STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395846	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Campbelltown	2880 Horseshoe Pike Palmyra, PA 17078

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on facility policy review, resident group interviews, review of facility grievance forms, and staff interview, it was determined that the facility failed to act promptly upon resident grievances. Findings include: Review of a facility policy entitled, Grievance Policy, revealed that the reasonable timeframe the resident could expect a completed review of a grievance was within five days. The grievance official would issue written grievance decisions to the resident. The written grievance decision would include a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. During a confidential group interview conducted on June 4, 2025, at 1:30 p.m., six of 12 residents reported that the facility did not act promptly upon resident grievances. Review of resident grievance forms revealed that grievances were completed and submitted on the following dates: December 31, 2024, February 3, 2025 (three grievances for this date), March 26, 2025, April 8, 2025 (four grievances for this date), and May 1, 2025. There was a lack of evidence that the facility reviewed or investigated the grievances. There was a lack of evidence that the facility determined if corrective action was necessary or issued a written decision to the residents within the reasonable timeframe, per facility policy. In an interview on June 6, 2025, at 10:43 a.m., the Administrator confirmed that there was no evidence the grievances were addressed. 28 Pa. Code 201.14(a) Responsibility of licensee.

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on facility policy review, clinical record review, observation and staff interview, it was determined the facility failed to assess a resident for a physical restraint and conduct an on-going assessment of a restraint for one of 19 sampled residents. (Resident 3) Findings include: Review of the facility policy entitled Physical Restraints, revealed that the need for restraints would be reevaluated monthly and that the interdisciplinary assessment team would develop a comprehensive care plan for the resident. Clinical record review revealed that Resident 3 had diagnoses that included severe intellectual disabilities, anxiety, and lack of coordination. Observations on June 3, 2025 from 11:28 a.m. through 1:30 p.m., June 4, 2025 from 9:00 a.m. through 1:00 p.m., and on June 5, 2025 from 9:37 a.m. through 12:30 p.m., revealed Resident 3 in her wheelchair with a seat belt intact. In an interview on June 5, 2025, at 11:31 a.m., Nurse Aide 1 stated Resident 3 could not self remove the seat belt. There was no documented evidence that the facility obtained a physician's order or rationale for use, or did an initial restraint evaluation and continued restraint assessments to determine if the restraint was needed per facility policy. 28 Pa. Code 211.8(d)(e)(f) Use of restraints.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to notify the resident and the resident's representative of the bed hold and transfer, including the reasons for the move, and Ombudsman information, in writing upon transfer from the facility for seven of seven sampled residents who were transferred to the hospital. (Residents 21, 31, 36, 38, 39, 49, 201) Findings include: Clinical record review revealed that Resident 21 was transferred and admitted to the hospital on [DATE], after a change in condition. There was no documentation to support that the resident's representative was provided written information regarding a bed hold or the transfer to the hospital. Clinical record review revealed that Resident 31 was transferred and admitted to the hospital on [DATE], after a change in condition. There was no documentation to support that the resident's representative was provided written information regarding a bed hold or the transfer to the hospital. Clinical record review revealed that Resident 36 was transferred and admitted to the hospital on [DATE], after a change in condition. There was no documentation to support that the resident's representative was provided written information regarding a bed hold or the transfer to the hospital. Clinical record review revealed that Resident 38 was transferred and admitted to the hospital on [DATE], after a change in condition. There was no documentation to support that the resident's representative was provided written information regarding a bed hold or the transfer to the hospital. Clinical record review revealed that Resident 39 was transferred and admitted to the hospital on [DATE], after a change in condition. There was no documentation to support that the resident's representative was provided written information regarding a bed hold or the transfer to the hospital. Clinical record review revealed that Resident 49 was transferred and admitted to the hospital on [DATE], after a change in condition. There was no documentation to support that the resident's representative was provided written information regarding a bed hold or the transfer to the hospital. Clinical record review revealed that Resident 201 was transferred and admitted to the hospital on [DATE], after a change in condition. There was no documentation to support that the resident's representative was provided written information regarding a bed hold or the transfer to the hospital. In an interview on June 6, 2025, at 9:10 a.m., the Administrator confirmed there was no documentation to support that the above notices were sent.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to complete an accurate Minimum Data Set (MDS) assessment for one of 19 sampled residents. (Resident 28) Findings include: Clinical record review revealed that Resident 28 had diagnoses that included end stage renal disease, diabetes, and dependence on renal dialysis. Review of Resident 28's clinical record revealed a physician's order dated December 19, 2023, for dialysis three time per week. Review of Resident 28's MDS dated [DATE], did not indicate that Resident 28 was dependent on renal dialysis. In an interview on June 5, 2025, at 9:57 a.m., the Administrator confirmed Resident 28's MDS was inaccurate. CFR 483.20(g) Accuracy of Assessments Previously cited 7/18/24

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to complete a Preadmission Screening to identify a mental disorder for one of 19 sampled residents. (Resident 14) Findings include: Clinical record review revealed that Resident 14 was admitted to the facility on [DATE], with diagnoses that included borderline personality disorder, schizoaffective disorder, intermittent explosive disorder, major depressive disorder, and generalized anxiety. There was a lack of evidence that the facility completed or obtained a Preadmission Screening for Resident 14. In an interview on June 6, 2025, at 11:37 a.m., the Administrator confirmed that there was a lack of evidence that the facility completed or obtained a Preadmission Screening for Resident 14.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on clinical record review and resident interview, it was determined that the facility failed to provide services to maintain adequate grooming and hygiene, and assistance with eating for one of 19 sampled residents. (Resident 9) Findings include: Clinical record review revealed that Resident 9 had diagnoses that included multiple sclerosis, muscle weakness, adult failure to thrive, and dysphagia. Review of the care plan revealed that staff were to check the resident's nail length, trim, and clean on bath day and as necessary, and report to the nurse with any changes. On June 3, 2025, at 1:44 p.m., the resident was observed in her room. Her nails were long, dirt was observed under the nails. She stated that she preferred her nails to be short, staff have not offered to provide nail care, and she has not refused. On June 5, 2025, at 11:53 a.m., the resident was observed in bed, her nails remained long. She stated that staff had not offered to provide nail care, and she would like her nails to be cut. Review of the care plan revealed that the resident required assistance from staff with eating. A physician's order dated March 22, 2024, directed staff to assist the resident with feeding at all meals. On June 4, 2025, at 12:36 p.m., the resident was observed in her room with her meal tray on her bedside table. At 12:46 p.m., the resident was observed having difficulty obtaining her utensil that was placed on her meal tray. The resident stated, I am trying to get it, my arms are just too short. The resident was subsequently observed to be using red, built-up foam handles on the utensils. The foam handles continued to slide down the utensils which required the resident to bang the utensils on the table and pull them through the handle with her mouth to continue eating. Staff did not offer or provide the resident with any assistance with the meal until 1:12 p.m. , 36 minutes after she was observed with the meal tray. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to assess and document the status of wounds or provide physician ordered treatments to prevent new or worsened pressure ulcers for six of six sampled residents with wounds. (Residents 9, 24, 28, 36, 38, 201) Findings include: Review of the facility policy entitled, Skin and Wound Management Policy, last revised April 3, 2025, revealed that residents identified with skin impairments, their wound status would be assessed and documented in the electronic medical record, on the Wound Evaluation Flow Record by the Registered Nurse; for residents followed by contracted wound physician services or wound clinic physician, the facility would utilize the physician wound progress note to monitor wound status in addition to the in house Registered Nurse assessment. Clinical record review revealed that Resident 9 had diagnoses that included multiple sclerosis and adult failure to thrive. Review of wound consultation notes revealed that the resident had a stage four pressure ulcer to the sacrum (a bone at the base of the spine). A physician's order dated May 3, 2025, directed staff to apply calcium alginate (a wound dressing) and cover with a dressing every evening (3:00 p.m. to 11:00 p.m.) shift. Review of the Treatment Administration Record (TAR) for May 2025, revealed that there was a lack of evidence that staff provided the treatment as ordered on May 8, 10, 11, 17, and 21, 2025. A physician's order dated May 22, 2025, directed staff to apply calcium alginate and Santyl (a medication that removes dead tissue from wounds) to the wound and cover with a dressing every day (7:00 a.m. to 3:00 p.m.) shift. Review of the TAR for May 2025, revealed no evidence that staff provided the treatment as ordered on May 24 and 26, 2025. Clinical record review revealed that Resident 24 had diagnoses that included end stage renal disease, protein calorie malnutrition. Review of wound consultation notes revealed that the resident had a stage four pressure ulcer to the sacrum. On May 13, 2025, a nurse noted that the resident reported her wound care was not completed regularly. In an interview on June 5, 2025, at 12:30 p.m., the resident stated that staff are not always providing her wound care as ordered. A physician's order dated May 7, 2025, directed staff to cleanse the sacral wound with saline, pack the wound with a gauze soaked in 1/4 strength dakins, apply skin prep to the peri wound and cover with a gauze island dressing on the day shift, and evening shift daily. Review of the TAR for May 2025, revealed a lack of evidence that staff provided wound care as ordered on the evening shift on May 8 and 11, 2025, and the day shift on May 11, 13, and 15, 2025. There were no documented refusals. On May 20, 2025, the resident was assessed and treated by the wound care consultation company. The treatment orders to be implemented at that time were to continue with the 1/4 strength dakins solution with gauze island dressing and apply skin prep twice daily. There was no evidence that any wound treatment was ordered or completed on any shift from May 16 through 28, 2025. In an interview on June 6, 2025, at 1:00 p.m., the Infection Preventionist confirmed that there was no evidence that any wound care was completed for Resident 24 from May 16 through 28, 2025. Clinical record review revealed that Resident 28 had diagnoses that included end stage renal disease and a below the knee amputation. Review of the wound consultant note dated April 24,2025, revealed that Resident 28 had a pressure ulcer to the buttocks. There was no documented evidence that a Registered Nurse assessed or evaluated the wound per policy. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clinical record review revealed that Resident 36 had diagnoses that included lymphedema (accumulation of protein-rich fluid in the soft tissues, most frequently the arms and legs) and cellulitis (bacterial infection of the skin) of the left lower leg. Review of the wound consultant notes revealed that Resident 36 had an infected wound on the left leg. A physician's order dated April 23, 2025, directed staff to cleanse the left leg wound with normal saline solution (NSS), apply collagen silver soaked gauze and cover with bordered gauze. Review of Resident 36's May 2025 treatment administration record (TAR) revealed a lack of documentation to support that the treatment to her leg had been completed on May 8, 10, 11, 13, and 17, 2025. There was no documented evidence that a weekly skin assessment was completed since April 25, 2025. Clinical record review revealed that Resident 38 had diagnoses that included metabolic encephalopathy (change in brain function) and multiple sclerosis (autoimmune disease that affects the central nervous system). A physician's order dated May 16, 2025, directed staff to cleanse the left buttock open area with NSS and apply a foam dressing three times per week. There was no documented evidence that a Registered Nurse assessed or evaluated the wound per policy. Clinical record review revealed that Resident 201 had diagnoses that included osteomyelitis (infection in the bone) and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Review of the wound consultant notes revealed that Resident 201 had stage 4 pressure sores (full-thickness skin and tissue loss, exposing muscle, tendon, or bone) on his left heel, right heel, and right medial foot, with the right foot having osteomyelitis. A physician's order dated April 25, 2025, directed staff to cleanse the both heels and lateral foot wounds with NSS, dry, apply med-honey, and then border dressings, and wrap with kling every evening shift. Review of Resident 201's April 2025 TAR revealed a lack of documentation to support that the treatment to his feet had been completed on April 28, 2025. On May 8, 2025, the physician's order changed to twice daily. Review of Resident 201's May 2025 TAR revealed a lack of documentation to support that the treatment to his feet had been completed on May 8, 11, and 30, 2025. A physician's order dated June 4, 2025, directed staff to cleanse the left heel with NSS, apply 1/4 strength Dakin's soaked gauze, apply an abdominal (ABD) gauze pad and wrap in Kerlix (bandage roll) three times a day. Review of Resident 201's June 2025 TAR revealed a lack of documentation to support that the treatment to his left heel had been completed on June 4, 2025. There was no documented evidence that a weekly skin assessment was completed since May 3, 2025. In an interview on June 6, 2025, at 12:43 p.m., the Infection Preventionist confirmed that there was no documented evidence that the residents' wound treatments had been completed as ordered on the above dates and skin assessments should have been performed weekly and documented in the residents' electronic medical record. 28 Pa Code 211.12 (d)(1)(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. Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure that adequate catheter care was provided for two of two sampled residents with an indwelling urinary catheter. (Residents 24 and 31) Findings include: Review of the facility policy entitled, Urinary Catheter Care, last revised January 31, 2013, revealed that staff would perform perineal care to the resident every eight hours to prevent skin rashes and breakdown, empty the collection bag at least every eight hours and as needed (PRN), cleanse the catheter from the insertion site to approximately four inches outward, and check the drainage tubing and bag to ensure that the catheter was draining properly and kept off of the floor. Clinical record review revealed that Resident 24 had diagnoses that included urogenital implants. The resident required the use of a urinary catheter. On May 1, 2025, a physician's order for foley catheter care every shift was discontinued. There was no new order for catheter care placed and the resident continued with a foley catheter. There was a lack of evidence that catheter care was provided to the resident since May 1, 2025. Clinical record review revealed that Resident 31 had diagnoses that included diabetes mellitus and urinary retention. On October 6, 2023, the physician ordered for the resident to have an indwelling catheter. Observations on June 3, 2025, at 10:30 a.m., June 4, 2025, at 12:50 pm, and June 5, 2025, at 11:15 a.m., revealed Resident 31 was lying in bed with his indwelling catheter in place. There was no documented evidence that staff provided catheter care per facility policy. In an interview on June 6, 2025, at 11:53 a.m., the Infection Preventionist confirmed that there was no documented evidence that Resident 24's and 31's catheter care was provided per facility policy. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to adequately monitor and assess the nutritional status for seven of seven sampled residents at nutritional risk. (Residents 2, 9, 13, 18, 24, 28, and 38) Findings include: Review of the faiclity policy entitled, Nutrition Management, revealed that the facility would view bilateral edema and muscle wasting as potential indicators for malnutrition. The facility would also consider depression, dementia, and therapeutic and mechanically altered diets as potential risk factors for malnutrition. Clinical record review revealed that Resident 2 had diagnosis that included diabetes and feeding difficulties. Review of the Minimum Data Set assessment dated [DATE], revealed the resident had no cognitive impairment and required supervision or touching assistance with eating. Review of the current care plan revealed Resident 2 had a nutritional problem with an intervention to monitor and record weights. A physician's order dated March 2, 2024, directed staff to weight the resident monthly. There was no documented evidence that the resident was weighed as ordered in October or November 2024, or February or March 2025. There was no documented evidence that Resident 2 was evaluated by a dietitian or qualified nutrition professional. Clinical record review revealed that Resident 9 had diagnoses that included muscle weakness, dysphagia, pressure ulcers, and adult failure to thrive. Review of the current care plan revealed that the resident was at nutritional risk due to a history of weight loss, and impaired skin integrity. There was no evidence that a registered dietitian or qualified nutrition professional assessed the resident's nutritional status and risk for malnutrition since July of 2024. A physician's order dated November 10, 2023, directed staff to weigh the resident once per month. There was a lack of evidence that staff weighed the resident in February of 2025. There was no documented refusal. Clinical record review revealed Resident 13 had diagnosis that included diabetes. Review of the current care plan revealed Resident 13 had a nutritional risk with an intervention to monitor and record weights. A physician's order dated July 6, 2023, directed staff to weigh the resident monthly. There was no documented evidence that the resident was weight in May 2025. There was no documented evidence that Resident 2 was evaluated by a dietitian or qualified nutrition professional. Clinical record review revealed Resident 18 was admitted to the facility April 15, 2025, with diagnoses that included diabetes, hypertension (high blood pressure), and irritable bowel syndrome. Review of the current care plan revealed Resident 18 had a nutritional risk. There was no documented evidence that Resident 18 was evaluated by a dietitian or qualified nutrition professional since admission. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clinical record review revealed that Resident 24 had diagnoses that included major depressive disorder, end stage renal disease with hemodialysis, protein calorie malnutrition, and pressure ulcers. Review of physician's orders dated May 2, 2025, directed staff to weigh the resident daily at 6:00 a.m. on Tuesday, Thursday, Saturday, and Sunday, and on the night shift on Monday, Wednesday, and Fridays, due to congestive heart failure. Review of the Treatment Administration Record (TAR) for May 2025, revealed that there was a lack of evidence that staff weighed the resident on May 5, 11, 16, 17, 18, 21, 22, 25, 28, and 29, of 2025. There were no documented refusals. Further review of the clinical record revealed no evidence that a registered dietitian or qualified nutrition professional assessed the resident's nutritional status between August 17, 2024, and March 14, 2025. Clinical record review revealed Resident 28 had diagnoses that included end stage renal disease, diabetes, and dependence on renal dialysis. Review of the current care plan revealed Resident 28 had a nutritional risk with an intervention for the dietitian to evaluate. There was no documented evidence that Resident 28 was evaluated by a dietitian or qualified nutrition professional since 2023. Clinical record review revealed Resident 38 was admitted to the facility on [DATE], with diagnosis that included metabolic encephalopathy (change in brain function), multiple sclerosis (autoimmune disease that affects the central nervous system), and dysphagia (difficulty swallowing). Review of the current care plan revealed Resident 38 had a nutritional risk and required a feeding tube with an intervention for the dietitian to evaluate quarterly. There was no documented evidence that Resident 38 was evaluated by a dietitian or qualified nutrition professional. In an interview on June 6, 2025, at 10:27 a.m., the Administrator confirmed that there was no evidence that the residents' nutritional status was assessed and that the residents should have been reviewed monthly. CFR 483.25(g)(1) Maintain acceptable parameters of nutritional status. Previously cited 7/18/24 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on clinical record review and staff interview, it was determined that the facility failed to ensure that as needed pain medication was administered per the physician's order and that nonpharmacological interventions were attempted prior to the administration of as needed pain medication for one of 19 sampled residents. (Resident 24) Findings inlcude: Clinical record review revealed that Resident 24 had diagnoses that included muscle weakness, low back pain, and neuropathy. Review of the care plan revealed that the resident was on pain medication therapy and that pain medication was to be administered as ordered. A physician's order dated May 5, 2025, directed staff to administer oxycodone (a narcotic pain medication) every four hours as needed for severe pain at pain levels seven through ten. Review of the Medication Administration Record (MAR) for May 2025, revealed that staff administered the oxycodone when the resident's pain was noted at a level less than seven on 24 occasions in May 2025. Review of a physician's order dated May 31, 2025, directed staff to administer oxycodone every four hours as needed for severe pain at pain levels seven through ten, and to ensure that at least two non-pharmacological interventions were attempted before the pain medication was administered. Review of the June 2025 MAR revealed that staff administered the oxycodone when the resident's pain level was less than seven on four occasions in June 2025. In addition, there was no evidence that staff attempted two nonpharmacological interventions prior to the administration of the as needed pain medication on eight of nine occasions in June 2025. In an interview on June 6, 2025, the Infection Preventionist confirmed that the as needed pain medication was administered outside of the physician ordered parameters. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure that staff provided services consistent with professional standards, including monitoring and ongoing communication, for two of two sampled residents receiving dialysis (process of removing excess toxins and water from the blood). (Residents 24, 28) Findings include: Review of the facility policy entitled, Hemodialysis Policy and Procedure, revealed a communication notebook with relevant information regarding the resident's medication, condition, and treatment would be shared between the facility and the dialysis provider. In addition, nursing staff would check the access site to ensure appropriate function, prevent infection, and prevent coagulation (blood clotting) at the site each shift. Clinical record review revealed that Resident 24 had a diagnosis of end stage renal disease which required dialysis. Review of the resident's dialysis communication forms revealed no evidence that staff had completed and obtained dialysis communication forms with information from the dialysis center for any dialysis sessions completed during the week of May 4, 2025, or between the dates of May 26, 2025, and June 4, 2025. A physician's order dated January 27, 2024, directed staff to monitor the resident's dialysis catheter site every shift. Review of the resident's treatment administration record (TAR) for May 2025, revealed no evidence that staff monitored the catheter site on the night shift (11:00 p.m. to 7:00 a.m.) on May 2, 2025, or on the evening shift (3:00 p.m. to 11:00 p.m.) on May 17, 2025. In an interview on June 5, 2025, at 2:31 p.m., the resident stated that staff do not always monitor her dialysis catheter site. On May 5, 2025, a physician ordered for staff to document the post dialysis weight obtained at the facility every day shift (7:00 a.m. to 3:00 p.m.), every Monday, Wednesday, and Friday. Review of the TAR for May 2025, revealed that there was a lack of evidence that the facility obtained and documented the post dialysis weights on May 16, 19, and 21, 2025. Clinical record review revealed that Resident 28 had diagnoses that included end-stage renal disease and had a physician's order for hemodialysis three times a week. There was no documented evidence to support that the facility monitored Resident 28's access site each shift per policy. During an interview on June 6, 2025, at 9:57 a.m., the Infection Control Nurse confirmed that there was no documented evidence that Resident 28's access was monitored per policy. CFR 483.25(l) Dialysis Previously cited 7/18/24 28 Pa. Code 211.12(1)(3)(5) Nursing services.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interview, and a review of facility documentation it was determined that the facility failed to provide care in accordance with resident preference and plan of care due to insufficient staffing. Findings include: Clinical record review revealed Resident 18 was admitted to the facility on [DATE] with diagnosis that included difficulty in walking and weakness. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident 18 was alert and oriented. Review of the care plan revealed Resident 18 required assistance from staff with transferring. In an interview on June 3, 2025, at 12:19 p.m., Resident 18 stated she wanted to get out of bed on Sunday but could not because there was not enough staff. Review of Resident 18's clinical record revealed a lack of documentation that she was transferred out of bed on Sunday. Review of the facility staffing documentation for Sunday, June 1, 2025, revealed the facility failed to meet the required Nurse Aide ratios, Licensed Practical Nurse ratios, Registered Nurse ratios, and minimum direct care hours per resident. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.12(d)(4)(5) Nursing services.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on review of facility personnel files and staff interview, it was determined that the facility failed to ensure that licensed nursing staff demonstrated competencies and skill sets necessary to care for residents' needs. Findings include: In an interview on June 6, 2025, at 9:23 a.m. the Administrator confirmed that the facility did not conduct any in-service training or skills competency evaluations for licensed nursing staff. 28 Pa. Code 201.20(a)(b) Staff development. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on review of facility personnel files and staff interview, it was determined that the facility failed to ensure that nurse aides received annual education necessary to care for residents' needs. Findings include: In an interview on June 6, 2025, at 9:23 a.m. the Administrator confirmed that the facility did not conduct any in-service training or skills competency evaluations for nurse aides. 28 Pa. Code 201.20(a)(b) Staff development. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure that pharmacy recommendations were reviewed by the physician in a timely manner for four of five sampled residents. (Residents 14, 24, 44, 47) Findings include: Review of the facility policy entitled, Pharmacy Services, revealed that a licensed pharmacist would review the drug regimen of each resident at least once per month. The pharmacist would report any irregularities to the attending physician, the Director of Nursing, and the Medical Director. The reports would be acted upon, signed off, and addressed in the physician's progress note. Clinical record review revelaed that Resident 14 was admitted to the facility on [DATE], with diagnoses that inlcuded schizoaffective disorder, intermittent explosive disorder, major depressive disorder, and anxiety. Review of monthly drug regimen reviews revealed that the pharmacist made recommendations regarding Resident 14's medications on February 28, 2025, and April 30, 2025. There was no evidence that the recommendations were addressed by the physician. Clinical record review revelaed that Resident 24 had diagnoses that included anxiety and depression. Review of monthly drug regimen reviews revealed that the pharmacist made recommendations regarding Resident 24's medications on January 17, 2025, February 28, 2025, and April 30, 2025. There was no evidence that the recommendations were addressed by the physician. Clinical record review revealed that Resident 44 was admitted to the facility on [DATE], with diagnoses that included emphysema and a left femur fracture (broken leg). Review of the clinical record revealed that the pharmacist made recommendations regarding Resident 44's medications on March 31, 2025. There was no documentation to indicate what the recommendations were or that they were addressed by the physician. Clinical record review revealed that Resident 47 was admitted to the facility on [DATE], with diagnoses that included cerebral infarction (occurs when blood supply to part of the brain is blocked or reduced), dementia, and dysphagia (difficulty swallowing). Review of the clinical record revealed that the pharmacist made recommendations regarding Resident 47's medications on January 28 and February 28, 2025. There was no documentation to indicate what the recommendations were for January or February, or that they were addressed by the physician. In an interview on June 6, 2025, at 10:33 a.m., the Administrator confirmed that there was no documentation regarding specific pharmacy recommendations noted above and/or that they were acted upon in a timely manner. CFR 483.45 Drug Regimen Review (c)(1)(4)(ii)(iii) Previously cited 7/18/24 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and clinical record review, it was determined that the facility failed to ensure that medications/biologicals were securely stored in a medication or treatment cart in on one of one nursing units. Findings include: Observations on June 3, 2025, at 12:19 p.m., in Resident 14's revealed a tube of medicated cream on the bed. Clinical record review revealed no assessments for medication self administration or bedside storage of medications. Observations on June 4, 2025, at 8:37 a.m., and on June 5, at 10:15 a.m. and 12:00 p.m., in Resident 43's room revealed two bottles of nasal medications on the bedside table. Clinical record review revealed no assessments for medication self administration or bedside storage of medications. CFR 438.45(H) Storage of Drugs and Biologicals Previously cited 7/18/24 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on staff interview, it was determined that the facility failed to employ a full-time, qualified dietary services manager in the absence of a full-time qualified dietitian. Findings include: During an interview on June 3, 2025, at 11:43 a.m., the Director of dining stated that the facility did not employ a certified dietary manager or a full-time qualified dietitian. In an interview on June 6, 2025, at 12:57 p.m., the Administrator confirmed that there was not a full-time dietitian employed onsite at the facility and there were no regularly scheduled consultations with a qualified dietitian in the absence of a qualified certified dietary manager. CFR 483.60 (a)(2) Staffing Previously cited 12/17/24 28 Pa. Code 201.18(b)(3) Management

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, review of facility documentation, resident interview, staff interview, and results of a test tray audit, it was determined that the facility failed to provide food that was palatable and at an appetizing temperature on the nursing unit. Findings include: Review of the facility's Meal Test Tray, form revealed that hot foods were to be above 135 degrees Fahrenheit (F) when served. In an interview on June 3, 2025, at 11:30 a.m., resident 28 stated that the food was often served cold. A test tray conducted on June 4, 2025, at 12:36 p.m., on the nursing unit, revealed mixed vegetables at a service temperature of 116.6 degrees F. The Director of dining stated that the hot foods should be served at a temperature of 135-140 degrees F. In an interview during the lunch meal on June 4, 2025, at 12:43 p.m., Resident 201 stated that the mixed vegetables were cold when served. 28 Pa. Code 201.14 Responsibility of licensee.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 that the facility failed to store and serve food under sanitary conditions in the kitchen and on the nursing unit. Findings include: Observations in the kitchen on June 3, 2025, at 10:27 a.m., revealed the following: There was an accumulation of debris, which included food particles, under the dish machine. There were flies in the dishwashing area. There was a disconnected hose on the back of the ice machine that was leaking water onto the floor. There was an accumulation of water on the floor under the hose. The floor under the clean dish racks was dirty with an accumulation of debris. The inside of the microwave was soiled with various colored substances. There was an accumulation of dust on the grate cover of the juice machine. There was a bin of sugar with a measuring cup stored inside of the bin, in contact with the sugar. There was an open box of orange apple juice that was connected to the hose for the juice machine. The box was bulging and stained. The box of juice was dated March 6, there was no year noted. The Director of dining stated that the juice should be used or discarded within one month of opening. There were two other boxes of juice that were open and connected to the juice machine; they were not dated. The plastic pieces that connect the juice bag and hose to the juice machine were soiled with dried juice and particles of debris. In the walk-in refrigerator, there was a box of raw ground beef stored above ready to eat ham lunch meat. There was a container of prepared green beans dated May 27. The Director of dining stated that prepared items were to be used or discarded within three days. There was a container of strawberry jelly without a legible date. The latch on the top of the refrigerator door was not in working order. The door did not latch closed on its own and remained propped open if it was not manually lifted to latch shut and form a seal. In the walk-in freezer, there was a significant accumulation of ice inside of the entry way. The ice accumulated on the floor, shelves, and boxes of food products. There were two cooling neck rings stored on the shelf with resident food. In the food preparation area, there were dirty ceiling tiles above a food preparation table. There were flies in this same area. There was a broom and a dust pan stored next to a food preparation and storage table. There was a leaking pipe behind the same table. There was an accumulation of dust and debris on the surface of the cooking utensil storage drawers. In the dry storage room, there were dented cans of applesauce and pears. There were five bags of yellow cake mix dated February 17, and ten bags of chocolate cake mix dated January 15. All of the bags had been removed from the original boxes, there was no manufacturer use by date on the bags and the written date did not include a year. There were six bottles of prune juice dated April 4, 2025. There was a large hole in the wall of the dry storage room. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of the tray line service on June 3, 2025, at 12:05 p.m., revealed flies in the areas where resident trays were being assembled. There were flies on the clean cooking tools hanging from the storage rack. During this observation period, Dietary Aide (DA) 1, was observed using gloved hands to place potato fries on resident meal trays. DA 1 was then left the trayline, obtained bread and cheese, assembled and prepared grilled cheese sandwiches for resident trays. DA 1 then returned to the tray line and continued to place potato fries on resident meal trays. DA 1 did not change gloves or perform hand hygiene between tasks. During this same observation period, the refrigerator door was not properly latched closed and remained open for a total of seven minutes. Observation of the kitchen on June 4, 2025, at 11:56 a.m., revealed that there was debris and moisture on the drain grate and floor tiles under the sink in the food preparation table. There were small flies observed in that area. The dish machine sanitizer concentration log was observed to be incomplete for the morning of June 4, 2025. In an interview, DA 1 stated that although not documented, the concentration was tested for the morning of that date using a test strip that resulted in a green colored strip. Observation of the dish machine revealed that the machine used a chlorine based sanitizing solution, which are tested with chemical test strips that show a purple result. DA 1 used the incorrect tests strips that would not have properly indicated the concentration of that chemical sanitizer. Observation of the microwave on the nursing unit on June 5, 2025, at 12:00 p.m., revealed an accumulation of various colored substances adhered to the inside top if the microwave. 28 Pa. Code 210.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(2.1) Management.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on review of facility documentation and staff interview, it was determined that the facility's Quality Assurance Committee failed to meet on a quarterly basis. Findings include: Review of the facility documentation revealed no record that the facility's Quality Assurance Committee had met since January 2024. In an interview on June 5, 2025, at 11:59 a.m., the Administrator confirmed that there was no record that the facility's Quality Assurance Committee had met. CFR 483.75(g) Quality assessment and assurance. Previously cited 7/18/24 28 Pa code 201.18(b)(3) Management.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on facility policy review, clinical record review, and observation, it was determined that the facility failed to follow policies and procedures to prevent the spread of infection for three of 19 sampled residents. (Residents 28, 38, 201) In addition, the facility failed to have a documented water management program for Legionella. Failure to have a water management program had the potential to affect 45 of 45 residents in the facility. Findings include: Review of the facility policy entitled, Enhanced Barrier Precautions, revealed that enhanced barrier precautions (EBP) were to be used with any resident with a wound or indwelling medical device during encounters when contact was expected, including during wound care and the care of feeding tubes. Precautions included the use of protective gowns and gloves during high-contact care activities. Observations made during all days of the survey revealed none of the residents with chronic wounds or indwelling medical devices had signs posted to indicate that personal protective equipment (PPE) was required and no PPE was observed to have been available for use. Clinical record review revealed that Resident 28 had diagnoses that included a history of end stage renal disease with dependence on renal dialysis (a machine that filters wastes, salts, and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately). He received dialysis through a central venous catheter (a flexible tube inserted into a large vein in the neck, chest, or groin to provide access for dialysis treatments). On June 4, 2025, at 11:37 a.m., a nurse aide (NA 1) was observed entering resident 29's room to provide care. NA 1 did not use a protective gown in accordance with facility policy. Clinical record review revealed that Resident 38 had diagnoses that included a history of metabolic encephalopathy (a disorder that affects brain function) with difficulty swallowing. She received all nutrition through a feeding tube. On June 4, 2025, at 9:37 a.m., a licensed practical nurse (LPN 1) was observed flushing the feeding tube without wearing a gown as required by facility policy. Clinical record review revealed that Resident 201 had diagnoses that included a Stage 4 pressure sore on his left heel. On June 5, 2025, at 10:06 a.m., LPN 1 was observed entering Resident 201's room to provide wound care. LPN 1 did not use a protective gown in accordance with facility policy. In an interview on June 5, 2025, at 10:45 a.m., the Infection Preventionist confirmed that the Enhanced Barrier Precautions policy had not yet been implemented and was not being followed by staff. Review of the facility's Emergency Preparedness Plan and Infection Control Policies revealed no evidence of a water management program for Legionella. In an interview on June 6, 2025, at 12:43 p.m., the Administrator confirmed that there was no documented evidence that the water had been tested for Legionella. 28 Pa. Code 201.18(b)(1)(d) Management. 28 Pa. Code 211.10(b)(d) Resident care policies. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, it was determined that the facility failed to maintain an effective pest control program in the kitchen and on the nursing unit. Findings include: Observations in the kitchen on June 3, 2025, at 10:27 a.m. and 12:05 p.m., revealed flies in the dishwashing and food preparation areas. Observations on the nursing unit on June 3, 2025, from 10:28 a.m. through 12:40 p.m., revealed flies in resident rooms [ROOM NUMBER], at the nurses station, and in the resident shower room. Observations on the nursing unit on June 4, 2025, from 10:10 a.m. through 1:00 p.m., revealed flies in resident rooms [ROOM NUMBERS], and in the hallway by the food cart that was holding resident meal trays during the tray service. 28 Pa. Code 201.18(b)(3)(e)(2.1) Management