STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395853	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crawford Care Center	20881 State Highway 198 Saegertown, PA 16433

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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 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. Based on review of facility policies, clinical records, and staff interview it was determined that the facility failed to provide the resident and/or resident representative with a written notice of the facility bed-hold policy (explanation of how long a bed can be held during a leave of absence and the cost per day), and failed to make certain that the necessary resident information was communicated to the receiving health care provider upon transfer to the hospital for five of five residents reviewed (Residents R2, R3, R5, R7, and R56). Findings include: Facility policy entitled Bed-Hold Notice dated 1/22/26, indicated that It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold practices both well in advance, and at the time of, a transfer for hospitalization or therapeutic leave. The policy further revealed In the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed-hold policies to the resident and/or the resident representative within 24 hours. The facility will document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative. The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or representative in the resident's file and/or medical record. and The facility will provide this information to all facility residents, regardless of their payment source. Facility policy entitled Transfer and Discharge (including AMA [against medical advice]) dated 1/22/26, indicated that for a transfer to another provider, for any reason, the following information must be provided to the receiving provider: contact information for the practitioner responsible for care of resident, resident representative information, advanced directive, information necessary to meet the resident's needs, special instructions and/or precautions for ongoing care, and care plan goals. Resident R2's clinical record revealed an admission date of 12/4/24, with diagnoses that included chronic obstructive pulmonary disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), bipolar disorder (a mental health condition where you experience extreme mood swings that include emotional highs and lows. It causes significant shifts in mood, energy, activity levels, and concentration, affecting a person's overall functioning), and hypertension (high blood pressure). Resident R2's progress notes revealed notes dated 8/9/25, 8/20/25, 12/24/25, 1/13/26, and 3/6/26, indicating transfers to the hospital. Resident R2'2 clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. The clinical record also lacked evidence indicating that he/she and/or their representative were provided with a copy of the bed-hold policy upon transfers on 8/9/25, 8/20/25, 12/24/25, 1/13/26, and 3/6/26. Resident R3's clinical record revealed an admission date of 7/26/24, with diagnoses that included Parkinson's (a chronic and progressive movement disorder that causes shaking, slows a person's ability to move and worsens over time), vascular dementia (a disease that affects short term memory and the ability to think logically), and hypertension. Resident R3's progress notes revealed notes dated 8/14/25, 11/1/25, and 4/13/26, indicating transfers to the hospital. Resident R3's clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. The clinical record also lacked evidence indicating that Resident R3 and/or his/her representative were provided with a copy of the bed-hold (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	policy upon transfers on 8/14/25, 9/26/25, 11/1/25, 2/11/26, and 4/13/26. Resident R5's clinical record revealed an admission date of 3/16/18, with diagnoses that included hypertension, major depressive disorder, and insomnia (difficulty sleeping).Review of Resident R5's progress notes revealed notes dated 12/12/25, and 1/11/26, indicating transfers to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. His/her clinical record also lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon transfers on 12/12/25, and 1/11/26. Resident R7's clinical record revealed an admission date of 7/23/25, with diagnoses that included sleep apnea (a sleep disorder that causes breathing to stop and start multiple times during sleep), COPD, and diabetes (a health condition caused by the body's inability to produce enough insulin). Resident R7's progress notes revealed notes dated 12/14/25, indicating transfers to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. His/her clinical record also lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon transfers on 12/14/25. Review of Resident R56's clinical record revealed an admission date of 9/13/2024, with diagnosis that included but not limited to Dementia (a decline in cognitive function including memory, language, problem solving and thinking), Macular degeneration (vision loss affecting the central vision needed. Damage to the macula in the retina) of both eyes, Anxiety, and cognitive communication deficit. Review of Resident R56's progress notes revealed notes dated 1/12/2026, indicating transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. His/her clinical record also lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon transfers on 1/12/2026. During an interview on 4/29/26, at 3:14 p.m. the Director of Nursing confirmed that Residents R2, R3, R5, R7, and R56, clinical records lacked evidence that the necessary clinical information was provided to the receiving healthcare provider and lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon transfer. He/she also confirmed when the transfers occurred clinical information should have been provided to the receiving healthcare provider and bed hold policy should have been provided to the resident/representative upon transfer. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(c.3) (2) Resident rights

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to ensure that the attending physician documented required visits by writing, signing, and dating a physician progress note for each visit for 12 of 24 residents reviewed (Residents R2, R3, R5, R11, R13, R14, R25, R39, R42, R58, R60, and R94).Findings include: Facility policy entitled Physician Visits and Physician Delegation dated 1/22/26, revealed The resident must be seen at least once every 30 calendar days for the first 90 calendar days after admission and at least every 60 days thereafter by physician or physician delegate as appropriate by state law, Date, write, and sign a progress note for each visit and A physician visit is considered timely if it occurs no later than 10 days after the date the visit was required. Resident R2's clinical record revealed an admission date of 12/4/24, with diagnoses that included chronic obstructive pulmonary disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), bipolar disorder (a mental health condition where you experience extreme mood swings that include emotional highs and lows, causing significant shifts in mood, energy, activity levels, and concentration, affecting a person's overall functioning), and hypertension (high blood pressure). Resident R2's clinical record revealed the last documented physician progress note was 2/12/26. The clinical record lacked evidence of any physician progress notes being completed between 2/12/26, and 4/30/26, which is 7 days past the 10-day grace period for the required visit. Review of Resident R3's clinical record revealed an admission date of 7/26/24, with diagnoses that included Parkinson's (a chronic and progressive movement disorder that causes shaking, slows a person's ability to move and worsens over time), vascular dementia (a disease that affects short term memory and the ability to think logically), and hypertension. Resident R3's clinical record revealed the last documented physician progress note was 1/16/26. The clinical record lacked evidence of any physician progress notes being completed between 1/16/26, and 4/30/26, which is 33 days past the 10-day grace period for the required visit. Resident R5's clinical record revealed an admission date of 3/16/18, with diagnoses that included hypertension, major depressive disorder, and insomnia (difficulty sleeping).Resident R5's clinical record revealed the last documented physician progress note was 1/22/26. The clinical record lacked evidence of any physician progress notes being completed between 1/22/26, and 4/30/26, which is 27 days past the 10-day grace period for the required visit. Resident R11's clinical record revealed an admission date of 5/8/25, with diagnoses that included sleep apnea (a sleep disorder that causes breathing to stop and start multiple times during sleep), diabetes (a health condition caused by the body's inability to produce enough insulin), and hypertension. Resident R11's clinical record revealed the last documented physician progress note was 1/16/26. The clinical record lacked evidence of any physician progress notes being completed between 1/16/26, and 4/30/26, which is 36 days past the 10-day grace period for the required visit. Review of Resident R13's clinical record revealed an admission date of 3/13/24, with diagnoses that include Alzheimer's disease (brain disorder that slowly destroys memory, thinking skills, and, over time the ability to carry out the simplest tasks), anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and hyperlipidemia (high cholesterol). Resident R13's clinical record revealed the last documented physician progress note was 1/22/26. The clinical record lacked evidence of any physician progress notes being completed between 1/22/26, and 4/30/26, which is 27 days past the 10-day grace period for the required visit. Resident R14's clinical record revealed an admission date of date of 11/27/23, with diagnoses that included muscle wasting and atrophy (loss of muscle tissue resulting in decreased size and strength), weakness, and hypertension.Resident R14's clinical record revealed the last documented physician progress note was 1/29/26. The clinical record lacked evidence of any physician progress notes being completed between 1/29/26, and 4/30/26, which is 20 days past the 10-day grace period for the required visit. Review of Resident R25's clinical record (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed an admission date of 2/15/26, with diagnoses that included COPD, anxiety, and hypertension. Resident R25's clinical record revealed the last documented physician progress note was 2/19/26. The clinical record lacked evidence of any physician progress notes being completed between 2/19/26, and 4/30/26, which is 30 days past the 10-day grace period for the required visit. Resident R39's clinical record revealed an admission date of 1/9/25, with diagnoses that included anxiety, insomnia, and hypertension.Resident R39's clinical record revealed the last documented physician progress note was 1/22/26. The clinical record lacked evidence of any physician progress notes being completed between 1/22/26, and 4/30/26, which is 27 days past the 10-day grace period for the required visit. Resident R42's clinical record revealed an admission date of 4/26/24, with diagnoses that included COPD, dementia, and anxiety.Resident R42's clinical record revealed the last documented physician progress note was 1/22/26. The clinical record lacked evidence of any physician progress notes being completed between 1/22/26, and 4/30/26, which is 27 days past the 10-day grace period for the required visit. Review of Resident R58's clinical record revealed an admission date of 9/11/24, with diagnoses that included Alzheimer's disease, hypertension, and chronic kidney disease (a disease that affects the kidney's ability to filter waste products and extra fluid from the body). Resident R58's clinical record revealed the last documented physician progress note was 1/22/26. The clinical record lacked evidence of any physician progress notes being completed between 1/22/26, and 4/30/26, which is 27 days past the 10-day grace period for the required visit. Resident R60's clinical record revealed an admission date of 10/2/1018, with diagnoses that included Alzheimer's disease, diabetes, and dementia. Resident R60's clinical record revealed the last documented physician progress note was 1/29/26. the clinical record lacked evidence of any physician progress notes being completed between 1/22/26, and 4/30/26, which is 9 days past the 10-day grace period for the required visit. Resident R94's clinical record revealed an admission date of 10/6/21, with diagnoses that included COPD, sleep apnea, and hypertension. Resident R94's clinical record revealed the last documented physician progress note was 1/16/26. The clinical record lacked evidence of any physician progress notes being completed between 1/16/26, and 4/30/26, which is 36 days past the 10-day grace period for the required visit. During an interview on 4/30/26, at 10:46 a.m. the Director of Nursing confirmed that Residents R2, R3, R5, R11, R13, R14, R25, R39, R42, R58, R60, and R94's clinical records lacked evidence of the required physician progress notes at the time of review. 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.2 (d)(8) Medical director 28 Pa. Code 211.5 (f)(ii)(iv) Medical records

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to ensure the physician alternated required resident visits with the nurse practitioner or physician's assistant for 16 of 24 residents reviewed (Residents R2, R3, R5, R7, R9, R11, R12, R13, R14, R39, R42, R55, R58, R60, R61, and R94). Findings include: Facility policy entitled Physician Visits and Physician Delegation dated 1/22/26, revealed The resident must be seen at least once every 30 calendar days for the first 90 calendar days after admission and at least every 60 days thereafter by physician or physician delegate as appropriate by state law and At the option of the physician, required visits in SNFs (skilled nursing facilities), after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist that is acting within scope of practice defined by State law and under the supervision of the physician. ' Resident R2's clinical record revealed an admission date of 12/4/24, with diagnoses that included chronic obstructive pulmonary disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), bipolar disorder (a mental health condition where you experience extreme mood swings that include emotional highs and lows. It causes significant shifts in mood, energy, activity levels, and concentration, affecting a person's overall functioning), and hypertension (high blood pressure). Resident R2's clinical records revealed physician progress notes signed by the nurse practitioner dated 6/26/25, 8/29/25, 10/20/25, 1/8/26, and 2/12/26. The clinical record lacked evidence of progress notes being alternated between the physician and nurse practitioner as required. Review of Resident R3's clinical record revealed an admission date of 7/26/24, with diagnoses that included Parkinson's (a chronic and progressive movement disorder that causes shaking, slows a person's ability to move and worsens over time), vascular dementia (a disease that affects short term memory and the ability to think logically), and hypertension. Resident R3's clinical records revealed physician progress notes signed by the nurse practitioner dated 5/29/25, 7/31/25, 10/10/25, 11/13/25, and 1/16/26. The clinical record lacked evidence of progress notes being alternated between the physician and nurse practitioner as required. Resident R5's clinical record revealed an admission date of 3/16/18, with diagnoses that included hypertension, major depressive disorder, and insomnia (difficulty sleeping). Resident R5's clinical records revealed physician progress notes signed by the nurse practitioner dated 9/11/25, 11/20/25, and 1/22/26. The clinical record lacked evidence of progress notes being alternated between the physician and nurse practitioner as required. Resident R7's clinical record revealed an admission date of 7/23/25, with diagnoses that included sleep apnea (a sleep disorder that causes breathing to stop and start multiple times during sleep), COPD, and diabetes (a health condition caused by the body's inability to produce enough insulin). Resident R7's clinical records revealed physician progress notes signed by the nurse practitioner dated 9/4/25, 10/2/25, 11/6/25, 1/16/26, and 2/19/26. The clinical record lacked evidence of progress notes being alternated between the physician and nurse practitioner as required. Resident R9's clinical record revealed an admission date of 10/6/21 with diagnoses that included end stage renal disease (ESRD - when the kidneys have permanently lost their ability to function effectively), anemia (a reduction in red blood cells resulting in symptoms such as fatigue and weakness), and diabetes. Resident R9's clinical records revealed physician progress notes signed by the nurse practitioner dated 5/29/25, 7/31/25, 9/24/25, 12/15/25, and 2/26/26. The clinical record lacked evidence of progress notes being alternated between the physician and nurse practitioner as required. Resident R11's clinical record revealed an admission date of 5/8/25, with diagnoses that included sleep apnea, diabetes, and hypertension. Resident R11's clinical records revealed physician progress notes signed by both the physician and nurse practitioner dated 6/26/25, 7/31/25, 9/4/25, 11/13/25, and 1/16/26. The physician notes were not clear defined as to who actually saw Resident R11. Review of Resident R12's clinical record revealed an admission date of 12/24/25, with diagnoses that included Parkinson's (a chronic and progressive movement disorder that causes (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shaking, slows a person's ability to move and worsens over time), drug induced retention of urine (a condition where a person is unable to fully empty their bladder because of a medication), and hyperlipidemia (high cholesterol). Resident R12's clinical records revealed physician progress notes signed by the nurse practitioner dated 12/15/25, 1/16/26, and 2/19/26. The clinical record lacked evidence of progress notes being alternated between the physician and nurse practitioner as required. Review of Resident R13's clinical record revealed an admission date of 3/13/24, with diagnoses that included Alzheimer's disease (brain disorder that slowly destroys memory, thinking skills, and, over time the ability to carry out the simplest tasks), anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and hyperlipidemia (high cholesterol). Resident R13's clinical records revealed physician progress notes signed by the nurse practitioner dated 7/3/25, 9/4/25, 11/13/25, and 1/22/26. The clinical record lacked evidence of progress notes being alternated between the physician and nurse practitioner as required. Resident R14's clinical record revealed an admission date of 11/27/23, with diagnoses that included muscle wasting and atrophy (loss of muscle tissue resulting in decreased size and strength), weakness, and hypertension.Resident R14's clinical records revealed physician progress notes signed by the nurse practitioner dated 9/11/25, 11/20/25, and 1/29/26. The clinical record lacked evidence of progress notes being alternated between the physician and nurse practitioner as required. Resident R39's clinical record revealed an admission date of 1/9/25, with diagnoses that included anxiety, insomnia, and hypertension.Resident R39's clinical records revealed physician progress notes signed by the nurse practitioner dated 8/14/25, 10/2/25, 11/6/25, 1/8/26, and 1/22/26. The clinical record lacked evidence of progress notes being alternated between the physician and nurse practitioner as required. Resident R42's clinical record revealed an admission date of 4/26/24, with diagnoses that included COPD, dementia, and anxiety.Resident R42's clinical records revealed physician progress notes signed by the nurse practitioner dated 9/11/25, 11/20/25, and 1/22/26. The clinical record lacked evidence of progress notes being alternated between the physician and nurse practitioner as required. Review of Resident R55's clinical record revealed an admission date of 3/10/25, with diagnoses that included hypertension, emphysema (a chronic lung condition that causes shortness of breath due to lung damage), and hyperlipidemia.Resident R55's clinical records revealed physician progress notes signed by the nurse practitioner dated 6/26/25, 9/4/25, 11/13/25, and 2/26/26. The clinical record lacked evidence of progress notes being alternated between the physician and nurse practitioner as required. Review of Resident R58's clinical record revealed an admission date of 9/11/24, with diagnoses that include Alzheimer's disease, hypertension, and chronic kidney disease (a disease that affects the kidney's ability to filter waste products and extra fluid from the body). Resident R58's clinical records revealed physician progress notes signed by the nurse practitioner dated 6/26/25, 9/4/25, 11/13/25, and 1/22/26. The clinical record lacked evidence of progress notes being alternated between the physician and nurse practitioner as required. Resident R60's clinical record revealed an admission date of 10/2/1018, with diagnoses that included Alzheimer's disease, diabetes, and dementia. Resident R60's clinical records revealed physician progress notes signed by the nurse practitioner dated 5/29/25, 7/31/25, 10/10/25, 12/15/25, and 2/19/26. The clinical record lacked evidence of progress notes being alternated between the physician and nurse practitioner as required. Resident R61's clinical record revealed an admission date of 1/23/25, with diagnoses that included hypertension, atrial fibrillation (irregular heartbeat), and major depressive disorder. Resident R61's clinical records revealed physician progress notes signed by the nurse practitioner dated 8/14/25, 10/16/25, 12/29/25, and 2/26/25. The clinical record lacked evidence of progress notes being alternated between the physician and nurse practitioner as required. Resident R94's clinical record revealed an admission date of 10/6/21, with diagnoses that included COPD, sleep apnea, and hypertension. Resident R94's clinical records revealed physician progress notes signed by the nurse practitioner dated 5/29/25, 7/31/25, 8/14/25, 9/18/25, 10/10/25, 12/15/25, and 1/16/26. The clinical record lacked evidence of progress notes being alternated between the physician and nurse (continued on next page)

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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 review of a facility policy, observations, and staff interview, it was determined that the facility failed to maintain sanitary operations in the main kitchen and failed to ensure that food was stored in accordance with standards for food safety in the main kitchen and three resident pantries reviewed (Units 100/200, 200/300, and 400/500).Findings include: Review of policy entitled Date Marking for Food Safety dated 1/22/26, indicated The food shall be clearly marked to indicate the date or day by which food shall be consumed or discarded. The discard date or day may not exceed the manufacturer's use-by-date, or four days, whichever is earliest. The date of opening or preparation counts as day 1. Review of facility policy entitled Environment dated 1/22/26, indicated The Dining Service Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation. Review of facility policy entitled Equipment dated 1/22/26, indicated All non-food contact equipment will be cleaned and free of debris. Observations during tour of the kitchen on 4/27/26, between 10:35 a.m. and 10:55 a.m. with the Dietary Manager of the walk-in freezer revealed several metal containers all covered with aluminum foil with the name of the item and the date the item was placed in the metal container written on each one. The first container was labeled rolls with a date of 4/6/26, second was labeled chili with a date of 4/8/26, third was labeled sprouts with a date of 3/28/26, fourth was labeled pumpkin with a date of 2/5/26, and fifth was labeled roll ups with a date of 1/20/26. In the walk-in refrigerator was a container of garlic with a best by date of 4/4/26, in the reach in refrigerator was an open container of cottage cheese with a best buy date of 4/24/26, in the second reach in refrigerator was a container of cottage cheese with a best buy date of 4/24/26. During an interview with the Dietary Manager on 4/27/26, at the time of observations, he/she said that all the items in the metal pans should be used within fourteen days from the date that was written on the foil. He/she confirmed that the items in the metal pans, the containers of cottage cheese, and the container of garlic should have all been discarded. Observation on 4/27/26, at 12:26 p.m. of a pantry on unit 100/200 used for residents revealed an open container of 2.0 Cal med pass (a supplement given to residents during medication administration) with an open date of 4/23/26. During an interview on 4/27/26, at the time of observations with Licensed Practical Nurse Employee E1, he/she confirmed that the med pass was dated open on 4/23/26, which was beyond its use by date and should have been discarded. Observations on 4/27/26, between 12:30 p.m. and 12:35 p.m. of a pantry on unit 300/400 used for residents revealed an open box of mini wheats with a best buy date of 10/19/24, an open box of cheerios with a best by date of 10/22/25, a can of ravioli with an expiration date of 6/18/25, and an open container of ginger bread cookies with an expiration date of 4/16/26. Observations on 4/27/26, between 12:35 p.m. and 12:39 p.m. of a pantry on unit 500/600 used for residents revealed and in the cabinet was a clear plastic bag with no name or date and what appeared to be a large amount of cooked French toast. During an interview on 4/27/26, at the time of observations the Director of Nursing (DON) confirmed that the open box of mini wheats, open box of cheerios, can of ravioli, and the open container of gingerbread cookies were beyond their use by dates and should have been discarded. The DON also confirmed that the clear plastic bag of what appeared to be French toast should not be stored in the cabinet and should have been discarded. Observation of the kitchen on 4/27/26, between 10:35 a.m. and 10:55 a.m. revealed white, gray, black and brown substances on the floors under the sink, under the stove, under the pan rack, and there was a small brush lying on the floor beside the sink. There was a large amount of food crumbs behind the pot rack, under the sink, under the prep table, and under the stove. Observations of the dishwasher room revealed a thick white substance covering the front of the dishwasher, the sides of the dishwasher where the dishes exit, and the top of the dishwasher revealed crumbling chunks of a white substance. Further review revealed metal wheeled carts covered in a thick white substance. Observation on 4/28/26 between (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11:00 a.m. and 11:30 a.m. revealed the white, gray, black and brown substances on the floors under the sink, stove, and under the pan rack, and the small brush lying on the floor beside the sink remained. The large amount of food crumbs behind the pot rack, under the sink, under the prep table, and under the stove remained. The thick white substance covering the front of the dishwasher, the sides of the dishwasher where the dishes exit, and the top of the dishwasher the crumbling chunks of a white substance remained. The metal wheeled cart covered in a thick white substance remained. During an interview on 4/28/26, at the time of observations with the Dietary Manager, he/she confirmed the kitchen floors under the sink, stove, and under the pan rack had white, gray, black and brown substances, and there was a small brush lying on the floor beside the sink. He/she also confirmed that there was a large amount of food crumbs behind the pot rack, under the sink, under the prep table, and under the stove. He/she confirmed that the dishwasher had a thick white substance covering the front and the exit sides and that there were crumbling chunks of a white substance on the top of the dishwasher. He/she also confirmed that the kitchen floors, dishwasher and metal carts should be clean. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to ensure physician's orders and residents Physician Order for Life Sustaining Treatment (POLST- a legal document specifying the resident/responsible party choices regarding life-sustaining treatments) were consistent for one of 24 residents reviewed (Resident R123).Findings include: Review of facility policy entitled Communication of Code Status dated [DATE], indicated When an order is written pertaining to a resident's presence or absence of an Advance Directive, the directions will be clearly documented in designated sections of the medical record. Review of Resident R123's clinical record revealed an admission date of [DATE], with diagnoses that include hypertension (high blood pressure), parkinsonism (a syndrome with symptoms of tremors, stiff muscles, and slow and difficult movement because of disease of the nervous system), and chronic kidney disease (a disease that affects the kidney's ability to filter waste products and extra fluid from the body). Review of Resident R123's clinical record revealed a physician's order dated [DATE], indicating DNR (Do Not Resuscitate). Review of Resident R123's POLST revealed CPR (Cardiopulmonary Resuscitation - emergency life-saving procedure that is done when breathing or a heartbeat has stopped and when performed immediately can double or triple chances of survival after cardiac arrest). During an interview on [DATE], at 1:50 p.m. with Licensed Practical Nurse Employee E2, he/she revealed that during an emergent situation the staff refer to the physician's orders in the computer to determine resident life sustaining wishes. During an interview on [DATE], at 1:55 p.m. the Director of Nursing confirmed that Resident R123's physician orders and POLST were not consistent with one another. He/she also confirmed that the resident's physician's order and POLST should match. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.5(f)(i)(vii) Medical records 28 Pa. Code 211.10(c) Resident care policies

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide evidence that pharmacist medication regimen reviews were reviewed and signed by a physician prior to the administration of an as needed (PRN) psychotropic (mind altering) medication for one of one residents reviewed (Resident R109). Findings include: Review of facility policy entitled Psychotropic Medication Use Process Auditing Chart Review with an annual policy review of 1/22/2026, revealed is there a practitioner's order documented for the psychotropic medication. Are orders for antipsychotic medications only time limited to 14 days? If it needs to be extended, has the practitioner evaluated the resident and documented on the resident prior to writing the new PRN order? Review of Resident R109's clinical record revealed an admission date of 4/30/25, with diagnoses that included Cerebrovascular disease affecting right dominant side (a group of conditions that affect blood vessels and blood circulation to the brain, restricting oxygen and often causing strokes), anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), aphasia (a language disorder caused by damage to the brain), and major depressive disorder. Review of Resident R109's physician's orders revealed an order for Lorazepam (anti-anxiety) 0.5 milligrams (mg) by mouth every four hours PRN for anxiety. Review of Resident R109's medication regimen reviews and medication administration record revealed that the PRN Lorazepam was to be reviewed on 12/29/2025, 1/28/2026, and 2/24/2026 and lacked evidence that the physician reviewed and signed the regimen reviews. The medication regimen reviews revealed that 12/29/2025, was unsigned and that 1/28/2026, and 2/24/2026 were not signed off for reorders until 3/27/2026. The order was changed to an indefinite duration after 3/27/26. During an interview on 4/30/26, at 10:50 a.m. the Nursing Home Administrator and Director of Nursing confirmed that Resident R109's clinical record lacked evidence that medication regimen reviews were signed reviewed and signed by the physician for PRN psychotropic medication Lorazepam. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide a written summary of the baseline care plan and order summary to the resident and/or representative for two of 12 residents reviewed (Residents R12 and R7).Findings include: Facility policy entitled Baseline Care Plan dated 1/22/26, indicated A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand. The summary shall include, at a minimum, the following: The initial goals of the resident, a Summary of the resident's medications and dietary instructions, and Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. And The person providing the written summary of the baseline care plan shall: Obtain a signature from the resident/representative to verify that the summary was provided and Make a copy of the summary for the medical record. Resident R12's clinical record revealed an admission date of 12/24/25, with diagnoses that included Parkinson's (a chronic and progressive movement disorder that causes shaking, slows a person's ability to move and worsens over time), drug induced retention of urine (a condition where a person is unable to fully empty their bladder because of a medication), and hyperlipidemia (high cholesterol). Resident R12's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R12 and/or his/her representative. During an interview on 4/29/26, at 1:45 p.m. the Director of Nursing (DON) confirmed there was no evidence that a written summary of the baseline care plan and order summary were provided to Resident R12 and/or his/her representative. Resident R7's clinical record revealed an admission date of 7/23/25, with diagnoses that included Sleep Apnea (a sleep disorder that causes breathing to stop and start multiple times during sleep), Chronic Obstructive Pulmonary Disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), and Diabetes (a health condition caused by the body's inability to produce enough insulin). Resident R7's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R7 and/or his/her representative. During an interview on 4/29/26, at 3:27 p.m. the DON confirmed there was no evidence that a written summary of the baseline care plan and order summary were provided to Resident R7 and/or his/her representative. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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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. Based on review of facility policy and clinical record and staff interview, it was determined that the facility failed to develop a comprehensive care plan for one of 24 residents reviewed (Resident R11).Findings include: Facility policy entitled Comprehensive Care Plans date 1/22/26, indicated It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. Resident R11's clinical record revealed an admission date of 5/8/25, with diagnoses that included Sleep Apnea (a sleep disorder that causes breathing to stop and start multiple times during sleep), Diabetes (a health condition caused by the body's inability to produce enough insulin), and High Blood Pressure. Resident R11's physician's orders dated 5/9/25, revealed CPAP (Continuous Positive Airway Pressure - CPAP machine that delivers a steady stream of pressurized air through a mask worn over the nose and/or mouth which keeps the airway open and ensure consistent oxygen flow) nightly for sleep apnea. Review of Resident R11's comprehensive plan of care failed to reveal a care plan for the use of his/her CPAP. During an interview on 4/29/26, at 2:59 p.m. the Registered Nurse Assessment Coordinator confirmed that Resident R11's comprehensive plan of care did not include a care plan for the use of his/her CPAP and should have. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of facility policies and clinical record and staff interview, it was determined that the facility failed to review and/or revise resident care plans for one of 24 residents reviewed (Resident R11). Findings include: Facility policy entitled Comprehensive Care Plans' dated 1/22/26, revealed The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. Facility policy entitled Care Plan Revisions Upon Status Change dated 1/22/26, revealed The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a change. And The care plan will be updated with new or modified interventions. Resident R11's clinical record revealed an admission date of 5/8/25, with diagnoses that included Sleep Apnea (a sleep disorder that causes breathing to stop and start multiple times during sleep), Diabetes (a health condition caused by the body's inability to produce enough insulin), and High Blood Pressure. Resident R11's care plan for problem area of Respiratory included an intervention for Oxygen concentrators 3 liters via nasal canula or face mask. Resident R11's physician's orders revealed an order dated 12/25/25 to discontinue oxygen at 3 liters via nasal cannula. During an interview on 4/29/26, at 2:50 p.m. the Registered Nurse Assessment Coordinator (RNAC) confirmed that Resident R11's oxygen was discontinued on 12/25/25, and that his/her care plan was not updated to reflect this change. The RNAC confirmed this intervention should have been resolved. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on review of facility policies, clinical records, and staff interview, it was determined that the facility failed to follow physician's orders related to a medication gradual dose reduction (GDR-lowering a high-risk medication to determine if a person can function safely on a lower dose) and failed to administer pain medication timely resulting in a delay in treatment for two of 24 residents reviewed (Residents R3 and R5).Findings include:Facility policy entitled, Consulting Physician/Practitioner Orders dated 1/22/26, revealed .For consulting physician/practitioner orders received in writing or via fax, the nurse in a timely manner will:Call the attending physician to verify the order.Document the verification order by entering the order and the time, date, and signature on the physician order sheet.Follow facility procedures for verbal or telephone orders including: noting the order, submitting to pharmacy, and transcribing to medication or treatment administration record.Review of Resident R3's clinical record revealed an admission date of 7/26/24, with diagnoses that included Parkinson's (a chronic and progressive movement disorder that causes shaking, slows a person's ability to move and worsens over time), vascular dementia (a disease that affects short term memory and the ability to think logically), and hypertension (high blood pressure).Resident R3's clinical record revealed a psychiatry progress note dated 2/24/26, to reduce Quetiapine (antipsychotic mind-altering medication) to 25 mg (milligrams) po (by mouth) every HS (hour of sleep), reassess in two weeks.Resident R3's medication administration records for February, March, and April 2026 lacked evidence that Quetiapine was reduced and reassessed as ordered.Review of Resident R3's active and discontinued physician orders for Quetiapine revealed all orders were for 50 mg by mouth one time a day.During an interview on 4/29/26, at 3:14 p.m. the Director of Nursing confirmed that the facility failed to follow physician's orders related to Resident R3's Quetiapine GDR order. Review of Resident R5's clinical record revealed an admission date of 3/16/18, with diagnoses that included hypertension, major depressive disorder, and insomnia (difficulty sleeping).Review of Resident R5's medication administration record revealed that a new order was entered dated 12/11/25, at 5:30 p.m. for Oxycodone (an opioid used to treat moderate to severe pain) 5 mg every six hours as needed for severe pain. This was in addition to his/her existing order dated 11/20/2018, for Oxycodone 5 mg one time a day for back pain.Resident R5's pain scale (a numerical scale used to determine a person's pain level with zero indicating no pain and a 10 being the worst pain ever) revealed on 12/10/25, all pain assessments revealed his/her pain was a zero, on 12/11/25, his/her pain was documented as a zero, three, six, zero, and zero, and on 12/12/25, his/her pain was documented as a six, five, one, six, 10, seven, and 10. Resident R5 started to have severe pain on 12/11/25, at 2:13 p.m. An order for Oxycodone 5 mg every six hours for severe pain was available on 12/11/25, at 5:30 p.m. and he/she did not receive his/her first dose until 12/12/25, at 4:46 a.m. almost 12 hours after the order was received.During an interview on 4/29/26, at 2:06 p.m. the Director of Nursing confirmed that there was a delay in treatment related to Resident R5 and confirmed the Oxycodone 5mg as needed medication should have been provided to Resident R5 earlier to address their pain. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.5(f)(i)(x) Medical records

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on review of facility policy, facility documents, and facility meal schedule, observations, and resident and staff interviews, it was determined that the facility failed to ensure that alternate meals were served comparable to normal mealtime in accordance with resident preference and request for two of 24 residents (Residents R55 and R123).Findings include: Review of facility policy entitled Dining and Food Preferences dated 1/22/26, revealed The alternate meal and/or beverage selection will be provided in a timely manner. Review of facility meal schedule revealed that the scheduled time for lunch delivery starts at 11:00 a.m. and the last delivery is at 1:15 p.m. which identified that tray line would not be completed until 1:15 p.m. Observations on 4/27/26, and 4/28/26, revealed a sign on the dining services door indicating Alternate meals will be made at the end of tray line. Tray line does not stop! During an interview on 4/27/26, at approximately 12:45 p.m. Resident R55 stated, I have asked for an alternate meal, and it has taken over 30 minutes to get it, and it was only a peanut butter sandwich. I was told that I would have to wait until tray line was done before I would get the sandwich. During an interview on 4/27/26, at approximately 1:00 p.m. Resident R123 and his/her representative stated, We asked for a grilled cheese sandwich in place of [Resident R123's] meal and was told that we would have to wait until tray line was completed. They also stated that it took over 30 minutes to get the grilled cheese sandwich and that all the other residents were done eating their meals by the time Resident R123 received his/her sandwich. During an interview on 4/28/26, at 11:30 a.m. the Dietary Manager confirmed that an alternate meal would not be made until tray line was completed. During an interview on 4/30/26, at 11:24 a.m. the Nursing Home Administrator confirmed that when a resident requests for an alternate meal that it should be prepared and delivered timely. 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on review of facility policy, clinical records, observations, and staff interview, it was determined that the facility failed to provide appropriate urinary catheter (tubing inserted into the bladder to drain urine into a bag) care to help prevent urinary tract infections for one resident reviewed for catheter care (Resident R12).Findings include: Review of facility policy entitled Indwelling Catheter Use and Removal dated 1/22/26, revealed If an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice and resident care policies and procedures that include but are not limited to: Insertion, ongoing care and catheter removal protocols that adhere to professional standards of practice and infection prevention and control procedures. Review of Resident R12's clinical record revealed an admission date of 12/24/25, with diagnoses that include Parkinson's (a chronic and progressive movement disorder that causes shaking, slows a person's ability to move and worsens over time), drug induced retention of urine (a condition where a person is unable to fully empty their bladder because of a medication), and hyperlipidemia (high cholesterol). Review of Resident R12's care plan dated 4/8/26, for indwelling catheter revealed an intervention If resident is in a low bed, place foley [catheter] collection bag into a privacy bag then store that bag in a basin. Observations on 4/27/26, at 12:13 p.m. and again at 2:11 p.m. revealed Resident R12 lying in bed with their foley collection bag not in a privacy bag and was sitting on the floor. Observations on 4/28/26, at 9:33 a.m. and again at 1:20 p.m. revealed Resident R12 sitting in their wheelchair and the foley collection bag was not in a privacy bag and was sitting on the floor. During an interview on 4/28/26, at 1:45 p.m. the Director of Nursing confirmed that Resident R12's foley collection bag was not in a privacy bag and was sitting on the floor. He/she also confirmed that Resident R12's foley collection bag should not be sitting on the floor. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on review of clinical records and Minimum Data Set (MDS - federally mandated standardized assessment conducted at specific intervals to plan resident care), and staff interviews it was determined that the facility failed to ensure that MDS assessments accurately reflected the status of three of 27 residents reviewed (Residents R7, R11, and R120).Findings include: MDS instructions for section A2105 Discharge Status indicated to select the two-digit code that corresponds to the resident's discharge status. MDS instructions for section O0100b Special Treatments, Procedures, and Programs while a resident indicated to check all of the following treatments, procedures, and programs that were performed while a resident of this facility and within the last 14-days. Instructions for section O0110G1 Non-Invasive Mechanical Ventilator indicated to Code any type of CPAP (a machine that delivers a steady stream of pressurized air through a mask worn over the nose and/or mouth which keeps the airway open and ensure consistent oxygen flow.) or BiPAP (machine that delivers pressurized air through a mask worn over the nose and/or mouth to help keep the airway open and improv oxygen intake while reducing carbon dioxide buildup by delivering a higher pressure while inhaling and a lower pressure while exhaling) respiratory support devices. Instructions for section O0110G3 CPAP indicated to Check if the non-invasive mechanical ventilator support was a CPAP. Resident R7's clinical record revealed an admission date of 7/23/25, with diagnoses that included Sleep Apnea (a sleep disorder that causes breathing to stop and start multiple times during sleep), Chronic Obstructive Pulmonary Disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), and Diabetes (a health condition caused by the body's inability to produce enough insulin). Resident R7's physician's orders dated 9/16/25, revealed CPAP via nasal mask at bedtime. Review of the September 2025, December 2025, and March 2026 Treatment Administration Records (TAR) revealed Resident R7 utilized his/her CPAP nightly. Resident R7's quarterly MDS with an Assessment Reference Date (ARD) of 9/15/25, significant change MDS with an ARD of 12/19/25, and quarterly MDS with an ARD of 3/21/26, Section O0110G1 Non-Invasive Mechanical Ventilator were coded as No. Resident R11's clinical record revealed an admission date of 5/8/25, with diagnoses that included Sleep Apnea, Diabetes, and High Blood Pressure. Resident R11's physician's orders dated 5/9/25, revealed CPAP nightly for sleep apnea. Review of the May 2025, August 2025, November 2025, and February 2026 TARs revealed Resident R11 utilized his/her CPAP nightly. Resident R11's admission MDS with ARD 5/14/25, quarterly MDS with ARD of 8/14/25, and quarterly MDS with ARD of 11/14/25, Section O0110G1 Non-Invasive Mechanical Ventilator were coded as No. During an interview on 4/29/26, at 2:56 p.m. Registered Nurse Assessment Coordinator (RNAC) confirmed that Resident R7 and R11's MDS's Section O0110G1 was coded inaccurately and should have been coded as Yes. Resident R120's clinical record revealed an admission date of 2/6/26, with diagnoses that included Gastroesophageal reflux disease (GERD - happens when stomach acid flows back up into the esophagus and causes heartburn), Anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and History of Urinary Tract Infections. Resident R120's clinical record progress note dated 2/7/26, revealed he/she left the facility with a family member to go home against medical advice. Resident R120's admission / Discharge - Return Not Anticipated MDS with an ARD of 2/7/26, section A2105 Discharge Status was coded as 04 - Short-Term General Hospital (acute hospital). During an interview on 4/30/26, at 1:57 p.m. the RNAC confirmed that Resident R120's MDS Section A2105 was coded inaccurately and should have been coded as 01. Home/Community. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.5(f)(ix) Medical records