STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395891	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel View Village	2000 Cambridge Drive Davidsville, PA 15928

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on a review of clinical records, as well as staff interviews, it was determined that the facility failed to maintain clinical records that were complete and accurately documented for one of 24 residents reviewed (Resident 17).Findings include:A comprehensive MDS assessment for Resident 17, dated February 24, 2026, indicated that the resident was cognitively impaired, required assistance with daily care needs, received insulin, and had diagnoses that included diabetes.Physician's orders for Resident 17, dated February 14, 2026, included an order for the resident to receive 11 units insulin aspart 100 units/milliliter (ml) at 7:00 a.m. daily if blood glucose is less than 80 mg/dL give 4 units, and if blood glucose is less than 70 mg/dL hold insulin recheck 1 hour after eating and administer insulin per sliding scale order.Physician's orders for Resident 17, dated February 13, 2026, included an order for the resident to receive 9 units insulin aspart 100 units/ml at 11:00 a.m. daily if blood glucose is less than 80 mg/dL give 3 units, and if blood glucose is less than 70 mg/dL hold insulin recheck 1 hour after eating and administer insulin per sliding scale order.Physician's orders for Resident 17, dated February 13, 2026, included an order for the resident to receive 13 units insulin aspart 100 units/ml at 4:00 p.m. daily if blood glucose is less than 80 mg/dL give 5 units and if blood glucose is less than 70 mg/dL hold insulin recheck 1 hour after eating and administer insulin per sliding scale order. Review of Resident 17's Medication Administration Record (MAR) for February 2026, March 2026, April 2026, and May 2026 revealed no documented evidence of how many units received per physician's orders at the above times. Interview with the Director of Nursing on May 20, 2026, at 11:02 a.m. confirmed that there was no documented evidence in Resident 17's clinical record of how many units the resident received daily at the above times.28 Pa Code 211.5(f) Clinical Records. 28 Pa. Code 211.12(d)(5) Nursing Services.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on a review of clinical records, select facility policy, and staff interviews, it was determined the facility failed to ensure a resident's medication regimen was free from unnecessary psychotropic medications and that non-pharmacological interventions were implemented prior to initiation of an antipsychotic medication for one of 24 residents reviewed (Resident 10) for unnecessary medications.Findings included: The facility's policy regarding psychotropic medications (any medication that affects brain activities associated with mental processes and behavior), dated October 15, indicated that psychotropic medications are not used unless clinically indicated, are prescribed at the lowest effective dose, and are subject to gradual dose reduction and behavioral interventions in accordance with federal regulations and informed consent will be obtained per state law. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 10, dated April 8, revealed that the resident is cognitively impaired, requires assistance with daily care needs and has medical diagnoses that includes anxiety, depression, and Post Traumatic Stress Disorder (PTSD). Physician orders for Resident 10 dated March 21, 2026, included orders for the resident to receive 1 milligram of lorazepam (an antianxiety medication) every 12 hours as needed. A review of the Medication Administration Record (MAR) for Resident 10 revealed that she received 1mg lorazepam on April 5, 2026, at 12:00 a.m. and on April 7,2026, at 4:15 a.m. A review of the clinical record for Resident 10 revealed that there was no non-pharmacological interventions attempted prior to the medication administration. During an interview with the Director of Nursing on May 21, 2026, at 9:35 a.m. confirmed that there were no non-pharmacological interventions attempted prior to the as needed medication and there should have been. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to develop and implement an individualized care plan for one of 24 residents reviewed (Resident 5).Findings include: A Quarterly Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated April 16, 2026, revealed that the resident was cognitively impaired, was sometimes understood and could sometimes understand others, and required assistance from staff with daily care needs. A physician's order for Resident 5, dated November 28, 2025, included orders for the resident to maintain a 1500cc fluid restriction. A physician's order for Resident 5 dated January 21, 2026, revealed that the resident's humidifier was no longer to be filled with distilled water due to the resident drinking the water. A nursing note for Resident 5 dated, January 22, 2026, revealed that the resident has been attempting to get water where she can in bathrooms and was observed drinking the water from her humidifier. A nursing note for Resident 5 dated, January 27, 2026, revealed that the resident has been non-compliant with her fluid restrictions. She was observed taking medicine cups from the med cart and filling them up with water from the bathroom. There was no documented evidence that a care plan was developed to address Resident 5's non-compliance with fluid restrictions. Interview with the Nursing Home Administrator on May 20, 2026, at 9:25 a.m. confirmed that Resident 5 did not have care plans developed to address her non-compliance with fluid restrictions. 28 Pa. Code 211.11(d) Resident care plan. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on review of Pennsylvania's Nursing Practice Act, facility policies, and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that an assessment was completed by a professional (registered) nurse after a change in condition occurred for two out of 24 residents reviewed (Resident 2, 8). Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals. The facility's policy for change in condition, dated October 21, 2025, indicated that if a resident has a change in condition, it is the registered nurse's responsibility to observe, record and update the physician regarding that resident's altered condition. A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated April 16, 2026, revealed that the resident was cognitively intact, required assistance from staff for daily care, and had diagnoses that included heart failure and high blood pressure. Vital Signs for Resident 2 dated April 4, 2026, revealed that the resident had a blood pressure of 84/60. Vital Signs for Resident 2 dated April 19, 2026, revealed that the resident had a blood pressure of 80/50. A nursing note for Resident 2, dated April 18, 2026, at 1:47 p.m. revealed that the resident was not able to tolerate the sit-to-stand lift. There was no documented evidence that a registered nurse assessed Resident 2's change in condition when he was not able to tolerate the sit-to-stand lift and when he had low blood pressure readings. Interview with the Director of Nursing on May 20, 2026, at 9:46 a.m. confirmed that Resident 2 should have been assessed by a registered nurse and the assessment should have been documented in the resident's medical record for the change in condition and the two days he had low blood pressures. A quarterly admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated October 1, 2025, revealed that the resident was severely cognitively impaired and had diagnoses that included dementia, depression and Alzheimer's disease. A general progress note for Resident 8, dated March 25, 2026, at 3:57 p.m. revealed that the resident's son was in to visit earlier in the afternoon and stated that he thinks his mom is brewing something, that he can just tell by her face. There was no documented evidence that a registered nurse assessed the resident's change in condition referenced by her son. An activity participation note for Resident 8, dated March 25, 2026, at 6:08 p.m. revealed that the resident completed the scheduled activity for 30 minutes, though she appeared to not feel well today, however, there was no documented evidence that registered nurse assessed the resident's change in condition. A health status note for Resident 8, dated March 26, 2026, at 8:00 a.m. indicated that the Licensed Practical Nurse notified the Registered Nurse that Resident 8 was not looking good. The resident was assessed at that time and the physician was updated. Physician orders included; breathing treatments, lab work, a swab check for the Flu, Covid and RSV (a common respiratory virus that causes cold-like symptoms), and a chest x-ray. A physician communication note for Resident 8, dated March 26, 2026, at 4:26 p.m. indicated that the physician was notified of the chest x-ray results and the resident was sent to the emergency room for evaluation. Interview with the Director of Nursing on May 20, 2026, at 2:45 p.m. confirmed that there was no documented evidence of a registered nurse assessment regarding Resident 8's change in condition on March 25, 2026, at 3:57 p.m. and 6:08 p.m., and there should have been. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders regarding medication administration were followed for two of 24 residents reviewed (Residents 17, and 33).Findings include: A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) dated February 24, 2026, for Resident 17 revealed that the resident was cognitively impaired, was rarely understood and rarely understood others, required assistance from staff for daily care needs, received insulin and had a diagnosis of diabetes. Physician's orders for Resident 17, dated February 14, 2026, included an order for the resident to receive Novolog flexpen insulin aspart 100unit/milliliter and Inject 11 units subcutaneously at 7:00 a.m. and if blood glucose is <80 mg/dL inject 8 units and if blood sugar <70 mg/dL to hold insulin and obtain another blood glucose in 1 hour after meals and to administer per sliding scale order. Review of Resident 17's Medication Administration Record (MAR) for April 2026, revealed that on April 22 during the 7:00 a.m. medication pass the blood glucose level was 71mg/dL and that 11 units of Novolog flexpen insulin aspart 100 unit/milliliter was administered. Physician's orders for Resident 17, dated February 13, 2026, included an order for the resident to receive Novolog flexpen insulin aspart 100 unit/milliliter and Inject 13 units subcutaneously at 4:00 p.m. and if blood glucose is <80 mg/dL to inject 5 units of Novolog flexpen insulin aspart and if blood glucose is <70 mg/dL to hold insulin and obtain another blood glucose in 1 hour after meals and to administer per sliding scale order. Review of Resident 17's MAR for April 2026, revealed that on April 22 at 4:00 p.m. the resident's blood glucose level was 78 mg/dL and that 13 units of Novolog flexpen insulin aspart was injected. Interview with Director of Nursing on May 20, 2026, at 9:22 a.m. confirmed that on the above dates and times the wrong dose of insulin was administered to Resident 17. A comprehensive MDS assessment dated [DATE], for Resident 33 revealed that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included high blood pressure. Physician's order for Resident 33, dated July 9, 2024 revealed the resident was to receive 5 milligrams (mg) of lisinopril (a medication to treat high blood pressure) once a day and to hold the medication if the resident' systolic blood pressure (top number of blood pressure) is <100 mmHg or if the heart rate is < 60 beats per min (bpm). A review of the MAR for Resident 33 for April 2026 revealed that on April 26, 2026, the resident's blood pressure was 98/66 mmHg and they received 5mg lisinopril. Interview with the Director of Nursing on May 20, 2026, at 1:06 p.m. confirmed that the resident received 5mg lisinopril on the above date and time and shouldn't have. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that interventions were in place as ordered for two of 24 residents reviewed, a left palm guard to reduce contractures and pain and prevent skin breakdown (Resident 4) and a left hand towel roll to prevent contractures (Resident 33). Findings include:The facility's policy regarding splints and braces dated October 1, 2025, indicated that the purpose was to prevent or reduce contractures, maintain proper joint alignment, reduce pain and/or promote skin integrity.A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated April 3, 2026, indicated that the resident was moderately cognitively impaired, dependent on staff for care, had diagnoses that included a stroke which resulted in a decrease in hand muscle function and an increase in weakness of the left arm/hand. Resident 4's care plan, dated October 1, 2025, indicated that the resident had impaired left side mobility and a potential for decline in skin integrity related to his stroke. Physician's orders, dated November 17, 2025, included an order for the resident to have a palm guard in place in the left hand during the day.Observations on May 18, 2026, at 10:40 a.m., 1:18 p.m. and 2:45 p.m., and May 19, 2026, at 9:29 a.m. and 11:05 a.m. revealed that Resident 4 did not have a left palm guard in place as ordered.Interview with Registered Nurse 1 on May 19, 2026, at 11:22 a.m. indicated that if the left palm guard is ordered to be in place and documented as such, then it should be in place on the resident's left hand.Interview with Nurse Aide 2 on May 19, 2026, at 12:20 p.m. indicated that she was unaware that Resident 4 was ordered or had a left palm guard.Interview with Physical Therapy Assistant 3 on May 19, 2026, at 3:35 p.m. indicated that one of the purposes of the left palm guard was to provide comfort to the resident.A comprehensive MDS assessment for Resident 33, dated May 18, 2026, indicated that the resident was moderately cognitively intact, dependent on staff for care, had diagnoses that included hemiparesis resulted in a decrease in hand muscle function and an increase in weakness of the left arm/hand.Resident 33's care plan, dated May 20, 2025, indicated that the resident had left hand contractures and hemiparesis and required a left handroll to be utilized as ordered.Physician's orders for Resident 33 dated May 19, 2025, included an order for the resident to utilize a handroll in her left hand during the day for contracture managementObservations on May 18, 2026, at 10:00 a.m., 1:18 p.m. and 2:45 p.m., and May 20, 2026, at 9:01 a.m., 10:05 a.m., and 11:35 a.m., 12:03 p.m. and 1:15 p.m. revealed that Resident 33 did not have a left handroll in place as ordered. Interview with Nurse Aide 4 on May 20, 2026, at 1:15 p.m. indicated that the resident did not have her left handroll in and it should be utilized.Interview with the Director of Nursing on May 20, 2026, at 1:37 p.m. confirmed that Resident 4's left palm guard and Resident 33's left hand towel roll, were to be in place as per physician order, and they were not, and that there was no documented evidence that the residents refused the interventions. 42 CFR 483.25(c)(1)-(3) Increase/Prevent Decrease in Range of Motion/Mobility.28 Pa. Code 211.12(d)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, and staff interviews, it was determined that the facility failed to provide a separately locked, permanently affixed compartment in the refrigerator for the storage of controlled drugs (medications with the potential to be abused) in one of two medication rooms reviewed. Findings include:Observations in the facility's main medication room on May 20, 2026, at 10:12 a.m. revealed one small, refrigerator containing one bottle of liquid Ativan (a controlled medication used to treat anxiety). The liquid Ativan was not in a secured, permanently affixed locked compartment. The locked compartment was affixed to the shelf, but the shelf was easily removed from the refrigerator. Interview with Registered Nurse 5 at the time of the observation confirmed that the shelf containing the locked container was removable from the refrigerator.Interview with the Nursing Home Administrator on May 20, 2026, at 2:54 p.m. confirmed the bottle of liquid Ativan was not in a permanently affixed compartment and should have been.28 Pa. Code 211.9(a)(1) Pharmacy Services.