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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 - Few	Based on clinical record review and staff interview it was determined that the facility failed to implement a comprehensive person-centered care plan regarding a cardiac pacemaker for one of 24 residents reviewed (Resident 38) and develop a comprehensive and person-centered care plan for one of two residents reviewed with a tracheostomy (Resident 42).Findings Include: Clinical record review for Resident 38 revealed a diagnosis list that included the presence of a cardiac pacemaker (an electronic device to help regulate the beating of the heart) and sick sinus syndrome (a disorder that causes the heart to beat abnormally). Nursing documentation for Resident 38 on admission to the facility on August 20, 2025, at 5:07 PM revealed that the resident had a cardiac pacemaker. Hospital documentation for Resident 38 dated August 14, 2025, noted a problem list for the resident that included a history of a cardiac pacemaker. Review of Resident 38's care plan revealed no current comprehensive, person-centered care plan that addressed the resident's pacemaker, any associated pacemaker checks, assessments, and/or precautions. The above information for Resident 38 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on September 10, 2025, at 2:30 PM. Review of the policy titled, Tracheostomy Care Policy, last reviewed without changes on June 4, 2025, revealed a purpose to guide tracheostomy care and the cleaning of reusable tracheostomy findings. Under the section titled, General Guidelines, the policy noted that a replacement tracheostomy tube must be available at the bedside at all times. Clinical record review for Resident 42 revealed a diagnosis list that included a tracheostomy (trach, an artificial opening through which a medical tube is placed through the front of the neck into the airway to facilitate breathing). Review of the current physician orders for Resident 42 revealed orders for daily and as needed tracheostomy care that included changing the inner cannula. Further review of the physician orders revealed an order that instructed staff to perform trach care as per policy and check skin integrity around the trach site and neck. Resident 42's care plan revealed the resident has a tracheostomy related to the medical history. The care plan interventions included the following: ensure that trach ties are secured at all times, head of bed is elevated to prevent any shortness of breath while flat, provide good oral care daily and as needed, and suction as necessary. Further clinical record review for Resident 42 revealed a quarterly Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated August 11, 2025, that noted facility staff assessed the resident as having a BIMS (Brief Interview for Mental Status) of 3, which indicated cognitive impairment. The care plan also noted a tracheostomy. Observation of Resident 42 on September 9, 2025, at 10:30 AM and September 12, 2025, at 10:16 AM revealed the resident had a tracheostomy present. Further review of Resident 42's tracheostomy care plan revealed the current care plan did not address possible complications (such as unplanned extubation or unplanned removal of the tracheostomy, or any other type of potential airway complication). The care plan did not address any emergency kit as indicated by staff or having an emergency tracheostomy tube at the bedside at all times as indicated in the policy. The above information for Resident 42 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on September 12, 2025, at 12:28 PM 28 Pa. Code 211.12(d)(1)(3)(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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, clinical record review, and staff interview, it was determined that the facility failed to coordinate hospice services per a coordinated plan of care for one of one resident reviewed for hospice care concerns (Resident 13).Findings include: Clinical record review for Resident 13 revealed nursing documentation dated April 1, 2025, at 3:17 PM that Resident 13 was admitted to a contracted hospice provider. Observation of Resident 13 on September 9, 2025, at 1:43 PM revealed that the registered nurse from the contracted hospice provider was at his bedside. The registered nurse explained to Resident 13 that he was not receiving services from the hospice aide because the contracted hospice provider did not have enough nurse aides currently on the schedule. The registered nurse explained to Resident 13 that people receiving hospice services in the community would get preference when assigning nurse aide services. Interview with Employee 9 (registered nurse from the facility's contracted hospice provider) on September 9, 2025, at 2:29 PM confirmed that according to her electronic hospice medical record (accessed via a small electronic tablet carried by her) Resident 13 was to receive nurse aide services three times a week on Mondays, Wednesdays, and Fridays; however, he had not received nurse aide services in at least two weeks. Employee 9 reviewed a binder of information available at the Lower-Level nurses' station that contained all communication and documentation for Resident 13 that pertained to his hospice services and confirmed that the last documentation completed by a hospice nurse aide was dated June 27, 2025. The interview confirmed that the facility's contracted hospice provider lost the nurse aide assigned to Resident 13 and the service area he resided in. Although the binder of handwritten documentation available at the facility did not include evidence of nurse aide services provided, Employee 9 stated that the electronic documentation available to her (not the facility) indicated that a nurse aide last provided services on August 29, 2025 (a Friday, 11 days earlier). The interview with Employee 9 confirmed that the information contained in Resident 13's binder did not include a plan of care that provided the information regarding what, and how often, hospice disciplines provided services to Resident 13 (e.g., frequency of visits from a hospice registered nurse or nurse aide or what days the facility could anticipate those services). The interview indicated that the hospice registered nurse visited the facility two days a week on Tuesdays and Thursdays. The interview indicated that the registered nurse completes a brief handwritten note (documented on the blank space on the back of a blank hospice nurse aide documentation form) in the hospice binder at the facility but the registered nurse completes a more comprehensive electronic note for the hospice provider's medical record, which is not supplied to the facility or incorporated into Resident 13's medical record at the facility. Previous electronic entries by the registered nurse were not in the hospice provider's binder or in the electronic medical record for Resident 13. The interview confirmed that four handwritten notes on the back of the nurse aide form was the only evidence of registered nurse visits at the facility. The handwritten notes did not include a full date (missing year) or staff name, signature, or discipline (e.g. RN' or registered nurse). Interview with Employee 8 (licensed practical nurse) on September 9, 2025, at 2:29 PM with Employee 9 revealed that the facility's second contracted hospice provider (different company) utilized pre-printed forms for registered nurses to document onsite visits (not the back of a blank nurse aide form). Review of Resident 13's electronic medical record at the facility revealed a scanned document from the contracted hospice provider entitled, Hospice Comprehensive Assessment, for a certification period of May 31, 2025, to July 29, 2025, that indicated, Coordination of Care with Facility, included that facility staff would be knowledgeable and involved in the hospice plan of care at initiation of hospice services/facility placement and with any update to the plan of care, and Resident 13 would receive, aide services, specific to patient care needs by April 2, 2025. The document included that the skilled nurse would initiate hospice aide services via physician's order and aide plan of care. The plan of care available in Resident 13's medical record at the facility initiated July 9, 2025, to address that he received hospice services noted only that a hospice aide would assist with care as needed (PRN) and that the facility would work cooperatively with the hospice team to ensure the resident's spiritual; emotional; intellectual; physical and social needs are met. The plan of care did not include that a registered nurse from the hospice provider would provide services or the frequency/days the hospice aide or hospice nurse would provide services. Neither Resident 13's facility medical record nor the hospice provider binder included a Hospice Comprehensive Assessment, for a certification period in effect after July 29, 2025. The surveyor reviewed the above concerns regarding the coordination of Resident 13's hospice services during an interview with the Nursing Home Administrator and

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on clinical record review and resident and staff interview, it was determined that the facility failed to obtain routine services from an eye care professional for one of one resident reviewed for vision concerns (Resident 31).Findings include: Interview with Resident 31 on September 10, 2025, at 10:34 AM revealed that she used eyeglasses only for reading. Resident 31 stated that she could not recall when the last time was she saw a doctor or eye care professional for vision services. Resident 31 stated, I need stronger ones (glasses). Clinical record review for Resident 31 revealed that the facility admitted her on February 17, 2022. Resident 31's diagnoses list included diagnoses known to create the potential for eye health concerns as follows: Diabetes (high blood sugar)Long-term use of non-steroidal anti-inflammatories (long term use of medications that can cause complications of the cornea, or outer surface of the eye)Hypertension (high blood pressure)Hyperlipidemia (high levels of fats/cholesterol in the blood) Documentation by the facility's contracted eye care professional dated April 23, 2025, indicated that Resident 31's appointment for services was cancelled. The, Reason for Cancelled Visit: Time Constraint; Comments: ran out of time; will reschedule. Documentation by the facility's contracted eye care professional dated June 17, 2025, indicated that Resident 31's appointment for services was cancelled. The Reason for Cancelled Visit: Refused. Resident 31's clinical record contained no evidence of any attempt to obtain professional eye care services in the last 12 months before April 23, 2025, or after June 17, 2025. The surveyor reviewed the above concerns regarding Resident 31's eye care services during an interview with the Nursing Home Administrator on September 12, 2025, at 11:15 AM. 28 Pa. Code 211.12(d)(3) Nursing services

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to obtain professional podiatry services for one of two residents reviewed for skin conditions (Resident 76).Findings include: Clinical record review for Resident 76 revealed her diagnoses list included diabetes (high blood sugar) and polyneuropathy (nerve damage that can include pain, numbness, weakness, and coordination issues, often affecting the hands and feet). Documentation by the facility's contracted podiatry provider dated January 16, 2025, revealed that the practitioner assessed Resident 76's nails as thickened, that she had complaints of burning in both of her feet, and that her diagnoses included peripheral angiopathy (diseased blood vessels) and diabetes. Documentation by the facility's contracted podiatry provider dated May 27, 2025, revealed that the practitioner continued to assess Resident 76's nails as thickened, that she had complaints of burning in both of her feet, and that her diagnoses included peripheral angiopathy and diabetes. The documentation indicated that Resident 76 had extensive symptomatic dry skin involving the feet, and the practitioner ordered lotion daily to affected areas. The documentation included that Resident 76 had underlying systemic risk factors for wound development if left untreated or unresolved. A physician's order dated March 26, 2025, instructed staff to apply Ketoconazole cream (antifungal medicated lotion) to Resident 76's bilateral feet every day. Review of Resident 76's treatment administration records dated July, August, and September 2025 revealed that licensed nursing staff initialed the completion of the foot lotion daily. There was no evidence in Resident 76's medical record that a foot care professional provided services in more than three months since May 27, 2025. Interview with Resident 76 on September 9, 2025, at 12:36 PM revealed that she believed that she had a raised area on her right foot, believed to be a callous, that was painful when she pressed on it in a certain way. Resident 76 could not recall the last time a podiatrist provided her care. The surveyor requested evidence of professional podiatry services for Resident 76 in the last 12 months during an interview with the Nursing Home Administrator and Director of Nursing on September 10, 2025, at 2:30 PM due to her complaints of a painful site on her right foot. Nursing documentation dated September 11, 2025, at 3:23 PM (following the surveyor's questioning) revealed that a physician assessed Resident 76 and provided a new order, for podiatry asap for corn on bottom of right foot. Observation of Resident 76 on September 12, 2025, at 1:31 PM with Employee 12 (licensed practical nurse) revealed a hardened, calloused, and dry area that was the size of an eraser head to dime-sized in diameter that was raised several millimeters from the surface of the skin on the right lateral side of Resident 76's right foot. Resident 76's feet appeared dry and scaley. Interview with Employee 12 at the time of the observation confirmed that the area of concern did not appear to have developed quickly; but had developed over some time. Interview with the Nursing Home Administrator on September 12, 2025, at 1:37 PM confirmed that Resident 76 had not received podiatry services in more than three months. The facility was unable to provide evidence that any staff identified the change in Resident 76's foot, notified the physician, or obtained professional podiatry services timely to address the issue before the surveyor's questioning although physician-ordered treatment required licensed staff to look at Resident 76's feet daily. 28 Pa. Code 211. 12(d)(1)(3)(5) Nursing services

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and resident and staff interview, it was determined that the facility failed to assess and implement interventions to maintain a resident's continence status for one of one resident reviewed (Resident 19).Findings include: In an interview with Resident 19 on September 10, 2025, at 10:21 AM the resident indicated she was admitted to the facility without any history of being incontinent of her bowel or bladder and knows when she needs go to the bathroom but has since had several instances of being incontinent of bladder since her admission to the facility. Resident 19 indicated she has to wait a long time for staff at times on the evening or night shift to assist her to the bathroom and even started to ring her bell early to give the staff more time to get to her, but they don't always make it to her in time. Resident 19 also stated sometimes the staff come in and shut off her bell and say they will be back, but they don't come back and she pees the bed because of waiting. Resident 19 stated she sometimes can get up from her bed herself, but when she can't she rings the bell for staff to help her. Clinical record review for Resident 19 revealed the resident was admitted to the facility on [DATE]. A modified admission MDS assessment (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated July 24, 2025, revealed facility staff assessed the resident as always continent of urine and bowel. The resident was also assessed as requiring partial/moderate assistance for a toilet transfer and to walk 10 feet. A review of Resident 19's documentation of bowel and bladder continence records for July 2025 through September 10, 2025, revealed the following: Resident 19 was documented as not having any incontinent episodes of bowel or bladder from July 17, 2025, (admission) until the evening shift on July 27, 2025. The resident was documented as being incontinent of urine on the night shift on July 28 and 31, 2025. Review of the August 2025 bladder elimination record revealed the resident was documented as being continent of urine August 1-19, 2025, and then incontinent on evening shift August 20, 21, 27, and the day shift (documented at 6:23 AM) on August 28, 2025. Review of the September 2025 bladder elimination records revealed the resident was documented as being incontinent on the evening shift on September 2, 5 and 10, 2025. Resident 19 had one episode of bowel incontinence documented on August 29, 2025, on day shift (documented at 6:23 AM). There was no ability to review call bell log activations to potentially correlate with the resident shifts of incontinence. There was no evidence facility staff evaluated or assessed Resident 19's episodes of incontinence primarily on the evening and night shift as noted above or developed any toileting plans to help the resident remain continent. The above information was reviewed with the Nursing Home Administrator and Director of Nursing on September 11, 2025, at 3:00 PM. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide respiratory and tracheostomy care consistent with professional standards of practice for one of two residents reviewed with a tracheostomy (Resident 42).Findings include: Review of the policy titled, Tracheostomy Care Policy, last reviewed without changes on June 4, 2025, revealed a purpose to guide tracheostomy care and the cleaning of reusable tracheostomy findings. Under the section titled, General Guidelines, the policy noted that a replacement tracheostomy tube must be available at the bedside at all times. Clinical record review for Resident 42 revealed a diagnosis list that included a tracheostomy (trach, an artificial opening through which a medical tube is placed through the front of the neck into the airway to facilitate breathing). Review of the current physician orders for Resident 42 revealed orders for daily and as needed tracheostomy care that included changing the inner cannula. Further review of the physician orders revealed an order that instructed staff to perform trach care as per policy and check skin integrity around the trach site and neck. Resident 42's care plan revealed the resident has a tracheostomy related to the medical history. The care plan interventions included the following: ensure that trach ties are secured at all times, head of bed is elevated to prevent any shortness of breath while flat, provide good oral care daily and as needed, and suction as necessary. Further clinical record review for Resident 42 revealed a quarterly Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated August 11, 2025, that noted facility staff assessed the resident as having a BIMS (Brief Interview for Mental Status) of 3, which indicated cognitive impairment. The care plan also noted a tracheostomy. Observation of Resident 42 on September 9, 2025, at 10:30 AM and September 12, 2025, at 10:16 AM revealed the resident had a tracheostomy present. Observation of Resident 42's room and concurrent interview with Employee 10, licensed practical nurse (LPN), on September 12, 2025, at 10:22 AM revealed that the facility keeps an emergency kit at the bedside; however, Employee 10 was unable to locate a kit or replacement tracheostomy tube at the bedside. Employee 10 reported that the resident sometimes will carry the items off and voiced it may be at the nurse's station. Employee 10 was unable to locate an emergency kit after searching the nursing station. A second LPN present was also unable to locate the items. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on September 12, 2025, at 12:28 PM. 483.25(i) Respiratory/tracheostomy Care and SuctioningPreviously cited deficiency 10/25/2024 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on review of select facility policies, observation, clinical record review, and staff and resident interview, it was determined that the facility failed to assess for the risk of side rail entrapment for 6 of 7 residents reviewed for accident hazards (Residents 2, 6, 8, 22, and 64). Findings include: The FDA (The United States Food and Drug Administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, is guidance that identifies key parts of the body at risk for entrapment, describes potential entrapment areas or zones, and recommends maximum and minimum dimensional limits of gaps or openings in hospital bed systems. Three key body parts at risk for life-threatening entrapment in the seven zones of a hospital bed system discussed in this guidance are the head, neck, and chest. To reduce the risk of head entrapment, openings in the bed system should not allow the widest part of a small head (head breadth measured across the face from ear to ear) to be trapped. The FDA is using a head breadth dimension of 120 mm (4.75 inches) as the basis for its dimensional limit recommendations. To reduce the risk of neck entrapment, openings in the bed system should not allow a small neck to become trapped. FDA is recommending 60 mm (two and three-eighths inches) as an appropriate dimension for neck diameter. The openings in a bed system should be wide enough not to trap a large chest through the opening between split rails. The FDA concurs with the dimension of 318 mm (12.5 inches) to represent chest depth for the population vulnerable to entrapment and has used this dimension as the basis for its recommended dimensional limits. This guidance describes seven zones in the hospital bed system where there is potential for patient entrapment. Zone six is the space between the end of the rail and the side edge of the headboard or footboard. This space may present a risk of either neck entrapment or chest entrapment. Review of the facility's current policy entitled Bed Safety, last reviewed June 4, 2025, revealed it is the facility's policy when using side rails for any reason, the staff shall take measures to reduce related risks. A Bed Entrapment Grid attached to the policy revealed areas of entrapment risk include zone one (within the rail), two (between the top of compressed mattress to the bottom of the rail, between rail and supports), three (in the horizontal space between rail and mattress), four (between the top of the compressed mattress and the bottom of the rail at the end of the rail), and zone 6 (entrapment between the rail and the edge of the head/foot board). Observation of Resident 8 on September 10, 2025, at 11:08 AM revealed she was in bed. Her bed was equipped with a headboard, footboard, and an assist rail on the right side of her bed. Clinical record review for Resident 8 revealed an active physician's order dated October 20, 2023, for her to have a right bed rail to assist her with increased mobility in bed and with transfers as able. A Bed System Measurement Device Test Results Worksheet dated September 3, 2025, indicated that the bed rail installed for Resident 8 passed inspection for zones one through four; however, zone four was only assessed at the proximal edge of the rail (closest to the headboard). Zone four was not assessed at the distal end (closest to the footboard). There was no evidence that other potential risks were assessed such as the area between her mattress and her headboard/footboard (zone seven) or the area between the edge of the siderail and the headboard (zone six). Observation of Resident 22's room on September 9, 2025, at 1:26 PM revealed a right-sided bed rail installed on his bed. Clinical record review for Resident 22 revealed an active physician's order dated September 1, 2025, for the use of a right-sided bed rail to increase bed mobility. A Bed System Measurement Device Test Results Worksheet dated September 3, 2025, indicated that the bed rail installed for Resident 22 passed inspection for zones one through four; however, zone four was only assessed at the proximal edge of the rail. Zone four was not assessed at the distal end. There was no evidence that other potential risks were assessed such as the area between her mattress and her headboard/footboard (zone seven) or the area between the edge of the siderail and the headboard (zone six). Interview with Employee 3 on September 11, 2025, at 12:25 PM revealed that he was told by someone, that zone four for the distal part of the rail was not assessed because there were no split rails on the bed; however, he confirmed that his directions indicate that zone four is the distance between the bottom of the rail and the mattress, which was applicable for Resident 8's and Resident 22's rails. The surveyor reviewed the above concerns regarding Resident 8's and Resident 22's bed rails during an interview with the Nursing Home Administrator and the Director of Nursing on September 11, 2025, at 2:30 PM. Observation of Resident 2 on September 9, 2024, at 12:10 PM revealed she was in bed sleeping. Bilateral enabler bars were observed on her bed. In a follow up interview with Resident 2 on September 10, 2025, at 10:41 AM she stated she uses the enabler bars to move in bed and hold herself to her side during care. Review of a Bed System Measurement Device Test

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on a review of financial accounting records, clinical record review, and resident and staff interview, it was determined that the facility failed to provide medically-related social services to assist a resident with financial matters for one of 24 residents reviewed (Resident 22).Findings include: Interview with Resident 22 on September 9, 2025, at 12:49 PM revealed that he did not believe that he had any money in a personal account, that he did not receive a statement, and that he did not know where any personal allowance funds were maintained. An interview with the Nursing Home Administrator on September 10, 2025, at 2:30 PM confirmed that Resident 22 entered the facility following his release from prison, and the facility determined that he had no resources. The surveyor requested Resident 22's financial accounting (e.g., monthly charges and payments for those charges) since his admission to the facility. The interview confirmed that Resident 22 had no designated responsible party. Resident 22 was his own responsible party; therefore, there would be no other individual that would receive a monthly personal fund statement. The interview indicated that because the facility believed that he had no monetary resource, he had no monthly personal allowance; therefore, he had no resident fund statement to provide. Clinical record review of census information for Resident 22 revealed that the facility admitted him on December 16, 2024, for Medicaid-provided services. Interview with Employee 11, assistant business office manager, on September 11, 2025, at 1:00 PM confirmed that Resident 22 arrived directly from incarceration at a prison in December 2024. The facility staff believed that the prison staff submitted documentation to have Resident 22's social security and Medicare benefits reinstated; however, the facility had no documented evidence (communication) between the prison and the facility to support that. The interview confirmed that the facility submitted the required documentation in January 2025 to obtain Medicaid payment for Resident 22's stay in the facility by entering that Resident 22 had no income. The facility did not assist Resident 22 to contact the Social Security Administration (SSA, United States government agency that administers monetary benefits to retired or disabled individuals) to have Resident 22's benefits (including monthly income) reinstated immediately after his incarceration. The interview indicated that the facility determined in May 2025 (five months after his admission) that the prison staff likely did not submit the necessary documentation to have Resident 22's benefits reinstated; therefore, the facility staff assisted Resident 22 at that time. The interview indicated that outside providers contacted the facility due to the Medicare non-payment of services during the time from December 2024 to May 2025. The interview with Employee 11 on September 11, 2025, at 1:00 PM revealed that, on this date, Employee 11 contacted the SSA to inquire about the backpay of Resident 22's social security benefits that he was entitled to from December 2024 to May 2025. Employee 11 discovered that the SSA deposited Resident 22's money in an account that he no longer had a banking access card to obtain. Employee 11 then assisted Resident 22 to obtain a new banking card to access the more than $1700.00 (seventeen hundred dollars) deposited into his account. The interview indicated that it would take several business days to receive the new banking card. A review of a Health and Human Service Benefits application dated January 7, 2025, indicated that the facility's contracted provider applied for Medicaid benefits for Resident 22 for a requested effective date of December 16, 2024. The application indicated that Resident 22 had a checking or savings account with an estimated resource value of $1,654.94 (one thousand six hundred fifty-four dollars and 94 cents). The application indicated that Resident 22 received money from one or more sources other than a job; and that source was supplemental security income (SSI, a federal program that helps people with disabilities and older adults who have low income and few resources) of $985.10 monthly. The facility, who had reasonable knowledge to determine Resident 22 was entitled to monthly monetary benefits, failed to assist Resident 22 to obtain financial assistance timely. The surveyor confirmed the above findings with the Nursing Home Administrator on September 11, 2025, at 1:45 PM. 28 Pa. Code 201.18(b)(2)(e)(1) Management 28 Pa. Code 201.29(a) Resident rights

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility documentation, clinical record review, and staff and resident interviews, it was determined that the facility failed to provide professional dental services for three of three residents reviewed for dental concerns (Residents 8, 31, and 56).Findings include: Interview with Resident 31 on September 10, 2025, at 10:32 AM revealed that she had natural teeth; however, she was missing some teeth. Observation of Resident 31 on the date and time of the interview confirmed that she had natural teeth with noticeable gaps from missing teeth. Clinical record review for Resident 31 revealed documentation by the facility's consultant dentist dated March 13, 2024, that recommended a treatment plan that included an annual exam. Resident 31's clinical record contained no evidence of additional services from the consultant dentist in the 18 months since March 13, 2024. Interview with Resident 8 on September 10, 2025, at 10:57 AM revealed that she had no teeth or dentures in her top jaw and had some natural teeth on her bottom jaw. Resident 8 stated that she was missing teeth in her bottom jaw. Resident 8 stated that she had services to obtain impressions for dentures two months ago; however, she had no indication when she would receive them. Clinical record review for Resident 8 revealed an annual MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) assessment dated [DATE]; an admission MDS following a hospitalization dated July 24, 2024; and an annual MDS dated [DATE], that assessed Resident 8 as having obvious or likely cavities or broken natural teeth. Documentation by the facility's contracted dental provider dated July 19, 2022, and December 20, 2023, revealed that Resident 8 expressed a desire to have a full upper denture and a partial lower denture. Documentation on both dates indicated that the provider would apply to Medicaid for the fabrication of the upper and lower appliances. Documentation by the facility's contracted dental provider dated October 22, 2024, confirmed that Resident 8 had no upper teeth and numerous missing lower teeth. The documentation revealed that the plan of treatment included a recall for an annual exam on April 22, 2025, and Fabrication of full upper denture (DFU); Fabrication of partial lower denture (DPL). The documentation indicated that the provider Refiled [NAME] (Pennsylvania Medicaid) today for F/P (full/partial). Resident 8's clinical record contained no evidence of a recall visit with the dentist in April 2025. Documentation by the facility's contracted dental provider dated July 7, 2025, noted Resident 8's partial dentition, and she would like an upper denture and a lower partial denture. The documentation indicated that impressions for dentures occurred; but again, noted that a dental recall would be based on the pay source frequency. Resident 8's clinical record contained no evidence of a recall visit with the dentist after July 7, 2025. Clinical record review for Resident 56 revealed a diagnosis list that included dementia (general term to describe a group of symptoms related to loss of memory, judgment, language, complex motor skills, and other intellectual function, caused by the permanent damage or death of the brain's nerve cells, or neurons), and a need for assistance with personal care. Further clinical record review for Resident 56 revealed a quarterly Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated July 17, 2025, that noted facility staff assessed the resident as having a BIMS (Brief Interview for Mental Status) of 3, which indicated cognitive impairment. Resident 56's care plan initiated on December 12, 2024, noted the resident has oral/dental health problems and upper and lower dentures were noted under interventions. Clinical documentation for Resident 56 dated December 12, 2024, at 11:00 AM titled, admission Nursing Evaluation, documented the resident as having upper and lower dentures. Nursing documentation for Resident 56 dated December 12, 2024, at 11:26 AM revealed that the resident arrived at the facility and staff documented Upper/Lower dentures. Nursing documentation for Resident 56 dated July 6, 2025, at 2:27 PM revealed that the resident's family made the nurse aware that the resident's bottom dentures are missing and have been missing since Friday. The documentation noted that the nurse looked through the resident's room and did not find the dentures. Care plan meeting documentation for Resident 56 dated August 12, 2025, at 2:34 PM revealed that the family brought to nursing's attention of missing dentures and a .concern form filed with social services. The above information for Resident 56 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on September 10, 2025, at 2:30 PM and September 11, 2025, at 2:30 PM. The Nursing Home Administrator reported during the meeting on September 11, 2025, that he confirmed with the resident that he did not have any lower dentures. An interview with Resident 56 on September 12, 2025, at 10:22 AM revealed the resident is unsure what happened to the dentures. The resident pulled down

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, it was determined the facility failed to maintain a safe and sanitary environment in the facility's main kitchen. Findings include: Observation of the facility's main kitchen on September 9, 2025, at 10:12 AM revealed flooring throughout the main kitchen was blackened. Dirt/debris buildup was observed in several areas of the grout and under equipment. Significant black buildup was observed under the dish machine area, which was covered in water as staff were washing breakfast dishes during the observation. The cove base molding surrounding the kitchen contained black buildup. Several broken and cracked floor tiles were also observed in the area outside the dry storage room and corridor to the receiving dock. Employee 6, dietary manager, indicated during the observation that the flooring and cove base has been a repeated issue, and he has tried scrubbing it but has not been able to get it clean. The above findings were reviewed with the Nursing Home Administrator on September 10, 2025, at 2:30 PM. 28 Pa. Code 201.14 (a) Responsibility of Licensee

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on clinical record review and staff interview, it was determined that the facility failed to ensure accurate clinical documentation for one of 24 residents reviewed for clinical documentation issues (Resident 44; Residents 34 and 122).Findings include: Review of Resident 44's clinical record revealed a section of the electronic health record (EHR) where various documents are uploaded to the medical record for staff to review as needed. Further review of this section for Resident 44 revealed that scans for two other residents, Residents 34 and 122, were uploaded to Resident 44's clinical record. The following documents were erroneously uploaded to Resident 44's medical record: A POLST (Physician Orders for Life-Sustaining Treatment) form for Resident 122 that had an upload and effective date of July 21, 2025. A medication clarification notice for Resident 34 that was dated July 25, 2025. The Nursing Home Administrator and Director of Nursing were informed of the findings on September 10, 2025, at 2:30 PM. The facility failed to ensure an accurate clinical record for Resident 44. 483.70(h) Medical RecordsPreviously cited deficiency 3/6/2025 28 Pa. Code 211.5(i) Medical records 28 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 - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on a review of select facility policies and procedures, clinical record review, observation, and staff interview, it was determined that the facility failed to maintain an infection prevention and control and water management program to provide an environment to help prevent the development and transmission of communicable diseases and infections on two of two nursing units (Upper Level, Residents 4, 6, 19, 32, 57, 59, 64, 78, 123; and Lower Level, Residents 45 and 70). Findings include: The facility policy entitled, Infection Prevention and Control Program, last revised June 1, 2025 revealed that the elements of the infection prevention and control program consist of items that included coordination/oversight, policies, surveillance, and outbreak management. The infection prevention and control program is coordinated and overseen by an infection prevention specialist (infection preventionist) or designee. Surveillance data and reporting information is used to inform the committee of potential issues and trends. Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections, and detecting unusual pathogens with infection control implications. Data gathered during surveillance is used to oversee infections and spot trends. Outbreak management is a process that includes determining the presence of an outbreak, managing affected residents, preventing the spread to other residents, and monitoring for recurrences. The facility policy entitled, Infection Surveillance, last reviewed without changes on June 4, 2025, indicated that the infection preventionist will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that may require transmission-based precautions and other preventative measures. The facility's Infection Control Plan dated August 4, 2025, indicated that the plan outlined the infection prevention and control strategies implemented at the facility to prevent the spread of infectious diseases within the facility; and that the facility would adhere to federal guidelines established by the Centers for Disease Control and Prevention (CDC). Infection preventionist duties include ongoing facility-wide surveillance and reporting of HAI (Health Acquired Infections) and outbreaks. Surveillance is an ongoing process to identify MDROs (multi-drug-resistant organisms, bacteria or viruses that are resistant to many commonly used medications/antibiotics that can cause infections), communicable diseases, outbreaks, infection control practice breaches, and potential HAIs resulting from or involving any service rendered at the facility. Sources for surveillance data include, but are not limited to, laboratory records, infection control rounds and/or interviews, verbal reports from staff, infection document records, pharmacy records, antibiotic review, and transfer logs/summaries. Transmission-based precautions (TBPs) are a set of additional infection control practices used in healthcare settings to prevent the spread of infectious agents that can be transmitted through direct contact, droplets, or airborne particles. These precautions are implemented when a resident is known or suspected to be infected with a highly contagious pathogen and are used in conjunction with standard precautions (which are applied to all residents regardless of infection status). The type and duration of TBPs used at the facility are based on CDC's Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007). The use of isolation signage, medical record flag, and chart documentation is used to ensure the healthcare personnel are aware of the precautions in place. The facility can use the CDC-approved signs for all three types of isolation (contact, droplet, and airborne). Enhanced Barrier Precautions (EBP) is an approach to target gown and glove use during high-contact resident care activities, designed to reduce the transmission of an MDRO. EBP may be applied to residents with wounds or indwelling medical devices, regardless of MDRO colonization status; or to resident with infection or colonization with an MDRO. The facility has a Water Management Plan (WMP) to mitigate waterborne pathogens transmission risks. The facility's Legionella Water Management Pan, last reviewed June 19, 2025, defined Legionnaires' disease as an uncommon form of pneumonia caused by the legionella bacterium. Infection occurs when legionella bacteria has been released into the air from a contaminated source. Bacteria can live in all types of water (including water sources such as hot and cold water systems). Control and prevention includes good design and maintenance to prevent growth. Control Measures and Corrective Actions included identify the routine process of monitoring control measures, complete a flow diagram that can be easily understood by all members of the team, describe where control measures should be applied, describe how to monitor your control measure, and establish ways to intervene when control limits are not met. The facility will utilize the CDC Legionella Control Toolkit (included in the program packet). The facility will clean and maintain water system components weekly. The facility flow

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to offer residents pneumococcal immunizations for four of five residents reviewed for immunizations (Residents 3, 8, 31, and 76).Findings include: Review of the policy entitled Pneumococcal Vaccine Guidelines, last revised March 10, 2025, revealed that the facility will offer residents the pneumococcal vaccine to aid in preventing pneumococcal infections as applicable per physician order. The procedure noted that previous immunization information will be requested during the pre-admission process. A representative from the admissions office/designee will obtain and forward copies of the immunization records to the admitting nurse. Staff will verify the data with the resident and/or authorized representative when applicable. The pre-admission immunizations will be added to the electronic immunization record/EMR. The immunization record/EMR will be updated with each offer (administrations and refusals) of the pneumococcal vaccine. Each age-appropriate and/or diagnosis appropriate resident will be offered a pneumococcal vaccination per physician order, to minimize the risk of acquiring, transmitting, or experiencing complications from pneumococcal pneumonia; unless the vaccine is medically contraindicated, or the resident has already been vaccinated within the designated timeframe. Pneumococcal vaccines recommended for adults (refer to CDC, Centers for Disease Control, pneumococcal vaccine timing for adults) include: 13-valent pneumococcal conjugate vaccine (PCV13, Prevnar 13)15-valent pneumococcal conjugate vaccine (PCV15, Vaxneuvance)20-valent pneumococcal conjugate vaccine (PCV20, Prevnar 20)23-valent pneumococcal conjugate vaccine (PPSV23, Pneumovax 23) The nurse will document the administration of the vaccine in the electronic medical record (EMR). Facility and physicians will refer to CDC Pneumococcal Vaccine Timing for Adults along with resident's pneumococcal vaccine history prior to obtaining/writing physician orders for pneumococcal vaccines. The resident or resident's representative can refuse the vaccination. Declinations must be uploaded into the resident's electronic health record. The surveyor requested the availability of immunization information beyond what was available in the residents' electronic medical records (e.g., a binder of consents or evidence of education provided) during interviews with the Nursing Home Administrator and Director of Nursing on September 10, 2025, at 2:30 PM and September 11, 2025, at 2:30 PM. Clinical record review for Resident 8 revealed that the facility admitted her on October 31, 2017. Resident 8's clinical record indicated that she received a PPSV23 (pneumococcal, pneumovax) immunization on October 1, 2011 (at the age of 64 years), January 1, 2014 (at the age of 68 years), February 3, 2022 (at the age of 75 years), and April 13, 2023 (at the age of 77 years). Resident 8's clinical record contained no evidence of any pneumococcal immunizations except the PPSV23 vaccine. Clinical record review for Resident 3 revealed that the facility admitted him on January 29, 2018. Resident 3's clinical record indicated that he received the PPSV23 immunization on April 3, 2012 (at the age of 51 years). Resident 3's clinical record contained no evidence of any pneumococcal immunizations while a resident at the facility. Clinical record review for Resident 31 revealed that the facility admitted him on February 17, 2022. Resident 31's clinical record indicated that he received the PPSV23 immunization on February 24, 2022 (at the age of 73 years). Resident 31's clinical record contained no evidence of any pneumococcal immunizations except the PPSV23 vaccine. Clinical record review for Resident 76 revealed that the facility admitted her on February 22, 2022. Resident 76's clinical record indicated that she received the PPSV23 immunization on June 22, 2010 (at the age of 64 years), February 28, 2022 (at the age of 75 years), and on April 11, 2023 (at the age of 76 years). Resident 76's clinical record contained no evidence of any pneumococcal immunizations except the PPSV23 vaccine. Resident 76's clinical record indicated that Resident 76's responsible party refused a Prevnar 20 (pneumococcal) immunization May 20, 2025; however, the same documentation indicated that the facility did not provide education regarding the risks and benefits of the vaccine. The surveyor reiterated to the Director of Nursing that the facility had yet to provide additional immunization information beyond what was available in the residents' electronic medical records as requested during the afternoon meetings on September 10 and 11, 2025, during an interview on September 12, 2025, at 9:01 AM. The Director of Nursing instructed the surveyor to email resident immunization concerns to her for review. Email communication to the Director of Nursing on September 12, 2025, at 10:11 AM reported the above immunization concerns for Residents 8, 3, 31, and 76. Interview with the Director of Nursing on September 12, 2025, at 11:35 AM indicated that the facility administered no pneumococcal immunizations in the past year. The facility had no evidence that the four residents were offered the vaccines