STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395883	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burgh Care Center	909 West Street Pittsburgh, PA 15221

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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 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 interviews it was determined that the facility failed to employ a qualified Director Manager to manage the daily operations of the Dietary Department for six months.Findings include: During an interview on 4/8/26, at 11:45 a.m. Dietary Manager Employee E1 indicated the Registered Dietitian normally comes to the facility once per week, usually Thursdays. During an interview on 4/9/26, at 1:00 p.m. Dietary Manager Employee E1 stated he has been employed as the Dietary Manager since November 2025, and that he was not a Certified Dietary Manager. During an interview on 4/9/26, at 2:45 p.m., the Nursing Home Administrator (NHA) confirmed that the facility failed to provide documented evidence that Dietary Manager Employee E1 met the qualifications for the position. Pa Code: 201.18(e)(6) Management.

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 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 a review of observations, and staff interviews, it was determined that the facility failed to properly monitor food temperatures creating the potential for cross contamination in the main kitchen of the facility, and failed to monitor refrigerator temperatures in one of three unit refrigerators (Ground Floor).Findings include: Review of facility policy Preventing Foodborne Illness- Food Handling dated 2/11/26, indicated that functioning of refrigeration and food temperatures will be monitored at designated intervals thorough the day and documented according to state-specific requirements. Federal standards require that refrigerated food be stored below 41-degrees Fahrenheit. During an observation in the main kitchen on 4/8/26, at 11:45 a.m., Tray line Temperature Log for March, April 2025, was noted to have missing data. 114 meals had been served during the month of March and beginning of April. 18 meals had no recorded food temperatures. The missing data was as follows: 10 breakfast meals with no recorded food temperatures 10 lunch meals with no recorded food temperatures 18 dinner meals with no recorded food temperatures During an interview on 4/8/26, at 12:30 p.m., Dietary Manager Employee E1 confirmed that the facility failed to monitor temperatures of foods to prevent food born illness. During an observation on 4/10/26, at 9:26 a.m. Receptionist Employee E22 entered into the Conference Room and asked State Agency (SA) if she could come in and grab a prepared, bagged lunch for a dialysis resident. Receptionist Employee E22 then proceeded to open a door to the refrigerator and take a prepared, bagged lunch. During an observation on 4/10/26, at 9:26 a.m. it was noted that the refrigerator did not have a thermometer, or Temperature Log to ensure that residents' lunches were being kept at an appropriate temperature. During an interview on 4/10/26, at 12:15 p.m. Nursing Home Administrator Employee E18 confirmed that the facility failed to properly monitor refrigerator temperatures in one of three unit refrigerators. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1) Management.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical record review, and staff interview, it was determined that the facility failed to make certain resident medication regimens were free from potentially unnecessary psychotropic (substances that act on the brain to alter cognition, perception, and mood) medications for three of five residents (Residents R4, R46, and R50).Findings include: Review of facility policy Antipsychotic Medication Use dated 2/11/26, indicated residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. Review of facility policy Consultant Pharmacist Services Provider Requirements dated 2/11/26, indicated the consultant pharmacist performs the medication regimen review (MRR) of each resident at least monthly, incorporating federally mandated standards of care in addition to other professional standards, and documenting the review and findings in the resident's medical record. Communicates to the responsible prescriber and the facility leadership potential or actual problems detected and other findings relating to medication therapy orders and recommendations for changes in medication therapy and monitoring, as well as regulatory compliance issues at least monthly. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/13/26, indicated diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and psychotic disorders (severe mental illnesses that cause abnormal thinking and perception). Review of Resident R4's MRR failed to include documented evidence that June 2025, was completed by the physician. During an interview on 4/8/26, at 11:32 a.m. the Director of Nursing stated, I can't find a completed pharmacy review for June 2025. Review of Resident R4's MRR dated 2/10/26, indicated the following recommendation from the pharmacist to the physician: Medication: The resident has an order for Zyprexa (a medication used to treat mental health disorders) 10 milligrams. Recommendation: Please assess the resident for a gradual dose reduction (GDR) of the Zyprexa order. Review of Resident R4's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 2/10/26. On 2/11/26, a Certified Registered Nurse (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Practitioner (CRNP) addressed the MRR stating, No GDR. After assessing resident, I would like to continue the Zyprexa order because it has been effective at alleviating the behavioral and physical symptoms that can present a risk of harm to the resident or others. During an interview on 4/8/26, at 9:53 a.m. the Director of Nursing confirmed that the facility failed to provide documentation that medication regimen reviews (MRR) were completed and reviewed by the resident's attending physician monthly for Resident R4. Review of the clinical record indicated Resident R46 was admitted to the facility on [DATE], with the diagnoses of dementia with agitation (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), stroke (damage to the brain from an interruption of blood supply), and anxiety. Review of Resident R46's MRR dated 1/10/26, indicated the following recommendation from the pharmacist to the physician: the resident has an order of Remeron (antidepressant medication) and Seroquel (antipsychotic medication) that do not have an FDA- (Food and Drug Administration) Labeled indication. Review of Resident R46's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 1/10/26. The recommendation was signed by Nurse Practitioner (NP) Employee E19. Review of Resident R46's MRR dated 1/23/26, indicated the medication regimen of the resident was reviewed, and a recommendation was made to the attending physician. Review of Resident R46's clinical record failed to include a description of the MRR and failed to have a response from the resident's attending physician regarding the recommendation made on 1/23/26. Interview on 4/11/26, at 11:30 a.m. Registered Nurse (RN) Employee E11 confirmed the MRR dated 1/10/26, was not completed by the physician, and that the MRR from 1/23/26, could not be located and the clinical record failed to have a response to the MRR from 1/23/26 for Resident R46. Review of the clinical record indicated Resident R50 was admitted to the facility on [DATE]. Review of Resident R50's MDS dated [DATE], indicated diagnoses of high blood pressure, repeated falls and depression (persistent sadness). Review of Resident R50's MRR dated 5/30/25, indicated the following recommendation from the pharmacist to the physician: Medication: The resident has an order for Effexor (a medication used to treat depression) 300 mg. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Recommendation: Please reassess the order to determine if symptoms, conditions, or the risks of depression can be managed by: A potentially higher daily dose. A potentially lower daily dose. The current daily dose is appropriate. Review of Resident R50's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 5/30/25. On 6/6/25, the CRNP addressed the MRR stating, No, I have assessed the resident, and a GDR is contraindicated because a change in their current regimen will cause symptoms such as depression or anxiety to return or worsen. Review of Resident R50's MRR dated 11/24/25, indicated the following recommendation from the pharmacist to the physician: Medication: The resident has an order of Effexor (a medication used to treat depression) 225 mg. Recommendation: Please reassess the order to determine if symptoms, conditions, or the risks of depression can be managed by: A potentially higher daily dose. A potentially lower daily dose. The current daily dose is appropriate. Review of Resident R50's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 11/24/25. On 11/25/25, the CRNP addressed the MRR stating, No, I have assessed the resident, and a GDR is contraindicated because a change in their current regimen will cause symptoms such as depression or anxiety to return or worsen. During an interview on 4/8/26, at 12:22 p.m. the DON confirmed that the MMR was not addressed by the resident's attending physician for Resident R50. 28 Pa Code: 201.14(a) Responsibility of licensee.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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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 review of facility policy, clinical record review and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for four of five residents sampled with facility-initiated transfers (Residents R2, R7, R40, and R76), failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for one of five resident hospital transfers (Residents R2), and failed to notify the Office of the State Long-Term Care Ombudsman upon transfer to the hospital for four of five resident hospital transfers (Residents R2, R7, R36 and R76). Findings include: Review of facility policy Transfer or Discharge, Emergency dated 2/11/26, indicated transfers may be necessary to protect the health or well-being of the resident. Should it become necessary for transfer, prepare a transfer form to send with the resident. Review of facility policy Transfer or Discharge Notice dated 2/11/26, indicated a copy of the notice is sent to the Office of the State Long-Term Care Ombudsman. Review of facility policy Bed-Hold and Returns dated 2/11/26, indicated residents are informed (in writing) of the facility bed hold policies. Resident or representatives are provided bed hold policy at the time of transfer. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/9/26, indicated diagnoses of high blood pressure, coronary artery disease (damage or disease in the heart's major blood vessels), and cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain). Review of the clinical record indicated Resident R2 was transferred to the hospital on [DATE], and returned to the facility on [DATE]. Review of Resident R2's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of Resident R2's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on [DATE]. Review of the clinical record indicated Resident R7 was admitted to the facility on [DATE]. Review of Resident R7's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes (a (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	metabolic disorder in which the body has high sugar levels for prolonged periods of time), and seizures (abnormal electrical activity in the brain). Review of the clinical record indicated Resident R7 was transferred to the hospital on 3/16/26, and returned to the facility on 3/16/26. Review of Resident R7's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. During an interview on 4/8/26, at 1:56 p.m. the Director of Nursing confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for Residents R2, and R7 and failed to notify the resident or resident's representative of the facility bed-hold policy for Residents R2. Review of clinical record indicated Resident R36 was admitted to the facility on [DATE]. Review of Resident R36's Minimum Data Set, MDS (MDS-a mandated assessment of a resident's abilities and care needs) assessment, dated 3/27/26, indicated the diagnoses of congestive heart failure (chronic condition where the heart is unable to pump blood effectively), anemia and coronary atherosclerosis (buildup of plaque inside the coronary arteries). Review of the clinical record indicated Resident R36 was transferred to the hospital on 1/16/26 and returned to the facility on 1/23/26. During an interview on 4/7/26, at 9:39 a.m. the Social Worker Employee E15 confirmed that there was no evidence that the State Ombudsman office was notified for transfers to the hospital for Resident R36. Review of the clinical record indicated Resident R40 was admitted [DATE]. Review of Resident R40's Minimum Data Set, MDS (minimum data set a periodic review of assessment needs) dated 2/2/26, indicated diagnosis of epilepsy (chronic brain disorder characterized by recurrent, unprovoked seizures), spinal stenosis (narrowing of space within the spine, which can compress the spinal cord and nerves) and chronic obstructive pulmonary disease(lung disease causing restricted airflow and breathing problems). Review of the clinical record indicated Resident R40 was transferred to the hospital on 8/7/25 and returned to the facility on 8/12/25. Review of Resident R40's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. During an interview on 4/9/26, at 1:15 p.m. the Director of Nursing confirmed the facility failed to (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	make certain that the necessary resident information was communicated to the receiving health care provider for Residents R40 as required. Review of the clinical record indicated Resident R76 was admitted to the facility on [DATE]. Review of Resident R76's MDS dated [DATE], indicated diagnoses of diabetes, nicotine dependence, and chronic pain. Review of the clinical record indicated Resident R76 was transferred to the hospital on 3/19/26. Review of Resident R76's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. During an interview on 4/8/26, at 1:55 p.m. the Director of Nursing confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for Residents R76 During an interview on 4/7/26, at 9:39 a.m. the Social Worker Employee E15 confirmed that there was no evidence that the State Ombudsman office was notified for transfers to the hospital for Resident R2, R7, R36, and R76. 28 Pa. Code: 201.14(a)Responsibility of licensee.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to make certain that residents were provided appropriate treatment and care in accordance with professional standards of practice for two of three residents (Resident R62, and R77).Findings include: Review of facility policy Neurological assessment dated [DATE], indicated that neurological assessments (an evaluation of the nervous system's function to monitor mental status, nerve, motor, and sensory function, and reflexes) shall be conducted: Upon physician order When following an unwitnessed fall Subsequent to a fall with a suspected head injury When indicated by resident condition Review of the admission record indicated Resident R62 was admitted to the facility on [DATE]. Review of Resident R62's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/21/26, indicated the diagnoses of high blood pressure, right below the knee amputation (surgical removal of part of leg), and frostbite (severe cases include tissue blackening into gangrene (tissue death). Review of Resident R62's hospital discharge orders dated 2/17/26, indicated right lower extremity apply 4 x 4, ABD (abdominal) pad, kerlix (gauze wrap) and ACE wrap. Change every day. Review of Resident R62's physician orders dated 2/17/26, failed to include the order for right lower extremity - apply 4 x 4, ABD (abdominal) pad, kerlix (gauze wrap) and ACE wrap. Change every day. Review of Resident R62's physician orders indicated a treatment was not ordered to the right lower extremity surgical site until ten days later on 2/27/26. Interview on 4/10/26, at 11:45 a.m. RN Employee E11 confirmed a treatment was not ordered to Resident R62's right lower extremity surgical site until ten days later on 2/27/26. Review of the clinical record indicated Resident R77 was admitted to the facility on [DATE]. Review of Resident R77's MDS dated [DATE], indicated diagnoses of high blood pressure, Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior), and repeated falls Review of Resident R77's clinical record revealed a nursing progress note dated 1/24/26, at 10:07 a.m. that indicated that resident was found on the floor after he tripped, and that facility should complete neurological assessments as follows: every 15 minutes for one hour, every 30 minutes for one hour, hourly for four hours , then every four hours for 24 hours. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R77's clinical record revealed that a neurological assessment had been completed on 1/24/26, at 10:59 a.m. Further review failed to reveal that any subsequent neurological assessments had been completed after the first one on 1/23/26, at 10:59 a.m. During an interview on 4/9/26, at 12:21 p.m. the Director of Nursing confirmed that the facility failed to complete additional neurological assessments as ordered for Resident R77. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, staff interview, and observations, it was determined that the facility failed to provide appropriate respiratory care for three of three residents (R25, R26, and R70).Findings include: Review of facility policy Administering Medications through a Nebulizer dated 2/11/26, indicated the purpose of this procedure is to safely and aseptically administer particles of medication into the resident's airway. Store in a plastic bag with the resident's name and date on it. Change equipment tubing every seven days. Review of the clinical record indicated Resident R25 was admitted to the facility on [DATE]. Review of Resident R25's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/9/26, indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized speech and behavior). Review of physician orders on 4/6/26, indicated Ipratropium-Albuterol Solution (a medication used to treat lung diseases) inhale orally every six hours as needed via nebulizer (a machine used to deliver medication) for shortness of breath, wheezing, or coughing. During an observation on 4/6/26, at 11:30 a.m. Resident R25 was lying in bed with nebulizer machine on over bed table. The nebulizer tubing was not dated, was not being stored in a bag when not in use, and the nebulizer machine had dried debris on the front of it. Review of the clinical record indicated Resident R26 was admitted to the facility on [DATE]. Review of Resident R26's MDS dated [DATE], indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), high blood pressure, and depression. Review of physician orders on 4/6/26, indicated Albuterol Sulfate Nebulization Solution (a medication used to treat lung diseases) orally every six hours for cough. During an observation on 4/6/26, at 11:37 a.m. Resident R26 was lying in bed with nebulizer machine on bedside table. The nebulizer tubing was dated 3/19/26, and was not being stored in a bag when not in use. Review of the clinical record indicated Resident R70 was admitted to the facility on [DATE]. Review of Resident R70's MDS dated [DATE], indicated diagnoses of schizophrenia, Parkinson's disease (neuromuscular disorder causing tremors and difficulty walking), and anxiety. Review of physician orders on 4/6/26, indicated Ipratropium-Albuterol Solution orally every eight hours for shortness of breath and wheezing. During an observation on 4/6/26, at 11:41 a.m. Resident R70 was sitting in wheelchair with the nebulizer machine on the windowsill. The nebulizer tubing was dated 3/19/26, and was not being stored in a bag when not in use. During an interview on 4/6/26, at 11:48 a.m. Licensed Practical Nurse (LPN) Employee E12 stated that the tubing should get changed weekly and confirmed nebulizer tubing that was dated 3/19/26 or failed to have a date on the tubing, nebulizer tubing and masks not stored in bags when not in use and a nebulizer machine with dried debris on it for Resident R25, R26, and R70. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of personnel records and staff interview, it was determined that the facility failed to complete annual performance evaluations at least once every 12 months for three of three nurse aide (NA) personnel records (NA Employee E8, NA Employee E9, and NA Employee E10).Findings include: Review of facility policy In-Service Training, Nurse Aide dated 2/11/26, indicated the facility completes a performance review of nurse aides at least every 12 months. Review of NA Employee E8's personnel file indicated a date of hire on 12/8/20. Review of NA Employee E8's personnel record failed to include an annual performance evaluation at least every 12 months as required. Review of NA Employee E9's personnel file indicated a date of hire on 6/5/05. Review of NA Employee E9's personnel record failed to include an annual performance evaluation at least every 12 months as required. Review of NA Employee E10's personnel file indicated a date of hire on 2/21/24. Review of NA Employee E10's personnel record failed to include an annual performance evaluation at least every 12 months as required. During an interview on 4/8/26, at 1:23 p.m. the Nursing Home Administrator (NHA) stated, We discovered performance evaluations were not being completed when we identified that the previous Human Resources person was not completing staff education correctly. We did a performance evaluation for everyone in March. During an interview on 4/8/26, at 1:23 p.m. the NHA confirmed that the facility failed to complete annual performance evaluations at least once every 12 months for three of three nurse aide personnel records (NA Employee E8, NA Employee E9, and NA Employee E10). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.19(2) Personnel records.

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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 review of the clinical records and staff interview, it was determined that the facility failed to provide documentation that medication regimen reviews (MRR) were completed and reviewed by the resident's attending physician monthly for five of five residents (Residents R4, R9, R10, R46, and R50).Findings include: Review of facility policy Consultant Pharmacist Services Provider Requirements dated 2/11/26, indicated the consultant pharmacist performs the medication regimen review (MRR) of each resident at least monthly, incorporating federally mandated standards of care in addition to other professional standards, and documenting the review and findings in the resident's medical record. Communicates to the responsible prescriber and the facility leadership potential or actual problems detected and other findings relating to medication therapy orders and recommendations for changes in medication therapy and monitoring, as well as regulatory compliance issues at least monthly. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/13/26, indicated diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and psychotic disorders (severe mental illnesses that cause abnormal thinking and perception). Review of Resident R4's MRR failed to include documented evidence that June 2025, was completed by the physician. During an interview on 4/8/26, at 11:32 a.m. the Director of Nursing stated, I can't find a completed pharmacy review for June 2025, for Resident R4. Review of Resident R4's MRR dated 2/10/26, indicated the following recommendation from the pharmacist to the physician: Medication: The resident has an order for Zyprexa (a medication used to treat mental health disorders) 10 milligrams (mg). Recommendation: Please assess the resident for a gradual dose reduction (GDR) of the Zyprexa order. Review of Resident R4's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 2/10/26. On 2/11/26, a Certified Registered Nurse Practitioner (CRNP) addressed the MRR stating, No GDR. After assessing resident, I would like to continue the Zyprexa order because it has been effective at alleviating the behavioral and physical symptoms that can present a risk of harm to the resident or others. During an interview on 4/8/26, at 9:53 a.m. the Director of Nursing confirmed that the facility failed to provide documentation that medication regimen reviews (MRR) were completed and reviewed by the (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's attending physician monthly for Resident R4. Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE]. Review of Resident R9's MDS dated [DATE], indicated diagnoses of high blood pressure, chronic pain, and diabetes. Review of Resident R9's MRR failed to include documented evidence that June 2025, was completed by the physician. During an interview on 4/8/26, at 11:32 a.m. the Director of Nursing stated that she was unable to find the pharmacy review for June 2025, for Resident R9. Review of the clinical record indicated that Resident R10 was admitted to the facility on [DATE]. Review of Resident R10's MDS dated [DATE], indicated diagnoses of high blood pressure, bipolar disorder (a mental condition marked by alternating periods of elation and depression) and schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized speech and behavior). Review of Resident R10's MRR failed to include documented evidence that June 2025, was completed by the physician. During an interview on 4/8/26, at 11:32 a.m. the Director of Nursing stated that she was unable to find the pharmacy review for June 2025, for Resident R10. Review of Resident R10's MRR dated 5/31/25, indicated the following recommendation from the pharmacist to the physician: Medication: The resident has an order of Detemir insulin (a long-acting insulin to treat high blood sugar). Recommendation: Please consider ordering a hemoglobin A1c (a blood test that measures average blood sugar over three months) Review of Resident R10's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 5/31/25. On 6/6/25, the CRNP addressed the MRR stating, No, do not order the recommended hemoglobin A1c because it isn't medically necessary at this time. During an interview on 4/8/26, at 12:22 p.m. the DON confirmed that the MMR was addressed by the facility CRNP and not the resident's attending physician for Resident R10. Review of Resident R46's MRR dated 1/10/26, indicated the following recommendation from the pharmacist to the physician: the resident has an order of Remeron (antidepressant medication) and Seroquel (antipsychotic medication) that do not have an FDA- (Food and Drug Administration) Labeled indication. Review of Resident R46's clinical record failed to include a response from the resident's attending (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician regarding the recommendation made on 1/10/26. The recommendation was signed by Nurse Practitioner (NP) Employee E19. Review of Resident R46's MRR dated 1/23/26, indicated the medication regimen of the resident was reviewed, and a recommendation was made to the attending physician. Review of Resident R46's clinical record failed to include a description of the MRR and failed to have a response from the resident's attending physician regarding the recommendation made on 1/23/26. Interview on 4/11/26, at 11:30 a.m. Registered Nurse (RN) Employee E11 confirmed the MRR dated 1/10/26, was not completed by the physician, and that the MRR from 1/23/26, could not be located and the clinical record failed to have a response to the MRR from 1/23/26. During an interview on 4/10/26, at 9:30 a.m. the Director of Nursing confirmed that the monthly medication regimen reviews are addressed by the facility and Nurse Practitioners and not the resident's attending physician for Resident R46 Review of the clinical record indicated Resident R50 was admitted to the facility on [DATE]. Review of Resident R50's MDS dated [DATE], indicated diagnoses of high blood pressure, repeated falls and depression (persistent sadness). Review of Resident R50's MRR dated 5/30/25, indicated the following recommendation from the pharmacist to the physician: Medication: The resident has an order for Effexor (a medication used to treat depression) 300 mg. Recommendation: Please reassess the order to determine if symptoms, conditions, or the risks of depression can be managed by: A potentially higher daily dose. A potentially lower daily dose. The current daily dose is appropriate. Review of Resident R50's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 5/30/25. On 6/6/25, the CRNP addressed the MRR stating, No, I have assessed the resident, and a GDR is contraindicated because a change in their current regimen will cause symptoms such as depression or anxiety to return or worsen. Review of Resident R50's MRR dated 11/24/25, indicated the following recommendation from the pharmacist to the physician: Medication: The resident has an order of Effexor (a medication used to treat depression) 225 mg. Recommendation: Please reassess the order to determine if symptoms, conditions, or the risks of depression can be managed by: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A potentially higher daily dose. A potentially lower daily dose. The current daily dose is appropriate. Review of Resident R50's clinical record failed to include a response from the resident's attending physician regarding the recommendation made on 11/24/25. On 11/25/25, the CRNP addressed the MRR stating, No, I have assessed the resident, and a GDR is contraindicated because a change in their current regimen will cause symptoms such as depression or anxiety to return or worsen. During an interview on 4/8/26, at 12:22 p.m. the DON confirmed that the MMR was addressed by the facility CRNP and not the resident's attending physician for Resident R50. 28 Pa Code: 201.14 (a) Responsibility of licensee.28 Pa. Code 211.5(f) Medical records.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, menu, observations, and staff interviews, it was determined that the facility failed to follow the menu for five of ten residents (Resident R13, R34, R39, R53, and R72).Findings include: Review of the policy Resident Food Preferences dated 2/11/26, indicated the food services department will offer a variety of foods at each scheduled meal, as well as access to nourishing snacks throughout the day and night. Review of the admission record indicated Resident R39 was admitted to the facility on [DATE]. Meal observation on 4/7/26, at 12:15 p.m. Resident R39's mechanical soft hamburger, onion rings, peas and carrots and ice cream. Review of Resident R13's tray failed to include a hamburger bun. Review of the admission record indicated Resident R34 was admitted to the facility on [DATE]. Meal observation on 4/8/26, at 9:00 a.m. Resident R34's tray ticket indicated two slices of bacon, cold cereal, two waffles, diet syrup, margarine, orange juice, and milk. Review of Resident R34's tray failed to include bacon, cold cereal, or milk. The resident received two sausage patties instead of bacon, and hot cereal instead of cold, and no milk. Review of the admission record indicated Resident R53 was admitted to the facility on [DATE]. Meal observation on 4/6/26, at 12:15 p.m. Resident R53's tray ticket indicated apple/cranberry drink, baked chicken, gravy, potatoes, Brussel sprouts, fruit cocktail, and milk. Review of Resident R53's tray failed to include milk. Review of the admission record indicated Resident R72 was admitted to the facility on [DATE]. Meal observation on 4/6/26, at 12:10 p.m. Resident R72's tray ticket indicated apple/cranberry drink, baked chicken, gravy, potatoes, Brussel sprouts, fruit cocktail, and milk. Review of Resident R72's tray failed to include milk. Interview on 4/6/26, at 12:18 p.m. Nurse Aide (NA) Employee E20 confirmed Resident R72 and Resident R53's meal trays failed to include milk. Interview on 4/8/26, at 9:02 a.m. NA Employee E21 confirmed Resident R34 received two sausage patties instead of bacon, hot cereal instead of cold, and no milk. Review of the admission record indicated Resident R13 was admitted to the facility on [DATE]. Meal observation on 4/7/26, at 12:10 p.m. Resident R13's tray ticket indicated milk, hot beverage, turkey sandwich with Swiss cheese, onion rings, peas and carrots and ice cream. Review of Resident (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R13's tray failed to include turkey sandwich. Sandwich was bologna with American cheese because the kitchen was out of Swiss and turkey. 28 Pa. Code: 211.6(a) Dietary services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, facility documentation, observations, and staff interview, it was determined that the facility failed to implement an infection control program that included a system of surveillance to identify possible communicable diseases or infections for seven of 11 months (May 2025, June 2025, July 2025, August 2025, September 2026, October 2025, and November 2025), failed to properly monitor a resident's personal refrigerator temperature for one of two residents (Resident R19), and failed to prevent cross contamination during a medication pass for one of three resident's (Resident R67). Findings include: Review of facility policy Surveillance for Infections dated 2/11/26, indicated the infection preventionist will conduct ongoing surveillance for healthcare-associated infections (HAIs) and other epidemiologically significant infection that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and healthcare-associated infections, to guide appropriate interventions, and to prevent future infections. Review of facility policy Administering Oral Medications dated 2/11/26, indicated the purpose of this procedure is to provide guidelines for the safe administration of oral medications. Review of the facility's Infection Control documentation for the previous 11 months (May 2025 - March 2026) failed to reveal surveillance for tracking infections for residents for seven of 11 months (May 2025, June 2025, July 2025, August 2025, September 2026, October 2025, and November 2025). During an interview on 4/7/26, at 12:01 p.m. the Director of Nursing (DON) stated, The previous IP [Infection Preventionist Employee E16] handed me a bunch of papers in December to put in the infection control binder. I didn't like the way she did things. During this interview, the DON confirmed that the facility failed to implement an infection control program that included a system of surveillance to identify possible communicable diseases for seven of 11 months (May 2025, June 2025, July 2025, August 2025, September 2026, October 2025, and November 2025). Review of the admission record indicated Resident R19 was admitted to the facility on [DATE]. Review of Resident R19's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/6/26, indicated the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), high blood pressure, and diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). Observation on 4/6/26, at 10:16 a.m. Resident R19's personal refrigerator was adorned with a temperature log dated January 2026. Interview on 4/6/26, at 10:16 a.m. Resident R19 indicated using the refrigerator daily. Interview on 4/6/26, at 10:20 a.m. Registered Nurse (RN) Employee E11 confirmed the facility failed to properly monitor a resident's personal refrigerator temperature for one of two residents (Resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R19). During a medication pass observation on 4/6/26, at 10:50 a.m. the Licensed Practical Nurse (LPN) Employee E12 was passing medications to Resident R67. The LPN Employee E12 put the medication in an ungloved hand, then put the medication in a medicine cup. LPN Employee E12 then administered the medication to Resident R67. During an interview on 4/6/26, at 11:01 a.m. LPN Employee E12 confirmed that the medication was touched without a glove and then administered to Resident R67 and failed to prevent cross contamination during a medication pass for one of three residents (Resident R67). 28 Pa. Code: 201.14 (a) Responsibility of licensee.28 Pa. Code: 201.18 (b)(1)(e)(1) Management.28 Pa. Code: 211.10(c)(d) Resident care policies.28 Pa. Code: 211.12 (d)(1)(2)(5) Nursing services.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on review of the facility's infection control policies and procedures, facility documentation, and staff interview, it was determined that the facility failed to implement an antibiotic stewardship program for seven of 11 months (May 2025, June 2025, July 2025, August 2025, September 2026, October 2025, and November 2025).Findings include: Review of facility policy Antibiotic Stewardship dated 2/11/26, indicated the purpose of the antibiotic stewardship program is to monitor the use of antibiotics in our residents. Review of facility policy Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes dated 2/11/26, indicated the IP (infection preventionist), or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify situations that are not consistent with the appropriate use of antibiotics. Review of facility-provided documentation for May 2025 revealed an Order Listing Report printed on 12/9/25, at 12:02 p.m. The printed report failed to include evidence that antibiotic monitoring was completed for May 2025. Review of facility-provided documentation for June 2025 revealed an Order Listing Report printed on 12/9/25, at 12:01 p.m. The printed report failed to include evidence that antibiotic monitoring was completed for June 2025. Review of facility-provided documentation for July 2025 revealed an Order Listing Report printed on 12/9/25, at 11:57 a.m. The printed report failed to include evidence that antibiotic monitoring was completed for July 2025. Review of facility-provided documentation for August 2025 revealed an Order Listing Report printed on 12/9/25, at 11:58 a.m. The printed report failed to include evidence that antibiotic monitoring was completed for August 2025. Review of facility-provided documentation for September 2025 revealed an Order Listing Report printed on 12/9/25, at 11:59 a.m. The printed report failed to include evidence that antibiotic monitoring was completed for September 2025. Review of facility-provided documentation for October 2025 revealed an Order Listing Report printed on 12/9/25, at 12:00 p.m. The printed report failed to include evidence that antibiotic monitoring was completed for October 2025. Review of facility-provided documentation for November 2025 revealed an Order Listing Report printed on 12/9/25, at 12:00 p.m. The printed report failed to include evidence that antibiotic monitoring was completed for November 2025. During an interview on 4/7/26, at 12:01 p.m. the Director of Nursing (DON) stated, The previous IP [Infection Preventionist Employee E16] handed me a bunch of papers in December to put in the infection control binder. I didn't like the way she did things. During this interview, the DON confirmed that the facility failed to implement an antibiotic stewardship program for seven of 11 months (May 2025, June 2025, July 2025, August 2025, September 2026, October 2025, and November 2025). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18 (b)(1)(e)(1) Management.28 Pa. Code: 211.10(c)(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on review of facility policy, facility in-service documentation, personnel files, and staff interviews, it was determined that the facility failed to provide training on Effective Communication for five of five staff members (Licensed Practical Nurse (LPN) Employee E6, Registered Nurse (RN) Employee E7, Nurse Aide (NA) Employee E8, NA Employee E9, and NA Employee E10).Findings include: Review of facility policy In-Service Training, All Staff dated 2/11/26, indicated all staff are required to participate in regular in-service education. Required training topics include the following: Effective communication with residents and family (direct care staff); Resident rights and responsibilities; Preventing abuse, neglect, exploitation, and misappropriation of resident property including dementia management and resident abuse prevention; elements and goals of the facility QAPI (Quality Assurance and Performance Improvement); the infection prevention and control program standards, policies and procedures; Behavioral health; and the compliance and ethics program standards, policies, and procedures. Training requirements are met prior to staff providing care to residents, annually, and as necessary based on the facility assessment. Completed training is documented by the staff development coordinator, or his or her designee and includes: the date and time of training, the topic of the training; a summary of the competency assessment; and the hours of training completed. During an interview on 4/6/26, at 1:39 p.m. the Nursing Home Administrator (NHA) stated, I'm not sure what the previous education system was. We just recently within the past month made everyone [staff] do their education. On 4/7/26, at 8:53 a.m. employee education files were requested for review for 2025. At this time, the NHA stated, It's going to take me a while for education, I have to contact the outgoing corporate company. During an interview on 4/7/26, at 1:11 p.m. the NHA stated, I still haven't been able to locate employee education, I will have to contact someone else who might be able to help. During an interview on 4/8/26, at 9:16 a.m. the NHA stated, There is no employee education for 2025. The previous Human Resources employee was horrible and didn't do the job correctly. The outgoing corporate company wasn't monitoring his work. When he finally left on March 1st, we were able to go through the education and realized there was none. We immediately started educating all of the staff. Review of LPN Employee E6's personnel file indicated a date of hire on 1/7/10. The facility provided an education test packet dated 3/14/26. Review of LPN Employee E6's personnel file did not include annual in-service training on Effective Communication from 1/1/25 through 12/31/25. Review of RN Employee E7's personnel file indicated a date of hire on 1/26/21. The facility provided an education test packet dated 3/13/26. Review of RN Employee E7's personnel file did not include annual in-service training on Effective Communication from 1/1/25 through 12/31/25. Review of NA Employee E8's personnel file indicated a date of hire on 12/8/20. The facility provided two education test packets dated 3/13/26. Review of NA Employee E8's personnel file did not include annual in-service training on Effective Communication from 1/1/25 through 12/31/25. Review of NA Employee E9's personnel file indicated a date of hire on 6/5/05. The facility provided two education test packets dated 3/17/26. Review of NA Employee E9's personnel file did not include annual in-service training on Effective Communication from 1/1/25 through 12/31/25. Review of NA Employee E10's personnel file indicated a date of hire on 2/21/24. The facility provided two education test packets signed by NA Employee E10, however no date was present. Review of NA Employee E10's personnel file did not include annual in-service training on Effective Communication from 1/1/25 through 12/31/25. During an interview on 4/8/26, at 9:16 a.m. the NHA confirmed that the facility failed to provide training on Effective Communication for five of five staff members (LPN Employee E6, RN Employee E7, NA Employee E8, NA Employee E9, and NA Employee E10). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a)(d) Staff development.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. Based on review of facility policy, facility in-service documentation, personnel files, and staff interviews, it was determined that the facility failed to provide training on Resident Rights for five of five staff members (Licensed Practical Nurse (LPN) Employee E6, Registered Nurse (RN) Employee E7, Nurse Aide (NA) Employee E8, NA Employee E9, and NA Employee E10).Findings include: Review of facility policy In-Service Training, All Staff dated 2/11/26, indicated all staff are required to participate in regular in-service education. Required training topics include the following: Effective communication with residents and family (direct care staff); Resident rights and responsibilities; Preventing abuse, neglect, exploitation, and misappropriation of resident property including dementia management and resident abuse prevention; elements and goals of the facility QAPI (Quality Assurance and Performance Improvement); the infection prevention and control program standards, policies and procedures; Behavioral health; and the compliance and ethics program standards, policies, and procedures. Training requirements are met prior to staff providing care to residents, annually, and as necessary based on the facility assessment. Completed training is documented by the staff development coordinator, or his or her designee and includes: the date and time of training, the topic of the training; a summary of the competency assessment; and the hours of training completed. During an interview on 4/6/26, at 1:39 p.m. the Nursing Home Administrator (NHA) stated, I'm not sure what the previous education system was. We just recently within the past month made everyone [staff] do their education. On 4/7/26, at 8:53 a.m. employee education files were requested for review for 2025. At this time, the NHA stated, It's going to take me a while for education, I have to contact the outgoing corporate company. During an interview on 4/7/26, at 1:11 p.m. the NHA stated, I still haven't been able to locate employee education, I will have to contact someone else who might be able to help. During an interview on 4/8/26, at 9:16 a.m. the NHA stated, There is no employee education for 2025. The previous Human Resources employee was horrible and didn't do the job correctly. The outgoing corporate company wasn't monitoring his work. When he finally left on March 1st, we were able to go through the education and realized there was none. We immediately started educating all of the staff. Review of LPN Employee E6's personnel file indicated a date of hire on 1/7/10. The facility provided an education test packet dated 3/14/26. Review of LPN Employee E6's personnel file did not include annual in-service training on Resident Rights from 1/1/25 through 12/31/25. Review of RN Employee E7's personnel file indicated a date of hire on 1/26/21. The facility provided an education test packet dated 3/13/26. Review of RN Employee E7's personnel file did not include annual in-service training on Resident Rights from 1/1/25 through 12/31/25. Review of NA Employee E8's personnel file indicated a date of hire on 12/8/20. The facility provided two education test packets dated 3/13/26. Review of NA Employee E8's personnel file did not include annual in-service training on Resident Rights from 1/1/25 through 12/31/25. Review of NA Employee E9's personnel file indicated a date of hire on 6/5/05. The facility provided two education test packets dated 3/17/26. Review of NA Employee E9's personnel file did not include annual in-service training on Resident Rights from 1/1/25 through 12/31/25. Review of NA Employee E10's personnel file indicated a date of hire on 2/21/24. The facility provided two education test packets signed by NA Employee E10, however no date was present. Review of NA Employee E10's personnel file did not include annual in-service training on Resident Rights from 1/1/25 through 12/31/25. During an interview on 4/8/26, at 9:16 a.m. the NHA confirmed that the facility failed to provide training on Resident Rights for five of five staff members (LPN Employee E6, RN Employee E7, NA Employee E8, NA Employee E9, and NA Employee E10). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a)(d) Staff development.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395883	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burgh Care Center	909 West Street Pittsburgh, PA 15221

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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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on review of facility policy, facility in-service documentation, personnel files, and staff interviews, it was determined that the facility failed to provide training on Abuse, Neglect, and Exploitation for five of five staff members (Licensed Practical Nurse (LPN) Employee E6, Registered Nurse (RN) Employee E7, Nurse Aide (NA) Employee E8, NA Employee E9, and NA Employee E10).Findings include: Review of facility policy In-Service Training, All Staff dated 2/11/26, indicated all staff are required to participate in regular in-service education. Required training topics include the following: Effective communication with residents and family (direct care staff); Resident rights and responsibilities; Preventing abuse, neglect, exploitation, and misappropriation of resident property including dementia management and resident abuse prevention; elements and goals of the facility QAPI (Quality Assurance and Performance Improvement); the infection prevention and control program standards, policies and procedures; Behavioral health; and the compliance and ethics program standards, policies, and procedures. Training requirements are met prior to staff providing care to residents, annually, and as necessary based on the facility assessment. Completed training is documented by the staff development coordinator, or his or her designee and includes: the date and time of training, the topic of the training; a summary of the competency assessment; and the hours of training completed. During an interview on 4/6/26, at 1:39 p.m. the Nursing Home Administrator (NHA) stated, I'm not sure what the previous education system was. We just recently within the past month made everyone [staff] do their education. On 4/7/26, at 8:53 a.m. employee education files were requested for review for 2025. At this time, the NHA stated, It's going to take me a while for education, I have to contact the outgoing corporate company. During an interview on 4/7/26, at 1:11 p.m. the NHA stated, I still haven't been able to locate employee education, I will have to contact someone else who might be able to help. During an interview on 4/8/26, at 9:16 a.m. the NHA stated, There is no employee education for 2025. The previous Human Resources employee was horrible and didn't do the job correctly. The outgoing corporate company wasn't monitoring his work. When he finally left on March 1st, we were able to go through the education and realized there was none. We immediately started educating all of the staff. Review of LPN Employee E6's personnel file indicated a date of hire on 1/7/10. The facility provided an education test packet dated 3/14/26. Review of LPN Employee E6's personnel file did not include annual in-service training on Abuse, Neglect, and Exploitation from 1/1/25 through 12/31/25. Review of RN Employee E7's personnel file indicated a date of hire on 1/26/21. The facility provided an education test packet dated 3/13/26. Review of RN Employee E7's personnel file did not include annual in-service training on Abuse, Neglect, and Exploitation from 1/1/25 through 12/31/25. Review of NA Employee E8's personnel file indicated a date of hire on 12/8/20. The facility provided two education test packets dated 3/13/26. Review of NA Employee E8's personnel file did not include annual in-service training on Abuse, Neglect, and Exploitation from 1/1/25 through 12/31/25. Review of NA Employee E9's personnel file indicated a date of hire on 6/5/05. The facility provided two education test packets dated 3/17/26. Review of NA Employee E9's personnel file did not include annual in-service training on Abuse, Neglect, and Exploitation from 1/1/25 through 12/31/25. Review of NA Employee E10's personnel file indicated a date of hire on 2/21/24. The facility provided two education test packets signed by NA Employee E10, however no date was present. Review of NA Employee E10's personnel file did not include annual in-service training on Abuse, Neglect, and Exploitation from 1/1/25 through 12/31/25. During an interview on 4/8/26, at 9:16 a.m. the NHA confirmed that the facility failed to provide training on Abuse, Neglect, and Exploitation for five of five staff members (LPN Employee E6, RN Employee E7, NA Employee E8, NA Employee E9, and NA Employee E10). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a)(d) Staff development.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on review of facility policy, facility in-service documentation, personnel files, and staff interviews, it was determined that the facility failed to provide training on the Quality Assurance and Performance Improvement (QAPI) program for five of five staff members (Licensed Practical Nurse (LPN) Employee E6, Registered Nurse (RN) Employee E7, Nurse Aide (NA) Employee E8, NA Employee E9, and NA Employee E10).Findings include: Review of facility policy In-Service Training, All Staff dated 2/11/26, indicated all staff are required to participate in regular in-service education. Required training topics include the following: Effective communication with residents and family (direct care staff); Resident rights and responsibilities; Preventing abuse, neglect, exploitation, and misappropriation of resident property including dementia management and resident abuse prevention; elements and goals of the facility QAPI; the infection prevention and control program standards, policies and procedures; Behavioral health; and the compliance and ethics program standards, policies, and procedures. Training requirements are met prior to staff providing care to residents, annually, and as necessary based on the facility assessment. Completed training is documented by the staff development coordinator, or his or her designee and includes: the date and time of training, the topic of the training; a summary of the competency assessment; and the hours of training completed. During an interview on 4/6/26, at 1:39 p.m. the Nursing Home Administrator (NHA) stated, I'm not sure what the previous education system was. We just recently within the past month made everyone [staff] do their education. On 4/7/26, at 8:53 a.m. employee education files were requested for review for 2025. At this time, the NHA stated, It's going to take me a while for education, I have to contact the outgoing corporate company. During an interview on 4/7/26, at 1:11 p.m. the NHA stated, I still haven't been able to locate employee education, I will have to contact someone else who might be able to help. During an interview on 4/8/26, at 9:16 a.m. the NHA stated, There is no employee education for 2025. The previous Human Resources employee was horrible and didn't do the job correctly. The outgoing corporate company wasn't monitoring his work. When he finally left on March 1st, we were able to go through the education and realized there was none. We immediately started educating all of the staff. Review of LPN Employee E6's personnel file indicated a date of hire on 1/7/10. The facility provided an education test packet dated 3/14/26. Review of LPN Employee E6's personnel file did not include annual in-service training on the QAPI program from 1/1/25 through 12/31/25. Review of RN Employee E7's personnel file indicated a date of hire on 1/26/21. The facility provided an education test packet dated 3/13/26. Review of RN Employee E7's personnel file did not include annual in-service training on the QAPI program from 1/1/25 through 12/31/25. Review of NA Employee E8's personnel file indicated a date of hire on 12/8/20. The facility provided two education test packets dated 3/13/26. Review of NA Employee E8's personnel file did not include annual in-service training on the QAPI program from 1/1/25 through 12/31/25. Review of NA Employee E9's personnel file indicated a date of hire on 6/5/05. The facility provided two education test packets dated 3/17/26. Review of NA Employee E9's personnel file did not include annual in-service training on the QAPI program from 1/1/25 through 12/31/25. Review of NA Employee E10's personnel file indicated a date of hire on 2/21/24. The facility provided two education test packets signed by NA Employee E10, however no date was present. Review of NA Employee E10's personnel file did not include annual in-service training on the QAPI program from 1/1/25 through 12/31/25. During an interview on 4/8/26, at 9:16 a.m. the NHA confirmed that the facility failed to provide training on the QAPI program for five of five staff members (LPN Employee E6, RN Employee E7, NA Employee E8, NA Employee E9, and NA Employee E10). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a)(d) Staff development.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on review of facility policy, facility in-service documentation, personnel files, and staff interviews, it was determined that the facility failed to provide training on Infection Control for five of five staff members (Licensed Practical Nurse (LPN) Employee E6, Registered Nurse (RN) Employee E7, Nurse Aide (NA) Employee E8, NA Employee E9, and NA Employee E10).Findings include: Review of facility policy In-Service Training, All Staff dated 2/11/26, indicated all staff are required to participate in regular in-service education. Required training topics include the following: Effective communication with residents and family (direct care staff); Resident rights and responsibilities; Preventing abuse, neglect, exploitation, and misappropriation of resident property including dementia management and resident abuse prevention; elements and goals of the facility QAPI (Quality Assurance and Performance Improvement); the infection prevention and control program standards, policies and procedures; Behavioral health; and the compliance and ethics program standards, policies, and procedures. Training requirements are met prior to staff providing care to residents, annually, and as necessary based on the facility assessment. Completed training is documented by the staff development coordinator, or his or her designee and includes: the date and time of training, the topic of the training; a summary of the competency assessment; and the hours of training completed. During an interview on 4/6/26, at 1:39 p.m. the Nursing Home Administrator (NHA) stated, I'm not sure what the previous education system was. We just recently within the past month made everyone [staff] do their education. On 4/7/26, at 8:53 a.m. employee education files were requested for review for 2025. At this time, the NHA stated, It's going to take me a while for education, I have to contact the outgoing corporate company. During an interview on 4/7/26, at 1:11 p.m. the NHA stated, I still haven't been able to locate employee education, I will have to contact someone else who might be able to help. During an interview on 4/8/26, at 9:16 a.m. the NHA stated, There is no employee education for 2025. The previous Human Resources employee was horrible and didn't do the job correctly. The outgoing corporate company wasn't monitoring his work. When he finally left on March 1st, we were able to go through the education and realized there was none. We immediately started educating all of the staff. Review of LPN Employee E6's personnel file indicated a date of hire on 1/7/10. The facility provided an education test packet dated 3/14/26. Review of LPN Employee E6's personnel file did not include annual in-service training on Infection Control from 1/1/25 through 12/31/25. Review of RN Employee E7's personnel file indicated a date of hire on 1/26/21. The facility provided an education test packet dated 3/13/26. Review of RN Employee E7's personnel file did not include annual in-service training on Infection Control from 1/1/25 through 12/31/25. Review of NA Employee E8's personnel file indicated a date of hire on 12/8/20. The facility provided two education test packets dated 3/13/26. Review of NA Employee E8's personnel file did not include annual in-service training on Infection Control from 1/1/25 through 12/31/25. Review of NA Employee E9's personnel file indicated a date of hire on 6/5/05. The facility provided two education test packets dated 3/17/26. Review of NA Employee E9's personnel file did not include annual in-service training on Infection Control from 1/1/25 through 12/31/25. Review of NA Employee E10's personnel file indicated a date of hire on 2/21/24. The facility provided two education test packets signed by NA Employee E10, however no date was present. Review of NA Employee E10's personnel file did not include annual in-service training on Infection Control from 1/1/25 through 12/31/25. During an interview on 4/8/26, at 9:16 a.m. the NHA confirmed that the facility failed to provide training on Infection Control for five of five staff members (LPN Employee E6, RN Employee E7, NA Employee E8, NA Employee E9, and NA Employee E10). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a)(d) Staff development.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide training in compliance and ethics. Based on review of facility policy, facility in-service documentation, personnel files, and staff interviews, it was determined that the facility failed to provide training on Compliance and Ethics for five of five staff members (Licensed Practical Nurse (LPN) Employee E6, Registered Nurse (RN) Employee E7, Nurse Aide (NA) Employee E8, NA Employee E9, and NA Employee E10).Findings include: Review of facility policy In-Service Training, All Staff dated 2/11/26, indicated all staff are required to participate in regular in-service education. Required training topics include the following: Effective communication with residents and family (direct care staff); Resident rights and responsibilities; Preventing abuse, neglect, exploitation, and misappropriation of resident property including dementia management and resident abuse prevention; elements and goals of the facility QAPI (Quality Assurance and Performance Improvement); the infection prevention and control program standards, policies and procedures; Behavioral health; and the compliance and ethics program standards, policies, and procedures. Training requirements are met prior to staff providing care to residents, annually, and as necessary based on the facility assessment. Completed training is documented by the staff development coordinator, or his or her designee and includes: the date and time of training, the topic of the training; a summary of the competency assessment; and the hours of training completed. During an interview on 4/6/26, at 1:39 p.m. the Nursing Home Administrator (NHA) stated, I'm not sure what the previous education system was. We just recently within the past month made everyone [staff] do their education. On 4/7/26, at 8:53 a.m. employee education files were requested for review for 2025. At this time, the NHA stated, It's going to take me a while for education, I have to contact the outgoing corporate company. During an interview on 4/7/26, at 1:11 p.m. the NHA stated, I still haven't been able to locate employee education, I will have to contact someone else who might be able to help. During an interview on 4/8/26, at 9:16 a.m. the NHA stated, There is no employee education for 2025. The previous Human Resources employee was horrible and didn't do the job correctly. The outgoing corporate company wasn't monitoring his work. When he finally left on March 1st, we were able to go through the education and realized there was none. We immediately started educating all of the staff. Review of LPN Employee E6's personnel file indicated a date of hire on 1/7/10. The facility provided an education test packet dated 3/14/26. Review of LPN Employee E6's personnel file did not include annual in-service training on Compliance and Ethics from 1/1/25 through 12/31/25. Review of RN Employee E7's personnel file indicated a date of hire on 1/26/21. The facility provided an education test packet dated 3/13/26. Review of RN Employee E7's personnel file did not include annual in-service training on Compliance and Ethics from 1/1/25 through 12/31/25. Review of NA Employee E8's personnel file indicated a date of hire on 12/8/20. The facility provided two education test packets dated 3/13/26. Review of NA Employee E8's personnel file did not include annual in-service training on Compliance and Ethics from 1/1/25 through 12/31/25. Review of NA Employee E9's personnel file indicated a date of hire on 6/5/05. The facility provided two education test packets dated 3/17/26. Review of NA Employee E9's personnel file did not include annual in-service training on Compliance and Ethics from 1/1/25 through 12/31/25. Review of NA Employee E10's personnel file indicated a date of hire on 2/21/24. The facility provided two education test packets signed by NA Employee E10, however no date was present. Review of NA Employee E10's personnel file did not include annual in-service training on Compliance and Ethics from 1/1/25 through 12/31/25. During an interview on 4/8/26, at 9:16 a.m. the NHA confirmed that the facility failed to provide training on Compliance and Ethics for five of five staff members (LPN Employee E6, RN Employee E7, NA Employee E8, NA Employee E9, and NA Employee E10). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a)(d) Staff development.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of facility policy, facility in-service documentation, personnel files, and staff interviews, it was determined that the facility failed to provide training on Dementia Management and Resident Abuse Prevention for five of five staff members (Licensed Practical Nurse (LPN) Employee E6, Registered Nurse (RN) Employee E7, Nurse Aide (NA) Employee E8, NA Employee E9, and NA Employee E10) and failed to ensure that three of three sampled Nurse Aides received a minimum of 12 hours of in-service education per year (NA Employee E8, NA Employee E9, and NA Employee E10).Findings include: Review of facility policy In-Service Training, All Staff dated 2/11/26, indicated all staff are required to participate in regular in-service education. Required training topics include the following: Effective communication with residents and family (direct care staff); Resident rights and responsibilities; Preventing abuse, neglect, exploitation, and misappropriation of resident property including dementia management and resident abuse prevention; elements and goals of the facility QAPI (Quality Assurance and Performance Improvement); the infection prevention and control program standards, policies and procedures; Behavioral health; and the compliance and ethics program standards, policies, and procedures. Training requirements are met prior to staff providing care to residents, annually, and as necessary based on the facility assessment. Completed training is documented by the staff development coordinator, or his or her designee and includes: the date and time of training, the topic of the training; a summary of the competency assessment; and the hours of training completed. During an interview on 4/6/26, at 1:39 p.m. the Nursing Home Administrator (NHA) stated, I'm not sure what the previous education system was. We just recently within the past month made everyone [staff] do their education. On 4/7/26, at 8:53 a.m. employee education files were requested for review for 2025. At this time, the NHA stated, It's going to take me a while for education, I have to contact the outgoing corporate company. During an interview on 4/7/26, at 1:11 p.m. the NHA stated, I still haven't been able to locate employee education, I will have to contact someone else who might be able to help. During an interview on 4/8/26, at 9:16 a.m. the NHA stated, There is no employee education for 2025. The previous Human Resources employee was horrible and didn't do the job correctly. The outgoing corporate company wasn't monitoring his work. When he finally left on March 1st, we were able to go through the education and realized there was none. We immediately started educating all of the staff. Review of LPN Employee E6's personnel file indicated a date of hire on 1/7/10. The facility provided an education test packet dated 3/14/26. The test packet did not include training related to Dementia Management. Review of LPN Employee E6's personnel file did not include annual in-service training on Dementia Management and Resident Abuse Prevention from 1/1/25 through 12/31/25. Review of RN Employee E7's personnel file indicated a date of hire on 1/26/21. The facility provided an education test packet dated 3/13/26. The test packet did not include training related to Dementia Management. Review of RN Employee E7's personnel file did not include annual in-service training on Dementia Management and Resident Abuse Prevention from 1/1/25 through 12/31/25. During an interview on 4/8/26, at 10:20 a.m. the Director of Nursing (DON) stated, I think only the nurse aides got both of the test packets. During this interview, the DON confirmed that only Nurse Aides received a test packet containing training for the following topics: HIPAA (The Health Insurance Portability Accountability Act - health information privacy rights), Falls Prevention, Restorative Nursing Services, Emergency Procedures, Workplace Safety, Understanding and Responding to Behavioral Symptoms of Dementia, Customer Service, Trauma Informed Care, and Dementia Training. Review of NA Employee E8's personnel file indicated a date of hire on 12/8/20. The facility provided two education test packets dated 3/13/26. Review of NA Employee E8's personnel file did not include annual in-service training on Dementia Management and Resident Abuse Prevention from 1/1/25 through 12/31/25. Review of facility nurse aide training records revealed that NA Employee E8 did not receive 12 hours of in-service training from 1/1/25 (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	through 12/31/25. Review of NA Employee E9's personnel file indicated a date of hire on 6/5/05. The facility provided two education test packets dated 3/17/26. Review of NA Employee E9's personnel file did not include annual in-service training on Dementia Management and Resident Abuse Prevention from 1/1/25 through 12/31/25. Review of facility nurse aide training records revealed that NA Employee E9 did not receive 12 hours of in-service training from 1/1/25 through 12/31/25. Review of NA Employee E10's personnel file indicated a date of hire on 2/21/24. The facility provided two education test packets signed by NA Employee E10, however no date was present. Review of NA Employee E10's personnel file did not include annual in-service training on Dementia Management and Resident Abuse Prevention from 1/1/25 through 12/31/25. Review of facility nurse aide training records revealed that NA Employee E10 did not receive 12 hours of in-service training from 1/1/25 through 12/31/25. During an interview on 4/8/26, at 9:16 a.m. the NHA confirmed that the facility failed to provide training on Dementia Management and Resident Abuse Prevention for five of five staff members (LPN Employee E6, RN Employee E7, NA Employee E8, NA Employee E9, and NA Employee E10) and failed to ensure that three of three sampled Nurse Aides received a minimum of 12 hours of in-service education per year (NA Employee E8, NA Employee E9, and NA Employee E10). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a)(d) Staff development.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on review of facility policy, facility in-service documentation, personnel files, and staff interviews, it was determined that the facility failed to provide training on Behavioral Health for five of five staff members (Licensed Practical Nurse (LPN) Employee E6, Registered Nurse (RN) Employee E7, Nurse Aide (NA) Employee E8, NA Employee E9, and NA Employee E10).Findings include: Review of facility policy In-Service Training, All Staff dated 2/11/26, indicated all staff are required to participate in regular in-service education. Required training topics include the following: Effective communication with residents and family (direct care staff); Resident rights and responsibilities; Preventing abuse, neglect, exploitation, and misappropriation of resident property including dementia management and resident abuse prevention; elements and goals of the facility QAPI (Quality Assurance and Performance Improvement); the infection prevention and control program standards, policies and procedures; Behavioral health; and the compliance and ethics program standards, policies, and procedures. Training requirements are met prior to staff providing care to residents, annually, and as necessary based on the facility assessment. Completed training is documented by the staff development coordinator, or his or her designee and includes: the date and time of training, the topic of the training; a summary of the competency assessment; and the hours of training completed. During an interview on 4/6/26, at 1:39 p.m. the Nursing Home Administrator (NHA) stated, I'm not sure what the previous education system was. We just recently within the past month made everyone [staff] do their education. On 4/7/26, at 8:53 a.m. employee education files were requested for review for 2025. At this time, the NHA stated, It's going to take me a while for education, I have to contact the outgoing corporate company. During an interview on 4/7/26, at 1:11 p.m. the NHA stated, I still haven't been able to locate employee education, I will have to contact someone else who might be able to help. During an interview on 4/8/26, at 9:16 a.m. the NHA stated, There is no employee education for 2025. The previous Human Resources employee was horrible and didn't do the job correctly. The outgoing corporate company wasn't monitoring his work. When he finally left on March 1st, we were able to go through the education and realized there was none. We immediately started educating all of the staff. Review of LPN Employee E6's personnel file indicated a date of hire on 1/7/10. The facility provided an education test packet dated 3/14/26. Review of LPN Employee E6's personnel file did not include annual in-service training on Behavioral Health from 1/1/25 through 12/31/25. Review of RN Employee E7's personnel file indicated a date of hire on 1/26/21. The facility provided an education test packet dated 3/13/26. Review of RN Employee E7's personnel file did not include annual in-service training on Behavioral Health from 1/1/25 through 12/31/25. Review of NA Employee E8's personnel file indicated a date of hire on 12/8/20. The facility provided two education test packets dated 3/13/26. Review of NA Employee E8's personnel file did not include annual in-service training on Behavioral Health from 1/1/25 through 12/31/25. Review of NA Employee E9's personnel file indicated a date of hire on 6/5/05. The facility provided two education test packets dated 3/17/26. Review of NA Employee E9's personnel file did not include annual in-service training on Behavioral Health from 1/1/25 through 12/31/25. Review of NA Employee E10's personnel file indicated a date of hire on 2/21/24. The facility provided two education test packets signed by NA Employee E10, however no date was present. Review of NA Employee E10's personnel file did not include annual in-service training on Behavioral Health from 1/1/25 through 12/31/25. During an interview on 4/8/26, at 9:16 a.m. the NHA confirmed that the facility failed to provide training on Behavioral Health for five of five staff members (LPN Employee E6, RN Employee E7, NA Employee E8, NA Employee E9, and NA Employee E10). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a)(d) Staff development.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on review of facility policy, review of personnel files, and staff interview, it was determined that the facility failed to properly screen an employee by failing to conduct a criminal background check prior to the start of employment for two of five personnel files reviewed (Nurse Aide (NA) Employee E4 and NA Employee E5).Findings include: Review of facility policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated 2/11/26, indicated to conduct employee background checks and not knowingly employ or otherwise engage in any individual who has: been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. On 4/7/26, at 9:03 a.m. employee personnel files were requested from the facility. Review of NA Employee E4's personnel file indicated a date of hire on 2/9/26. Review of NA Employee E4's personnel file included a criminal background check with a Date of Request of 2/26/26, at 8:38 a.m., after the employee's date of hire. Review of NA Employee E5's personnel file indicated a date of hire on 2/27/26. Review of NA Employee E5's personnel file included a criminal background check with a Date of Request of 4/7/26, at 10:38 a.m., after the employee's date of hire. During an interview on 4/8/26, at 1:32 p.m. the Nursing Home Administrator confirmed that the facility failed to properly screen an employee by failing to conduct a criminal background check prior to the start of employment for two of five personnel files reviewed (NA Employee E4 and NA Employee E5). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.19(8) Personnel records.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, facility documents, clinical record reviews and staff interview it was determined that the facility failed to initiate a thorough investigation for injury of unknown origin for one of two residents reviewed (Resident R10)Findings include: Review of facility policy Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating dated 2/11/26, indicated that all reports of resident abuse (including injuries of unknown origin), are reported to local, state, and federal agencies, and thoroughly investigated by facility management. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents. The individual conducting the investigation as a minimum:Reviews the documentation and evidenceReviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incidentObserves the alleged victim, including his or her interactions with staff and other residentsInterviews the person(s) reporting the incidentInterviews any witnesses to the incident Interviews the resident (as medically appropriate) or the resident's representativeInterviews the resident's attending physician as needed to determine the resident's conditionInterviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incidentInterviews the resident's roommate, family members, and visitorsInterviews other residents to whom the accused employee provides care or servicesReviews all events leading up to the alleged incidentDocuments the investigation completely and thoroughly Resident R10 was admitted to the facility on [DATE]. Review of Resident R10's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/21/26, indicated diagnoses of high blood pressure, chronic pain, and iron deficiency. Review of documentation provided by the facility dated 3/20/26, stated Resident R10 fell on 3/2/26 with no injury noted. On 3/8/26, resident was sent to ER (emergency room) for evaluation at hospital for altered mental status. While in the hospital she was diagnosed at the hospital with a left toe fracture and placed in a boot. She later returned to the center on 3/12/26. Upon review of discharge paperwork there was an ortho (orthopedic - a medical specialty dealing with the skeletal system) appointment that needed to be made. Multiple attempts to collect medical records from hospital after records obtained we confirmed at some point in time she experienced a fracture. Review of Resident R10 facility investigation failed to include a summary of the investigation/findings, any witness statements, or employee, and or resident/family interviews as to how the injury may have occurred. During an interview on 4/7/26, at 3:30 p.m. the Director of Nursing (DON) stated that the investigation included printing out and reviewing all of Resident R10's progress notes from the time of the fall on 3/2/26 through 3/8/26, when she was sent out to the hospital. The DON confirmed that no interviews were conducted, and that the facility failed to complete a thorough investigation for an injury of unknown origin one of three residents (Resident R10). 28 Pa. Code 201.14 (a) Responsibility of Licensee.28 Pa. Code 201.18 (b)(1)(e) (1) Management.

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, facility documentation, clinical record review, and staff interview, it was determined that the facility failed to ensure residents had the capacity to understand the terms of the admission agreement for one of three residents (Resident R64).Findings include: Review of facility policy admission Criteria dated 2/11/26, indicated an objective of the admission criteria is to review with the resident, and/or his/her representative, the facility's policies and procedures relating to resident rights, resident care, financial obligations, visiting hours, etc. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2025 indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions:13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of the clinical record revealed Resident R64 was admitted to the facility on [DATE]. Review of Resident R64's admission Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/17/25, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fats in the blood), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Question C0500 BIMS Summary Score indicated a score of 11, moderately impaired. Review of pre-admission hospital paperwork revealed a History and Physical progress note dated 8/6/25, completed by a physician at the discharging hospital. The progress note stated, [AGE] year-old male with CKD (chronic kidney disease), mood disorder, CLL (chronic lymphocytic leukemia), cognitive impairment/dementia likely worsening sent to the emergency department due to concerns for inability to care for self. Patient poor historian. Reportedly patient has not been taking care of himself not taking any medications for the past few months. Also has had frequent falls and issues with balance. Allegedly patient had called the police due to question of a stolen car however patients roommate states it did not happen. Patient expresses eating and drinking less and having decreased energy. Department of aging requested patient to come to the emergency department for placement due to concerns over inability self-care. The pre-admission hospital paperwork listed Resident Representative RR1 as Resident R64's emergency contact. Review of a Durable Health Care Power of Attorney (POA) paperwork revealed Resident Representative RR1 was listed as Resident R64's Health Care POA effective 12/13/23. Review of a nursing progress note dated 8/19/25, stated, Resident in bed relaxing at this time watching TV. VSS (vital signs stable). Resident is very confused, attempted to redirect, resident slightly agitated, seems to respond better if you agree with his confusion. Meds taken po (by mouth) whole, care ongoing. Review of a progress note dated 8/22/25, completed by Social Worker Employee E15 stated, Residents two cousins were in to see him. They wanted to speak with me. They said they were going to tell him today that his son was not allowing him back to his house. They told me a long sordid story about the family dynamics, and their suspicions about the current POAs intentions. Current POA is in Florida, and the cousins are questioning whether she is out for his money. They asked who they would report something like that to, and I gave them the number for the area agency on aging. The family said they will talk with [Resident R64] and if they feel there is a problem with anything, that they will call. Neither the POA or the resident has given us any indication that we need to report anything. Review of Resident R64's admission agreement indicated a completion date of 8/22/25, signed by Resident R64. During an interview on 4/9/26, at 2:15 p.m. the Nursing Home Administrator (NHA) stated, He [Resident R64] signed his own paperwork because no one was answering the phone and his family thought the POA was stealing his money. We had to get Psych involved, they said he is allowed to make his own decisions. Review of Resident R64's clinical record failed to include documentation that attempts were made to contact Resident R64's power of attorney. During an interview on 4/9/26, at 2:20 p.m. the NHA and Social Worker Employee E15 provided a Supportive Care Psychology Services progress note dated 12/29/25. During this interview (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the NHA stated, The resident was admitted in August, and it took us until December to get someone to agree to evaluate him for capacity. They determined he can make his own decisions. Review of the Supportive Care Psychology Services progress note dated 12/29/25, stated, Plan: Resident is a candidate for psychotherapy at this time and will continue to be seen on a needed basis. In terms of the determination of this psychological capacity evaluation, it is clear that due to his cognitive deficits and memory gaps, resident needs to have a power of attorney to help him make decisions regarding his medical, financial, and any other needs. As the result of the evaluation determined that [Resident R64] is only mildly cognitively impaired, it stands to reason that he could choose for himself who he would like to assign to be his Power of Attorney. During an interview on 4/9/26, at 2:20 p.m. when asked if a resident with a low BIMS score, a diagnosis of dementia, and a POA should sign their own paperwork, the NHA and Social Worker Employee E15 answered, Yes, it depends. During an interview on 4/9/26, at 2:20 p.m. the NHA confirmed that the facility failed to ensure residents had the capacity to understand the terms of the admission agreement for one of three residents (Resident R64). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1)(3)Management.28 Pa. Code: 201.24(e) admission policy.28 Pa. Code: 201.29(a) Resident rights.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and resident and staff interview, it was determined that the facility failed to promote a multidisciplinary approach with care conferences for two of six residents reviewed (Resident R36, R40).Findings include: Review of the clinical record indicated Resident R40 was admitted [DATE]. Review of Resident R40's Minimum Data Set, MDS (minimum data set a periodic review of assessment needs) dated 2/2/26, indicated diagnosis of epilepsy (chronic brain disorder characterized by recurrent, unprovoked seizures), spinal stenosis (narrowing of space within the spine, which can compress the spinal cord and nerves) and chronic obstructive pulmonary disease(lung disease causing restricted airflow and breathing problems). Review of Resident R40's Multidisciplinary Care Conference sign in sheet dated 4/2/26, included the following disciplinary: social worker, dietary and therapy. Review of Resident R40's Multidisciplinary Care Conference sign in sheet dated 1/8/26, included the following disciplinary: social worker, dietary and therapy. Review of clinical record indicated Resident R36 was admitted to the facility on [DATE]. Review of Resident R36's Minimum Data Set, MDS (MDS-a mandated assessment of a resident's abilities and care needs) assessment, dated 3/27/26, indicated the diagnoses of congestive heart failure (chronic condition where the heart is unable to pump blood effectively), anemia and coronary atherosclerosis (buildup of plaque inside the coronary arteries). Review of Resident R36's Multidisciplinary Care Conference sign in sheet dated 3/23/26, included the following disciplinary: social worker, dietary and therapy. During an interview on 4/9/26 at 1:00 p.m. Director of Social Services Employee E15 dated 3/12/26 and 2/26/26 indicated nursing was unavailable during care conference meetings dated 1/8/26, 3/23/26 and 4/2/26. 28 Pa. Code 211.12(d)(3) Nursing services

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, and staff interview, it was determined that the facility failed to make certain that residents received proper treatment for pressure ulcers for one of three residents (Resident R6).Findings include: Review of the admission record indicated Resident R6 admitted to the facility on [DATE]. Review of Resident R6's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/2/26, indicated the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), high blood pressure, and End Stage Renal Disease (ESRD -kidneys cease to function on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life). Review of Resident R6's care plan dated 3/7/26, indicated skin integrity: weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate (drainage). Review of Resident R6's progress note dated 1/30/26, indicated writer was notified by aide of resident's open skin. Upon assessment, open skin area noted on left outer heel. Skin is dry and flaky. Measurements 2x2 cm (centimeters). Area was cleaned with saline. Received an order for Medi honey (medical grade honey to treat wounds) 4x4 border gauze to apply once daily. Nurse practitioner made aware and wound care notified. Consult for wound care completed. Review of wound care note dated 2/3/26, indicated Resident R6 was unable to be evaluated by the skin and wound team today; resident at dialysis during time of visit. Review of longevity note dated 2/6/26, indicated Resident R6 had a left heel plantar (bottom) and left lateral (side) heel with two small open areas, no active drainage noted. Surrounding skin intact. The note failed to include measurements of the wound or type of wound present. Review of physician order dated 2/24/26, indicated measure and document in nurses note appearance of wound at bedtime every seven days for wound tracking. Review of progress note dated 2/24/26, indicated left heel pressure wound shows no bleeding with granulation observed to the area. No drainage observed at this time. Resident denies pain. The note failed to include measurements of the wound. Further review of the progress notes indicated the following dates failed to include measurements of the wound as ordered: -3/3/26, the record failed to include a progress note with measurements on this date from facility staff. The wound care team indicated resident was unable to be evaluated by the skin and wound team today; resident at dialysis during time of visit.-3/10/26, the progress note failed to include measurements of the wound from facility staff. The wound care team indicated resident was unable to be evaluated by the skin and wound team today; resident at dialysis during time of visit. Interview on 4/10/26, at 11:45 a.m. Registered Nurse (RN) Employee E11 confirmed the facility failed to categorize a wound timely, failed to care plan the actual wound, and failed to document weekly measurements as ordered for Resident R6. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10 (c)(d) Resident care policies.28 Pa. Code: 211.12 (d)(1)(2)(5) Nursing services.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, observations, clinical records, and staff interviews it was determined that the facility failed to make certain that appropriate treatments and services were provided for the use of a urinary catheter (a flexible tube inserted into the bladder to drain urine) for two of two residents (R1, and R73).Findings include: Review of the facility Catheters Care; Urinary last reviewed 2/11/26, Indicated the purpose of this procedure is to prevent infection of the resident's urinary tract. Be sure the catheter tubing and drainage bag are kept off the floor. Review of the admission record indicated Resident R73 was admitted to the facility on [DATE], with the diagnoses of neoplasm of prostate (abnormal growth of cells in the prostate gland), diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and obstructive uropathy (a blockage in the urinary tract that prevents normal urine flow). Review of the admission record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/20/26, indicated the diagnoses of Multiple Sclerosis (immune system eats away at protective covering of nerve cells), neurogenic bladder (lack of bladder control due to a brain, spinal cord or nerve problem), and malnutrition. Review of Resident R1's physician order dated 3/17/26, indicated foley catheter 16 French, 10 CC (cubic centimeters) balloon, change every 30 days for neurogenic bladder. Review of Resident R1's current care plan indicated resident will be free from catheter-related trauma through the review date. Observation on 4/7/26, at 9:04 a.m. Resident R1 was finishing the breakfast meal in bed. The urinary catheter bag was on the floor and failed to have a dignity bag. Interview on 4/7/27, at 9:10 a.m. Registered Nurse (RN) Employee E11 confirmed Resident R1's urinary catheter bag was on the floor and failed to have a dignity bag. Review of Resident R73's physician order dated 2/17/26, indicated empty suprapubic catheter (a thin flexible tube inserted through a small incision in the lower abdomen directly into the bladder to drain urine) every shift and document amount. Review of Resident R73's current care plan indicated Resident R73 will be free from catheter-related trauma through the review date. Observation on 4/6/26, at 9:15 a.m. Resident R73 was resting in bed. The catheter bag was on the floor. Interview on 4/6/26, at 9:20a.m. RN Employee E11 confirmed Resident R1's urinary catheter bag was on the floor. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(c)(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interviews it was determined that the facility failed to create a care plan for the care and management of a colostomy (a surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall so as to bypass a damaged part of the colon) for two of two residents (Resident R59, and R72).Findings include: Review of facility policy Colostomy/Ileostomy Care dated 2/11/26, indicated the purpose is to provide guidelines that will aid in preventing exposure of the resident's skin to fecal matter. Review the resident's care plan to assess for any special needs of the resident. Review of the admission record revealed that Resident R59 was admitted to the facility on [DATE]. Review of Resident R59's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/9/26, indicated diagnosis of malnutrition (lack of nutrients in the body), anal cancer, and difficulty walking. Section H0100 appliances indicated ostomy (including urostomy, ileostomy, and colostomy) present. Review of Resident R59s physician order dated 2/17/26, indicated colostomy appliance - change wafer and bag every week and as needed for colostomy. Review of Resident R59's current care plan failed to include a care plan for the care and management of a colostomy. Review of the admission record revealed that Resident R72 was admitted to the facility on [DATE]. Review of Resident R72's MDS dated [DATE], indicated diagnoses of chronic obstructive pulmonary disease (COPD- a group of diseases that block airflow and make it hard to breathe), Benign prostatic hyperplasia (BPH - a common enlargement of the prostate gland in aging men that squeezes the urethra), and cirrhosis of the liver (permanent scarring of the liver) Section H0100 appliances indicated ostomy (including urostomy, ileostomy, and colostomy) present. Review of Resident R72's physician order dated 2/17/26, indicated colostomy appliance - change wafer and bag everyweek and as needed. Review of Resident R72's current care plan failed to include a care plan for the care and management of a colostomy. Interview on 4/10/26, at 9:40 a.m. Registered Nurse Assessment Coordinator (RNAC) Employee E17 confirmed the facility failed to create a care plan for the care and management of a colostomy for two of two residents (Resident R59, and R72). 28 Pa. Code 211.10(c) Resident care policies28 Pa. Code 211.12(d)(1)(2)(5) Nursing services

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of resident clinical records, facility policy and staff interview it was determined the facility failed to provide consistent and complete communication with the dialysis (treatment that helps body remove extra fluid and waste products) center for one of five residents (Resident R6).Findings include: Review of the facility policy Hemodialysis dated 2/11/26, indicated that the facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include the ongoing assessments of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility. Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. Review of the admission record indicated Resident R6 admitted to the facility on [DATE]. Review of Resident R6's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/2/26, indicated the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), high blood pressure, and End Stage Renal Disease (ESRD -kidneys cease to function on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life). Section O0110 indicated dialysis. Review of Resident R6's physician order dated 2/24/26, indicated resident has dialysis on Tuesday and Saturday. Chair Time 10:15 a.m. Review of Resident R6's current care plan indicated resident needs dialysis related to renal failure. The resident has dialysis on Tuesday, Thursday, and Saturday. Pick up at 6:00 a.m. The care plan was not reflective of Resident R6's current orders. Review of Resident R6's Dialysis Record of Visit forms indicated incomplete communications from the dialysis center on the following dates: 2/10/26, 2/24/26, 3/7/26, 3/10/26, and 3/12/26. Interview on 4/7/26, at 2:30 p.m. Registered Nurse (RN) Employee E11 confirmed Resident R6's Dialysis Record of Visit forms had incomplete communications from the dialysis center on the following dates: 2/10/26, 2/24/26, 3/7/26, 3/10/26, and 3/12/26, and the current care plan was not reflective of Resident R6's current orders. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1) Management.28 Pa. Code: 211.10(c)(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.

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Burgh Care Center	909 West Street Pittsburgh, PA 15221

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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 review of facility policy, observations, and staff interviews, it was determined that the facility failed to properly store medical supplies in one of two medication carts (Fourth Floor South Cart).Findings: Review of facility Storage of Medications policy dated 2/11/26, indicated the facility stores all drugs and biologicals in a safe, secure, and orderly manner. Drugs and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received. Drugs that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling. Review of facility Labeling of Medication Containers policy dated 2/11/26, indicated all medication maintained in the facility are properly labeled in accordance with current state and federal guidelines and regulations. Any medication packaging that are inadequately or improperly labeled are returned to the issuing pharmacy. Only the dispensing pharmacy can label or alter the label on medication package. During a medication cart review on 4/6/26, at 10:21 a.m. the following were observed: Lantus Insulin Pen (used to treat high blood sugar) with an incorrect open date. Dated 4/7/26. Lantus Insulin Pen - No open date and no expiration date Novolog Insulin Pen (used to treat high blood sugar) - Three insulin pens that had no open date and no expiration date. Lantus Insulin Pen - The name on the insulin pen was altered and the dose was incorrect. During an interview on 4/6/26, at 10:45 a.m. Licensed Practical Nurse (LPN) Employee E13 confirmed the above findings and stated that an employee crossed out the original name on the insulin pen (resident discharged) with a blue marker and Resident R54's name was written on the pharmacy label with blue marker. LPN Employee E13 also confirmed that the dose was incorrect because the pen was not sent from pharmacy for Resident R54. During an interview on 4/6/26, at 11:21 a.m. LPN Employee E13 stated, The altered insulin pen should be destroyed. The original resident is no longer here. We can't use other insulins that are not labeled for that resident. We should not tamper with pharmacy labels. Someone could get the wrong dose of medication. On 4/6/26, at 11:21 a.m. the State Agency (SA) requested the Director of Nursing (DON). The DON arrived on nursing floor and was given the Lantus insulin pen with the altered pharmacy label. The DON confirmed that the facility failed to properly store medical supplies in one of two medication carts (Fourth Floor South Cart). During a medication pass observation on 4/9/26, at 8:30 a.m. a Lantus insulin was observed in the medication cart with no open date and no expiration date on it (Fourth floor South Medication Cart). During an interview on 4/9/26, at 8:45 a.m. Registered Nurse (RN) Employee E14 confirmed the above finding. 28 Pa Code: 211.9 (a)(1) Pharmacy services.28 Pa Code: 211.12 (d) (1) (5) Nursing services.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, facility documents, clinical record review, and staff interview it was determined that the facility failed to ensure residents had the capacity to understand the terms of a binding arbitration agreement (a binding agreement by the parties to submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship, whether contractual or not) for one of three residents (Resident R64).Findings include: Review of facility policy admission Criteria dated 2/11/26, indicated an objective of the admission criteria is to review with the resident, and/or his/her representative, the facility's policies and procedures relating to resident rights, resident care, financial obligations, visiting hours, etc. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2025, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions:13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of the clinical record revealed Resident R64 was admitted to the facility on [DATE]. Review of Resident R64's admission Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/17/25, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fats in the blood), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Question C0500 BIMS Summary Score indicated a score of 11, moderately impaired. Review of pre-admission hospital paperwork revealed a History and Physical progress note dated 8/6/25, completed by a physician at the discharging hospital. The progress note stated, [AGE] year-old male with CKD (chronic kidney disease), mood disorder, CLL (chronic lymphocytic leukemia), cognitive impairment/dementia likely worsening sent to the emergency department due to concerns for inability to care for self. Patient poor historian. Reportedly patient has not been taking care of himself not taking any medications for the past few months. Also has had frequent falls and issues with balance. Allegedly patient had called the police due to question of a stolen car however patients roommate states it did not happen. Patient expresses eating and drinking less and having decreased energy. Department of aging requested patient to come to the emergency department for placement due to concerns over inability self-care. The pre-admission hospital paperwork listed Resident Representative RR1 as Resident R64's emergency contact. Review of a Durable Health Care Power of Attorney (POA) paperwork revealed Resident Representative RR1 was listed as Resident R64's Health Care POA effective 12/13/23. Review of a nursing progress note dated 8/19/25, stated, Resident in bed relaxing at this time watching TV. VSS (vital signs stable). Resident is very confused, attempted to redirect, resident slightly agitated, seems to respond better if you agree with his confusion. Meds taken po (by mouth) whole, care ongoing. Review of a progress note dated 8/22/25, completed by Social Worker Employee E15 stated, Residents two cousins were in to see him. They wanted to speak with me. They said they were going to tell him today that his son was not allowing him back to his house. They told me a long sordid story about the family dynamics, and their suspicions about the current POAs intentions. Current POA is in Florida, and the cousins are questioning whether she is out for his money. They asked who they would report something like that to, and I gave them the number for the area agency on aging. The family said they will talk with [Resident R64] and if they feel there is a problem with anything, that they will call. Neither the POA or the resident has given us any indication that we need to report anything. Review of Resident R64's admission agreement indicated a completion date of 8/22/25, signed by Resident R64. During an interview on 4/8/26, at 8:37 a.m. the Nursing Home Administrator (NHA) stated the facility's binding arbitration agreement is in the admission paperwork and addressed when the admission agreement is reviewed and signed. During an interview on 4/9/26, at 2:15 p.m. the NHA stated, He [Resident R64] signed his own paperwork because no one was answering the phone and his family thought the POA was stealing his money. We (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had to get Psych involved, they said he is allowed to make his own decisions. Review of Resident R64's clinical record failed to include documentation that attempts were made to contact Resident R64's power of attorney. During an interview on 4/9/26, at 2:20 p.m. the NHA and Social Worker Employee E15 provided a Supportive Care Psychology Services progress note dated 12/29/25. During this interview the NHA stated, The resident was admitted in August, and it took us until December to get someone to agree to evaluate him for capacity. They determined he can make his own decisions. Review of the Supportive Care Psychology Services progress note dated 12/29/25, stated, Plan: Resident is a candidate for psychotherapy at this time and will continue to be seen on a needed basis. In terms of the determination of this psychological capacity evaluation, it is clear that due to his cognitive deficits and memory gaps, resident needs to have a power of attorney to help him make decisions regarding his medical, financial, and any other needs. As the result of the evaluation determined that [Resident R64] is only mildly cognitively impaired, it stands to reason that he could choose for himself who he would like to assign to be his Power of Attorney. During an interview on 4/9/26, at 2:20 p.m. when asked if a resident with a low BIMS score, a diagnosis of dementia, and a POA should sign their own paperwork, the NHA and Social Worker Employee E15 answered, Yes, it depends. During an interview on 4/9/26, at 2:20 p.m. the NHA confirmed that the facility failed to ensure residents had the capacity to understand the terms of a binding arbitration agreement for one of three residents (Resident R64). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(2) Management.28 Pa. Code: 201.24(b) admission policy. 28 Pa. Code: 201.29(a) Resident rights.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that an influenza immunization was offered to one of five residents (Resident R26).Findings include: Review of facility policy Influenza, Prevention and Control of Seasonal dated 2/11/26, indicated all residents and staff are offered the vaccine prior to the onset of the influenza season. Review of facility policy Vaccination of Residents dated 2/11/26, indicated all residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated or the resident has already been vaccinated. Review of the clinical record revealed Resident R26 was admitted to the facility on [DATE]. Review of Resident R26's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/7/26, indicated diagnoses of high blood pressure, anxiety, and depression. Question O0250: Influenza Vaccine indicated Resident R26 did not receive the influenza vaccine in the facility for this year's influenza vaccination season. Review of Resident R26's clinical record failed to include documentation that the influenza vaccination was offered and administered or declined. During an interview on 4/8/26, at 12:41 p.m. the Director of Nursing confirmed that the facility failed to make certain that an influenza immunization was offered to one of five residents (Resident R26). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.5(f) Medical records.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that a COVID-19 vaccination was offered to two of five residents (Residents R26 and R48).Findings include: Review of facility policy Coronavirus Disease (COVID-19) - Vaccination of Residents dated 2/11/26, indicated each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident has already been immunized. Review of the clinical record revealed Resident R26 was admitted to the facility on [DATE]. Review of Resident R26's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/7/26, indicated diagnoses of high blood pressure, anxiety, and depression. Question O0350 was coded no for Resident's COVID-19 vaccination is up to date. Review of Resident R26's clinical record indicated the resident last received a COVID-19 vaccination on 11/5/21. Review of Resident R26's clinical record failed to include documentation that the COVID-19 vaccination was offered and administered or declined since 11/5/21. Review of the clinical record revealed Resident R48 was admitted to the facility on [DATE]. Review of Resident R48's MDS dated [DATE], indicated diagnoses of anxiety, depression, and constipation. Question O0350 was coded no for Resident's COVID-19 vaccination is up to date. Review of Resident R48's clinical record indicated the resident last received a COVID-19 vaccination on 11/20/23. Review of Resident R48's clinical record failed to include documentation that the COVID-19 vaccination was offered and administered or declined since 11/20/23. During an interview on 4/8/26, at 12:41 p.m. the Director of Nursing confirmed that the facility failed to make certain that a COVID-19 vaccination was offered to two of five residents (Residents R26 and R48). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.5(f) Medical records.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility documentation, and staff interviews, it was determined that the facility failed to make certain that equipment was in safe operating condition for one of two of the facilities crash carts (a cart that contains supplies in the event of an emergency), (Fourth Floor) and one of two Automated External Defibrillator (AED-a portable, electronic device designed to diagnose and treat life-threatening cardiac arrhythmias), (Fourth Floor). Findings include: Review of facility Crash Cart policy dated [DATE], indicated to establish a standardized approach for the maintenance, accessibility, and utilization of crash carts to support timely responses to medical emergencies. All contents must be within expiration dates. Review of facility Automatic External Defibrillator, Use and Care of policy dated [DATE], indicated personnel have completed training on the initiation of cardiopulmonary resuscitation (CPR) and basic life support, including defibrillation, for victims of sudden cardiac arrest. Keep a spare battery and adhesive pads. Record the expiration date of the battery and the pads on the maintenance tasks. Document checks. During a review of facility provided document labeled Emergency Crash Cart of the facilities crash cart (Fourth Floor) on [DATE], at 12:00 p.m. revealed no monitoring of the facilities AED. During an observation of the facilities crash cart, located on the Fourth floor, on [DATE], at 12:15 p.m. revealed the following supplies to be expired: Oxygen masks - expired [DATE]Tracheostomy Kit (an opening in the neck to help breathing) - expired [DATE](1) Ambu bag (a handheld manual resuscitator used to provide positive pressure ventilation) - expired [DATE](1) Ambu bag - expired [DATE] During an observation of the facilities AED, located on the Fourth floor, on [DATE], at 12:18 p.m. revealed the following supplies to be expired: (1) AED pads - expired [DATE] During an interview on [DATE], at 12:20 p.m. Registered Nurse (RN) Employee E11 stated that the crash cart and AED should be checked daily and confirmed that no one monitors the function of the AED, and the expired supplies on the crash cart and AED. 28 Pa Code: 201.14(a) Responsibility of licensee.

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observations and staff interview, it was determined that the facility failed to post complete contact information for State Long-Term Care Ombudsman program, and accessible, and complete contact information for Adult Protective Services at the facility as required for three of three locations (First Floor, Nursing Unit Second Floor, and Nursing Unit Fourth Floor). Findings include: During observations completed on 4/7/26, from 12:51 p.m. through 1:10 p.m., on the First Floor and Second and Fourth Floor Nursing Units revealed State Long-Term Care Ombudsman information posted did not include the Ombudsman's name or email address as required. These observations also revealed that Adult Protective Services (APS) information posted did not include APS's name, mailing address, phone number, or email address as required. During an interview on 4/7/26, at 2:13 p.m. the Nursing Home Administrator confirmed that the facility failed to post complete contact information for the State Long-Term Care Ombudsman program and Adult Protective Services as required for three of three locations (First Floor, Nursing Unit Second Floor, and Nursing Unit Fourth Floor). 28 Pa. Code: 201.14(a)Responsibility of licensee.28 Pa. Code: 201.18(e) Management.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations and staff interview, it was determined the facility failed to ensure postings of the location Department of Health most recent survey results were readily accessible to residents and visitors for three of three locations (First Floor, Nursing Unit Second Floor, and Nursing Unit Fourth Floor).Findings include: During observations conducted on 4/7/26, from 12:51 p.m. through 1:10 p.m., no postings were observed in the facility identifying the location of the Department of Heath's most recent survey results. During an interview on 4/7/26, at 2:13 p.m. the Nursing Home Administrator (NHA) Stated, The survey results binder broke, it's in my office. During an interview on 4/7/26, at 2:13 p.m. the NHA confirmed that the facility failed to ensure postings of the location Department of Health most recent survey results were readily accessible to residents and visitors for three of three locations (First Floor, Nursing Unit Second Floor, and Nursing Unit Fourth Floor). 28 Pa. Code: 201.14(a) Responsibility of licensee.

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F 0579 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide information about how to apply for and use Medicare and Medicaid benefits. Based on observations and a staff interview, it was determined that the facility failed to display (for residents and/or their responsible person) written information on how to apply for Medicare and Medicaid benefits and receiving refunds for previous payments covered by Medicare and Medicaid as required, in the building, where postings are available (First Floor, Nursing Unit Second Floor and Nursing Unit Fourth Floor).Findings include: During observations conducted on 4/7/26, from 12:51 p.m. through 1:10 p.m. on the First Floor and Second and Fourth Floor Nursing Units revealed that facility failed to include information on how to apply for Medicare and Medicaid benefits and receiving refunds for previous payments covered by Medicare and Medicaid. During an interview on 4/7/26, at 2:13 p.m. the Nursing Home Administrator confirmed the facility failed to display (for residents and/or their responsible person) written information on how to apply for Medicare and Medicaid benefits and receiving refunds for previous payments covered by Medicare and Medicaid as required, in the building, where postings are available (First Floor, Nursing Unit Second Floor and Nursing Unit Fourth Floor). 28 Pa. Code: 201.14(a)Responsibility of licensee.28 Pa. Code: 201.18(e) Management.