of Resident R12's Kardex failed to include directions for assisting the resident out of bed for meals. Review of Resident R13's care plan for dysphagia reviewed 12/23/25, indicated Speech Therapy to address deficits through plan of care but failed to any further information on interventions included in that treatment plan and failed to include interventions related to safe positioning for meals. Review of Resident R13's Kardex failed to include directions for assisting the resident out of bed for meals. Review of Resident R14's care plan for potential for biting/chewing difficulties related to lack of teeth reviewed 12/18/25, indicated to monitor for signs and symptoms of dysphagia but failed to include interventions related to safe positioning for meals. Review of Resident R14's Kardex failed to include directions for assisting the resident out of bed for meals. Review of Resident R15's care plan for dysphagia reviewed 1/6/26, indicated Speech Therapy to address deficits through active treatment plan but failed to any further information on interventions included in that treatment plan and failed to include interventions related to safe positioning for meals. Review of Resident R15's Kardex failed to include directions for assisting the resident out of bed for meals. Review of Resident R16's care plan for dysphagia reviewed 2/26/26, indicated Speech Therapy to address deficits through active treatment plan but failed to any further information on interventions included in that treatment plan and failed to include interventions related to safe positioning for meals. Review of Resident R16's Kardex failed to include directions for assisting the resident out of bed for meals. Review of Resident R17's care plan for nutritional problem: altered texture diet reviewed 2/24/26, indicated to monitor for signs and symptoms of dysphagia but failed to include interventions related to safe positioning for meals. Review of Resident R17's Kardex failed to include directions for assisting the resident out of bed for meals. Review of Resident R18's care plan for inadequate oral intake reviewed 12/16/25, indicated to monitor for signs and symptoms of dysphagia but failed to include interventions related to safe positioning for meals. Review of Resident R18's Kardex failed to include directions for assisting the resident out of bed for meals. Review of Resident R19's care plan for nutritional problems reviewed 2/26/25, indicated that speech therapy would screen the resident but failed to include interventions related to safe positioning for meals. Review of Resident R19's Kardex failed to include directions for assisting the resident out of bed for meals. Review of Resident R20's care plan for nutritional problem related to CVA (cerebrovascular accident, stroke) reviewed 2/17/25, indicated to monitor for signs and symptoms of dysphagia but failed to include interventions related to safe positioning for meals. Review of Resident R20's Kardex failed to include directions for assisting the resident out of bed for meals. During interviews completed on 3/13/26, nurse aide staff were asked to state how they know if a resident has specific positioning requirements for meals. Nurse Aide (NA) Employee E2 stated that they review the Kardex.NA Employee E3 demonstrated how to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	navigate to the Kardex on the electronic hallway kiosk.NA Employee E4 stated that they review the kiosk or if they know they are a high aspiration risk.NA Employee E5 stated that they use a paper census sheet. Review of the census sheet at this time revealed that meal positioning requirements were not documented on the sheet.NA Employee E6 stated that they review the kiosk. During an interview on 3/13/26, at approximately 2:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that resident care plans failed to consistently include meal positioning requirements which prevented nurse aide staff from having accurate information available to provide safe care. During an interview on 3/13/26, at approximately 2:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to develop person-centered care plans related to safe positioning during meals for 19 of 32 residents. 483.21 (b)(1)(i) Comprehensive care planPreviously cited 9/12/25 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 - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to appropriately respond to a resident's change in condition for two of five residents (Resident R1 and R21).Findings include: Review of the United States Food and Drug Administration prescribing information for duloxetine (Cymbalta, an antidepressant medication) dated 08/2023, indicated, in the Warnings and Precautions section revealed abnormal bleeding was included. Review of the facility policy, Change in Condition dated 6/1/25, indicated, The facility shall notify the resident, his or her attending physician, and representative of changes in theresident's medical/mental condition and/or status. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs dated 1/13/26, included diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and history of a stroke. Review of Resident R1's physician orders indicated Resident R1 was ordered fluoxetine (Prozac, an antidepressant medication) originally on 11/19/22, and continuously reordered without a gap in the orders on 2/24/24, 4/23/24, 7/31/25, and 10/1/25, through 1/30/26. Review of a psychiatry progress note dated 1/26/26, 7:00 p.m. indicated Resident R1's dosage of fluoxetine was to be increased from 30 mg daily to 40 mg daily. Review of a physician's order dated 1/30/26, indicated for Resident R1 duloxetine 40 mg once daily. Review of Resident R1's Medication Administration Records (MARs) for January 2026, and February 2026, indicated Resident R1 received duloxetine on 1/30/26, 1/31/26, and 2/1/26. Review of a progress note dated 1/29/26, at 2:21 p.m. indicated, Psychiatric consult has made the following recommendation that Prozac from 30mg daily to 40mg for MDD (major depressive disorder). Review of a progress note dated 2/1/26, at 3:49 a.m. indicated, Resident noted to have bloody tissues and a small blood clot on their tray table. When prompted resident stated he doesn't know how it got there or where it came from. Resident was noted to have a bit of dried blood around his nares. Resident had no other complaints at this time. Review of a progress note dated 2/2/26, at 12:24 a.m. indicated, Resident received incorrect medication Duloxetine 40mg X 3 doses. Placed on Alert charting with vital signs QShift (every shift) for 24hrs. Review of a progress note dated 2/3/26, at 10:22 p.m. indicated, Resident noted to have active epistaxis (nosebleed) with large blood clots present. Vitals WNL (within normal limits), resident has no c/o dizziness or light headiness. Pressure applied to nares and blood cleansed from surrounding skin. Review of a progress note dated 2/4/26, at 5:49 a.m. indicated, Resident noted to have intermittent epistaxis beginning on second shift yesterday and continuing into third shift overnight, with increasing frequency and amount. During most recent episode, large clots observed. Resident had tissue placed in nares and refused removal, stating no, don't remove it if you do it just drips and drips. Tissue left in place per resident request. Medical provider notified of recurrent nosebleeds with clot formation. New orders received to hold Eliquis (anticoagulant medication) and aspirin for three (3) days and initiate alert charting. Review of a progress note dated 2/4/26, at 7:50 a.m. indicated, Upon arrival resident noted to have blood dripping from nose with large clot size of half dollar. Blood noted to be on floor to right of bed at approx. 15mls. Pressure applied x 15 minutes with no relief. Tissue wrapped and placed up right nostril. Active bleeding continues. Resident complains of weakness and dizziness. The progress note further indicated Resident R1 was provided orders to go to the hospital for cauterization. During an interview on 3/13/26, at 10:45 a.m. Licensed Practical Nurse (LPN) Employee E7 stated that excessive bleeding can be an adverse effect of anticoagulant use. When listing side effects to look for in a resident taking duloxetine, LPN Employee E7 was unaware that excessive bleeding can be an effect. During an interview on 3/13/26, at 10:55 a.m. LPN Employee E8 stated that nosebleeds can be an adverse effect of anticoagulant use. When asked what side effects to look for in a resident taking duloxetine, LPN Employee E8 stated, I honestly don't know. During an interview on 3/13/26, at 10:59 a.m. LPN Employee E9 stated that (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nosebleeds can be an adverse effect of anticoagulant use. When listing side effects to look for in a resident taking duloxetine, LPN Employee E9 stated only behavioral side effects. During an interview on 3/13/26, at 11:05 a.m. LPN Employee E10 stated that nosebleeds can be an adverse effect of anticoagulant use. When listing side effects to look for in a resident taking duloxetine, LPN Employee E10 confirmed that excessive bleeding can be an effect, and stated that after Resident R1 was hospitalized , she and other staff looked up the side effects of duloxetine as they were unaware that excessive bleeding can be an effect. During an interview on 3/13/26, at 2:15 p.m. LPN Employee E11 stated that bruising and excessive bleeding can be adverse effects of anticoagulant use. When listing side effects to look for in a resident taking duloxetine, LPN Employee E11 stated only behavioral side effects. Review of the clinical record indicated Resident R21 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of anemia (too little iron in the body causing fatigue), urinary tract infection, and the presence of a pressure ulcer (injury to the skin and underlying tissue, primarily caused by prolonged pressure on the skin). Review of a progress note dated 3/8/26, at 11:52 a.m. indicated, Resident had bottle of mixed pills in her room, staff is unaware what she took. All medication in the room was taken out of room and given to the RN (registered nurse) supervisor. CNA (nurse aide) came out of this resident room and notified, this writer that resident had multiple bottles of pills in her room. Resident this morning had slurred speech, leaning to the side, eye pinpoint. RN supervisor notified and made aware. This writer went back to resident room and educated resident we can't allow bottle of pills in her room. We will have to take all medication and hand it in to the supervisor. She was worried if she was going to get the medication back if she leaves here. Medication was taken to supervisor at the nursing station, resident had multiple bottles of mixed pills. There was Creon (pancreatic enzyme), Tylenol 3's (acetaminophen and codeine combination medication), Mucinex (expectorant), Tylenol Pm (acetaminophen and Benadryl combination medication) and a lot more. Resident's husband came in and he was notified of the pill situation, and that he will have to take all medication home she wasn't allowed to have medication in her room due to policies here. He came out multiple times to try and get the medication to take back into the room, Husband was informed we can only give him the medication when he is about to leave. This writer was also worried what she took this morning all AM medications were held except the Creon that the RN supervisor told this writer to give. Residents husband came out of the room and stated, she need pain medication. RN supervisor was made aware. RN said it was fine to give, but this writer was still concerned about what she took prior to us finding the pills in her room, with all the slurred speech, leaning to the side, and eyes pinpoint. Review of a progress note dated 3/8/26, at 1:08 p.m. indicated the RN Supervisor provided pain medication to Resident R21. Review of Resident R21's medication administration record revealed Resident R21 received Tramadol (a narcotic pain medication) on 3/8/26, at 11:18 a.m. and gabapentin (medication to treat seizures and pain, with the side effect of drowsiness) at approximately 2:00 p.m. Review of a progress note dated 3/8/26, at 3:37 p.m. indicated, This resident had a large amount of medications in various pill bottles/container. These were removed from the bedside. She has T-3 tabs which were recognized and investigated. It is this writer's perception that she may have taken these independently as this am she had slurred speech and appeared to be under the influence. Review of a progress note dated 3/8/26, at 6:15 p.m. indicated, Spouse and son report increase in altered mental status and request she be sent to ED (emergency department). Call placed to on call [provider] new order received to send to ED for evaluation and treatment. Family updated, 911 called for transport. Further review of Resident R21's progress notes failed to reveal that the possibility of Resident R3 consuming narcotic pain medication (Tylenol-3) when symptomatic for opiate ingestion was addressed by the facility and failed to reveal documentation of notification to the provider of possible consumption of narcotic pain medication in addition to the Tramadol provided by the RN Supervisor and the gabapentin provided by LPN E12 until concerns voiced by family members. During an interview on 3/15/26, at approximately 1:30 p.m. the Nursing Home Administrator and the Director confirmed the facility failed to appropriately respond to a (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's change in condition for two of five residents. 483.25 Quality of CarePreviously cited 9/12/25 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.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility policy, resident interviews, clinical records, and staff interview, it was determined that the facility failed to make certain that residents are free of significant medication errors for one of five residents reviewed (Resident R1).Findings include: Review of the United States Food and Drug Administration prescribing information for duloxetine (Cymbalta, an antidepressant medication) dated 08/2023, indicated, The recommended starting dosage in adults with MDD is 40 mg/day (given as 20 mg twice daily). Review of the facility policy Medication Error Reporting dated 6/4/25, indicated medication errors are documented and reported in an effort to identify the causes of the errors and develop strategies to prevent medication errors. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs dated 1/13/26, included diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and history of a stroke. Review of Resident R1's physician orders indicated Resident R1 was ordered fluoxetine (Prozac, an antidepressant medication) originally on 11/19/22, and continuously reordered without a gap in the orders on 2/24/24, 4/23/24, 7/31/25, and 10/1/25, through 1/30/26. Review of a psychiatry progress note dated 1/26/26, 7:00 p.m. indicated Resident R1's dosage of fluoxetine was to be increased from 30 mg daily to 40 mg daily. Review of a physician's order dated 1/30/26, indicated for Resident R1 duloxetine 40 mg once daily. Review of Resident R1's Medication Administration Records (MARs) for January 2026, and February 2026, indicated Resident R1 received duloxetine on 1/30/26, 1/31/26, and 2/1/26. Review of a progress note dated 1/29/26, at 2:21 p.m. indicated, Psychiatric consult has made the following recommendation that Prozac from 30mg daily to 40mg for MDD (major depressive disorder). Review of a progress note dated 2/2/26, at 12:24 a.m. indicated, Resident received incorrect medication Duloxetine 40mg X 3 doses. Placed on Alert charting with vital signs QShift (every shift) for 24hrs. During an interview on 3/13/26, at approximately 10:30 a.m. the Director of Nursing confirmed that duloxetine was inadvertently ordered in place of fluoxetine. During an interview on 3/13/26, at approximately 2:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that facility failed to make certain that residents are free of significant medication errors for one of five residents. 28 Pa Code: 211.10 (d) Resident care policies. 28 Pa. Code 211.12 (c)(1)(3) Nursing Services. 28 Pa Code: 201.18 (b)(1)(3) Management.