

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/02/2026
NAME OF PROVIDER OR SUPPLIER Ephrata Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 99 Bethany Road Ephrata, PA 17522	

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)
<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, hospital records, and staff interviews, it was determined that the facility failed to ensure appropriate social services were provided to ensure a safe discharge to home for one of the two residents reviewed (Resident CL1). Findings include: Review of Resident CL1 diagnosis list includes the following diagnoses: Altered mental status (Unusual changes in a person's emotional response, thinking, and behavior) and Metabolic Encephalopathy (A non-traumatic brain dysfunction caused by illnesses or chemical imbalance, resulting in altered mental status). Review of Resident CL1's admission Visit Physician Orders, dated December 4, 2025, revealed Resident is not capable of understanding rights and exercising own rights. Interview with Licensed Employee E3 was conducted on February 2, 2026, at 11:00 a.m. Employee E3 reported being the social worker (SW) assigned to Resident CL1. It was further reported that Resident CL1's emergency contact was an ex-husband who does not reside with the resident but aids with the resident's bills and finances. Employee E3 confirmed that the resident does not have a POA (Power of Attorney - A legal document that authorizes an agent to act on behalf of a principal for financial or medical matters). The residents had been deciding for themselves before hospitalization. Review of nursing progress notes revealed a note dated December 10, 2025, at 8:04 p.m., stating resident continues with frequent confusion/disorientation. Review of nursing progress notes revealed a note dated December 11, 2025, at 7:25 a.m., stating Staff report [the resident] is increasingly confused, found in the hallway carrying their purse saying they didn't know where their room was. Review of nursing progress notes revealed a note dated December 12, 2025, at 10:07 a.m., stating the resident's insurance company notified the facility of the resident's last cover date, which is December 13, 2025. A review of the Nurse Practitioner's (NP) notes dated December 12, 2025, revealed: Assessment and Plan - Dementia (A term used to describe a group of symptoms affecting memory, thinking, and social abilities severely enough to interfere with daily life) associated with alcoholism, oriented only to self. The same note revealed SLUMS (The St. Louis University Mental Status- Examination for detecting mild cognitive impairment and early dementia) done in the facility was 16 out of 30. Further note review indicated [The Resident] exhibits memory impairment and tangential (Someone whose conversation wanders off topic, bringing irrelevant details, without returning to the original point, failing to answer the question asked) thought process. Further review of the same notes revealed Resident is not capable of making sound medical decisions. There is concern regarding discharge plan as they live alone with limited support. History of Present Illness revealed [The resident] has a marked severe level of impairment, demonstrated by a SLUMS score of 16 out of 30 indicatives of dementia. [Name of insurance] gave an insurance cut, but due to concern for a safe discharge plan as they live alone in a dilapidated trailer with unsanitary living conditions, peer-to-peer was done by this provider with extension until December 17, 2025. The resident has limited support with an ex-husband who is minimally involved. Review of the social services (SS)</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 395857	If continuation sheet Page 1 of 2

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>notes revealed a note dated December 12, 2025, at 12:57 p.m., stating SS attempted to discuss discharge plans with [resident's name], though the resident presented confused, stating they had a two-story home and a manufactured home. Same note revealed [The resident] stated that ex-husband [name of ex-husband] assisted them and that ex-boyfriend [name of ex-boyfriend] was staying in the two-story home with them, the SS will continue to discuss discharge options with [resident's name]. Interview conducted with Employee E3 on January 2, 2026, at 1:00 p.m., revealed resident initially reported residing in a two-level house, then informed SS that they live in a mobile home. Employee E3 reported that the ex-husband reported concerns with the resident's home due to holes and some soft spots on the floor. The SS reported that the information, both provided by the resident and the ex-husband, was not verified by the facility. The SS reported rehab previously did home check, but not anymore. Interview with the rehab director, Employee E4, was conducted on January 2, 2026, at 1:30 p.m. Employee E4 reported that Resident CL1 was physically cleared by rehab but had cognitive impairment, making residents unsafe to go home. Employee E4 confirmed by getting mixed information between the resident, who claimed to live in a two-story house, and the ex-husband, who reported resident lives in a trailer. Employee E4 reported not doing a house check to ensure Resident CL1 will have a safe home discharge. Employee E4 stated, It's a base-to-base case, it was a quick discharge due to insurance cut, and the resident does not have anyone to drive them home. Review of Resident CL1's Physician orders revealed an order dated December 18, 2025, for Stable for discharge with support services. Social services notes dated December 19, 2025, at 4:03 p.m., revealed SS contacted the Office of Aging to report unsafe discharge for [Resident name]. SS spoke to a caseworker and provided the concerns regarding the safety/cleanliness of the home as well as the current mental status/increased confusion. Further review of Resident CL1's nursing progress notes revealed a note dated December 21, 2025, stating the resident was discharged home, accompanied by the ex-husband, despite the facility's knowledge that Resident CL1 was not safe to go home due to their impaired mental status and safety concerns at the resident's mobile home. Review of Resident CL1's Discharge summary, dated [DATE], revealed the facility arranged for homecare services with [name of home care company] for nurse, aide, and social services visit and evaluation once discharge. An interview was conducted with licensed SS Employee E5 on January 2, 2026, at 1:00 p.m. Employee E5 confirmed that there was no follow up made to the resident after being discharged on December 21, 2025. Employee E5 reported last hearing from [name of the hospital] that resident CL1 was sent back to the hospital a few days after being discharged home. The above findings were conveyed to the Nursing Home Administrator and Director of Nursing on January 2, 2026, at 2:00 p.m. The facility failed to ensure Resident CL1 was provided with all social services to ensure a safe discharge to home. 28 Pa. Code 211.5(f) Clinical Records 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 211.12(d)(1)(5) Nursing Services</p>		