| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395893 | A. Building<br>B. Wing | 12/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Care Pavilion Nursing and Rehabilitation Center | 6212 Walnut Street<br>Philadelphia, PA 19139 |

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

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observations and interviews with staff it was determined that the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety.Findings include: An initial tour of the Food Service Department was conducted on December 1, 2025, at 9:40 a.m. with Employee E8, Food Service Director, (FSD) which revealed the following: Observation of the sink in the mop room revealed that it was clogged and full of dirty water. Observation of the trash can near the door revealed that it was not covered and contained kitchen waste which was open to the air. Observation of the drain collection funnel under the prep sink was full of trash that was dried and caked on thick. Observation of the fan guard in the prep room revealed a thick covering of grease and dust. Observation of the reach in refrigerator revealed personal drinks and orange colored soda and a black metal drink container with a sticker with a first name on it, and the door gaskets were dirty, torn and lose. Observation of the stainless-steel shelf in the prep room revealed that it was covered with crumbs, dust and dirt. Observation of the top of the coffee urn revealed dark brown grounds stuck to the stainless steel and dirt and dust and dried dark brownish black stains. Observation of the reach in refrigerator in the kitchen revealed that the door gaskets are dirty and torn apart. Observation of the air conditioning unit next to tray line, which was missing the cover, revealed a thick build-up of grease, dust and dirt blowing out over the kitchen area. Observation in the dish room revealed a chemical sanitizing low temperature machine. Testing of chemical sanitizing dish machine on revealed that no sanitizer was present in the final rinse confirming that the machine was not sanitizing the dishes that were being run through. The FSD could not get the machine to pump the sanitizing chemical into the rinse water and the machine. The FSD attempted to reach the rep from the chemical company to have them check the machine, but they could not come out the same day. The facility switched to serving residents on disposable dishware and silverware. Interview with the FSD on December 1, 2025, at 12:45 p.m. confirmed the above findings. Observation during a follow up visit to the kitchen on December 2, 2025, at 12:10 p.m. revealed the trash can in the corner with no cover and filled with trash, and the dish machine was still out of service. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(3) 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 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of resident records, review of facility policy, and staff interviews, the facility failed to monitor residents for changes in nutritional status and failed to implement appropriate interventions in response to identified nutritional changes for three of seven residents reviewed (Residents R38, R183 and R375). Findings include: Review of the facility's policy titled Nutrition (Impaired) Unplanned Weight Loss Clinical Protocol dated September 2017, revealed nursing staff are responsible for monitoring and documenting residents' weight and dietary intake over time, and any significant changes in weight, appetite, or food/fluid intake must be reported to the physician. The policy requires that the physician, in collaboration with nursing and the multidisciplinary team, assess the resident's nutritional status, review for possible medical causes of weight loss or gain-including disease, medication effects, or fluid imbalances-and authorize appropriate interventions based on identified causes, overall condition, prognosis, and resident wishes. Interventions, such as dietary modifications or the use of appetite stimulants, should only be implemented after a thorough evaluation and documentation of underlying causes. In this instance, the physician was not notified of the resident's weight loss, and the dietician failed to initiate any interventions or provide documented guidance. As a result, there was no physician-directed assessment or follow-up, representing a clear deviation from the policy, which mandates timely physician notification, collaborative evaluation, and cause-specific interventions to manage impaired nutritional status. Review of Resident R38's quarterly Minimum Data Set (MDS- A federal mandated assessment tool for all residents) dated October 18, 2025, revealed Resident R38 was admitted to the facility on [DATE]. The resident was wheelchair dependent and was assessed with the BIMS (Brief Interview of Mental Status) of 00 (sever cognitive impairment). Continued review of Resident R38 revealed that the resident is on a regular soft bite sized diet and self-fed independently. Resident R38's diagnosis' included hypertension (high Blood pressure), Parkinson's disease (neurodegenerative disease of the central nervous system effecting motor and non-motor systems) depression (mood disorder that causes persistent feeling of sadness and loss of interest). Review of Resident R38's clinical record revealed that this resident was ordered on October 8, 2025 a regular diet, soft bite size, level 6 texture (soft solid foods cut into small pieces) thin level 0(thin regular liquids) with instructions to weigh resident as indicated. Continued review of Resident R38's clinical record indicated resident had a 12.8-pound weight loss in one month and a 19.0-pound weight loss over two months with the following documented weights: - September 19, 2025, weight 143.4 lbs.- October 9, 2025, weight 137.2 lbs.- November 5, 2025, weight 124.4 lbs.- November 25, 2025, weight 122.2 lbs. Review of resident R38's documented dietary assessment dated [DATE], (a documented 6.2 lb. weight loss) revealed that Resident R38 was on regular soft and bite sized diet no reports of difficulties chewing or swallowing on current diet textures, intake is highly variable per documentation likely related to decreased appetite with advanced age. (She/he) is able to sell feed independently per OT (occupational therapy). No new labs to review this quarter. Weight history reviewed, weight remains stable and is risk for fluctuations on diet diuretic medication. Current weight 137 normal per age standards weight maintenance without significant loss gain is desired registered dietician will continue to monitor and reassess as needed. Review of Resident R 38's documented dietary assessment dated [DATE] , revealed no reports of difficulties chewing or swelling on current diet oral intake is variable per documentation with unusual eating patterns (she/he) is self-fed independent per OT(occupational therapy) no new labs to review she remains on vitamin D and calcium supplement for support residents current weight is 124.4 pounds normal per standards (a documented 12.8 lb. weight loss) (she/he) is trigger for a significant weight loss compared to one and two months ago, previously stabled. Some weight loss may be related to advanced age and variable intake, however unlikely greater than 10-pound weight loss occurred in one month. Reweight requested on 11/14/25. Weight<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | fluctuations can also be anticipated related to heart failure diagnosis and resident on diuretic medication. Weight maintenance without significant weight loss is desired. Dieticians will continue to monitor and reassess as needed nursing to obtain re-weight as requested. Continued review of Resident's 38 clinical record revealed that a weight was not obtained until November 25, 2025, 11 days later. Review of the resident's progress notes revealed that the last two medical practitioner notes were completed by the Nurse Practitioner on November 1, 2025, and November 13, 2025. Both notes indicate that the resident was seen; however, there is no documentation that the resident was followed, assessed, or evaluated for significant weight loss. The notes state, I have reviewed records, including EMR (electronic medical records), vital signs, labs, and consults. Interview with Registered Dietitian, Employee E4 on December 2, 2025, at 11:10 a.m. revealed that she acknowledged the resident's significant weight loss but could not explain why the resident had not been reweighed and was unaware of any interventions initiated to address the weight loss. She stated that she would investigate the matter further and consult with Dietitian Employee E17 regarding appropriate follow-up and interventions. Interview with Registered Dietitian Employee E17 on December 2, 2025, at 3:00 p.m. revealed that she assessed the resident on November 13, 2025, acknowledged the resident's significant weight loss, and referred the resident to nursing for a reweight. She noted that the previous weight may not have been accurate and recognized that the resident was taking Furosemide, which could contribute to weight loss. Dietitian Employee E17 confirmed that the physician had not been notified of the weight loss. She planned to add a dietary supplement to the resident's orders and to reweigh the resident the following month. In our interview with the Director of Nursing (DON)Employee E2, on December 3, 2025, at 9:25 a.m. revealed that he reviewed the matter and found that the nurses reported that Resident R38 was refusing to be weighed, but documentation was not entered into the resident's clinical record in a timely manner. The resident's clinical record was later updated by the regional nurse employee E18 with late entries indicating that the resident had allegedly refused weights several times; however, there was no contemporaneous documentation of these refusals, and no discussion or notification to the physician occurred regarding the resident's weight loss or refusals. Review of Resident R375's care plan, dated November 5, 2025, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including malnutrition (lack of sufficient nutrients in the body), respiratory failure (not enough oxygen passes from your lungs to your blood), cerebral infarction (damage to the brain) and dysphagia (difficulty swallowing). Continued review of the care plan reviewed that the resident was at risk for malnutrition and that the resident required tube feedings. Further review of the care plan revealed a goal of weight stability. Review of Resident R375's weights revealed:On October 24, 2025, the resident weighed 165 pounds;On November 6, 2025, the resident weighed 165 pounds;On November 12, 2025, the resident weighed 144 pounds; [NAME] November 25, 2025, the resident weighed 106 pounds. Review of nutrition notes for Resident R375 revealed a note, dated November 19, 2025, which indicated that the resident is triggering for significant weight loss compared to previous admission weights, however, likely inaccurate as he did not lose 20 pounds over a few days. The note continued that weight maintenance and/or gain is desired. Interview on December 2, 2025, at 11:24 a.m. Employee E4, Registered dietician, confirmed that Resident R375's weights were inaccurate and that the resident needs to be re-weighed to confirm the weight loss. Review of the December 2025 physician order for R183 indicated that the resident was admitted into the facility on January 27, 2025 with diagnoses of anxiety, depression, dislocation of left hip, cocaine abuse; traumatic subdural hemorrhage; hypertension; seizures Review of the resident' initial nutritional assessment completed on January 29, 2025 indicated that the residents were also malnourished (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat). Review of the December 2025 physician orders included a physician's order dated January 30, 2025, for the resident to have one- 4 ounce house shake provided to him to drink two times a day with his breakfast and lunch meals. During an interview with the Registered dietitian, (continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | (Employee E4) on December 5, 2025, the registered dietician reported that the purpose of the resident consuming the house shakes was to promote weight gain. Review of a nursing note dated April15, 2025 at 3:52 p.m. documented that the resident was discharged to the hospital on April 15, 2025, and subsequently re-admitted to the facility on [DATE]. Review of the resident's physician orders upon return from the facility on April 28, 2025, did not include the physician's orders for the resident to have one-4ounce house shake for breakfast and lunch meals. Continued review of the resident's clinical record indicated that there was no documentation that the resident had an admission weight obtained upon (his/her) return to the facility on April 28, 2025 or any documentation that a nutritional assessment was completed upon (his/her) return to ensure that the resident's weight was properly obtained and the resident was properly assessed by the registered dietician for his nutritional needs. During an interview with the Registered dietician. Employee E4 on December 5, 2025 at 11:05 a.m. the resident's clinical record was reviewed and the registered dietician confirmed that there was no admission weight taken upon the resident's return, and nutritional assessment completed on the resident upon his returned, as required. The registered dietician also confirmed that upon the resident's return from the hospital, the house shake to promote weight loss was discontinued. It was confirmed with the registered dietician at this time that there was no documentation information in the clinical record as to why the facility did not resume the physician's order for the resident's house shakes upon his return from the hospital on April 28, 2025. Review of the resident's weight taken on May 13, 2025 by nursing staff recorded the resident's weight at 125.lbs. Review of the resident's weight taken on June 6, 2025 was recorded as 108.0 (pounds) lbs., indicating that the resident had a significant weight loss of -13.67% over less than a 30 day period. The significant weight loss of the resident was confirmed with the dietician on December 5, 2025 at 11:05 a.m. Review of the dietician's nutritional assessment that was completed on June 7, 2025 after the significant weight loss indicated, the previous dietician prescribed house shake BID (twice a day) but that it was not noted in the chart order. Review of the clinical record provided no documentation that the resident was consuming the house shakes twice a day upon his return from the hospital on April 28, 2025 through June 6, 2025. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12 (c)Nursing Services |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>Based on observations, resident and staff interviews, and a review of facility documentation, it was determined that the facility failed to provide food and drink that was palatable and served at palatable temperatures during test tray evaluation and for 15 of 35 residents reviewed (Residents R9, R42, R60, R63, R67, R72, R89, R144, R246, R288, R294, r299 R329, r315, and R339).Findings include: A review of Test Tray Evaluation Form, revealed that the standard temperature for hot foods, including entree and starch, on tray line was over 135 degrees and cold food, including milk and juice, was under 50 degrees. Interview with Resident R42 on December 1, 2025, at 10:15 a.m. revealed that the food is not what he ordered, that he supposed to be getting shakes and double portions. Interview with Resident R60 on December 1, 2025, at 10:18 a.m. revealed that the food is horrible and always cold. Interview with Resident R67 on December 1, 2025, at 10:21 a.m. revealed that she does not like food, it does not taste good. Interview with Resident R72 on December 1, 2025, at 10:25 a.m. revealed that the food is not warm enough. Interview with Resident R144 on December 1, 2025, at 10:30 a.m. revealed that the food that they bring is cold. Interview with Resident R246 on December 1, 2025, at 10:33 a.m. revealed that the food is cold. Interview with Resident R288 on December 1, 2025, at 10:37 a.m. revealed that the food is not good, that they don't bring us much for breakfast, only toast the other day, and the food is cold. Interview with Resident R294 on December 1, 2025, at 11:07 a.m. revealed that the food is cold. Interview with Resident R339 on December 1, 2025, at 11:07 a.m. revealed that the food is not what she wants, she wants the hot cereal and eggs, but they do not send this, and she has no allergies and is frustrated. Interview with Resident R9 conducted on December 1, 2025, at 11:06 AM revealed the food in the facility does not taste good and its always served cold. Interview on December 1, 2025, at 11:54 a.m. Resident R63 stated that foods are not cooked properly and that foods are served cold. Interview on December 1, 2025, at 12:30 p.m. Resident R89 stated the food is always cold and the that facility does not use anything to keep foods warm while the trays are being distributed. Interview on December 1, 2025, at 12:35 p.m. Resident R329 stated that the food doesn't taste good. Interview on December 2, 2025, at 9:54 a.m. Resident R315 stated that the food tastes fake, that the food is not cooked properly and that the coffee is undrinkable. Interview on December 2, 2025, at 9:54 a.m. Resident R299 stated that the food is cold, does not taste good and that the coffee is too strong, too bitter and undrinkable. Observations during a test tray conducted with the Food Service Director (FSD), Employee E8, on December 2, 2025, at 12:35 p.m. revealed that the fish, bow tie pasta, broccoli, pureed fish, mashed potatoes and pureed broccoli were all below acceptable 135 degrees, and the apple sauce and cranberry juice were above the acceptable 50 degrees. An interview with the FSD, on December 2, 2025, at 12:40 p.m. confirmed that these food items were outside the acceptable temperature and therefore not palatable, and a review of the Test Tray Evaluation Form revealed all foods and drinks except coffee and milk did not meet the standard of service temperature. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>Based on review of facility documents and interview with staff, it was determined that the facility failed to ensure that residents were provided with education related to influenza vaccines prior to administering influenzas vaccines to residents for eight of eight residents reviewed. (Resident R8, R9, R14, R17, R20, R128, R260 and R284)Review of facility policy on Infection Prevention and Control Program revealed that under section Policy Statement: The infection prevention and control program is a facility wide effort involving all disciplines and individuals. Under section Policy Interpretation and Implementation. Coordination and oversight a. The infection prevention and control program is coordinated and overseen by an infection prevention specialist. #8. Immunization: a. Immunization is a form of primary prevention. b. Widespread use of influenza vaccine in the nursing facility is strongly encouraged Review of consents/declination forms for the influenza vaccines and review of clinical record for Resident R8, R9, R14, R17, R20, R128, R260 and R284, revealed no documented evidence that that Resident R8, R9, R14, R17, R20, R128, R260 and R284, were provided with education on influenzas vaccines prior to the administration of the vaccine. Interview with Director of Nursing Employee E2 conducted on December 6, 2025, confirmed that the facility did not provided education to residents related to influenza vaccines prior to administering the vaccines for Resident R8, R9, R14, R17, R20, R128, R260 and R284. Further interview with Employee E2 revealed that the facility did not have a process in place for educating residents on influenza vaccines prior to the administration of the vaccine. 28 Pa. Code 201.18(e)(1) Residents rights |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews with residents and staff, it was determined that the facility failed to ensure a safe, functional, sanitary, and comfortable environment for residents, staff and the public for two of seven nursing units reviewed (3 [NAME] nursing unit, 3 East nursing unit.) and the boiler room. Findings include: Tour of the 3 East nursing unit on December 1, 2025, at 11:41 a.m. revealed the following: Resident room [ROOM NUMBER] the fan had fallen off of the wall, the dresser was missing a drawer, the bed remote had frayed wires, two holes in the floorboards were noted, a ceiling panel was loose and floor tiles were taped together.The dining room had five tables that were unsteady and wobbled when leaned on\.The cabinet in the dining room was covered in built-up debris and missing several handles. Tour of the 3 [NAME] nursing unit on December 1, 2025, at 11:02 a.m. revealed the following: Resident room [ROOM NUMBER] toilet was clogged, full of feces and unable to be flushed. Resident R45 stated that staff flush briefs down the toilet, which clogs it, and that it happens often. Also in resident room [ROOM NUMBER] there was a hole in the baseboard behind Resident R375's tube feeding pump. Resident room [ROOM NUMBER] the bathroom overhead light was not working. Resident room [ROOM NUMBER] the bathroom light had no cover and there was a large hole above the baseboard. Resident room [ROOM NUMBER] PTAC unit had wires sticking out from the underside of the unit, the drywall was torn apart next to the sink and the toilet lid cover was too large for the toilet so that the lid would not close properly; The pantry had two floor tiles missing, water was leaking from the water supply line to the floor, there were towels on the floor to absorb the water, and there was no refrigerator on the unit for the storage of resident foods; The medication storage room contained two oxygen tanks stored without holders; The PTAC unit in the dining room was being supported by five pieces of stacked wood pieces; Three tables in the dining room were unstable and wobbled when leaned on; Two windows in the dining room had no screen and one of them would not close all the way due to a missing piece of the window frame. The above findings were reviewed with Employee E12, Maintenance Director, on December 4, 2025, at 9:23 a.m. Observations during the initial tour of the building on December 1, 2025, at 10:05 a.m. revealed the following: Observations on the 2nd Floor [NAME] Unit revealed the fluorescent lighting in the ceiling was out and dark near rooms [ROOM NUMBERS]. Observations in the central bathroom on 2nd Floor [NAME] revealed an unlocked door and renovations inside the bathroom where all the floor tiles and baseboards had been removed leaving dangerous open holes in the floor where drain grates were removed. Observation in room [ROOM NUMBER] bed A revealed that the headboard of the bed was off and leaning against the wall. Observation in room [ROOM NUMBER] revealed that the baseboards were lose and there were holes in the wall above the baseboard near the sink and the walls were scuffed with dark marks. Observation in room [ROOM NUMBER] revealed that the walls were scuffed and dirty with black marks. Observation in room [ROOM NUMBER] revealed that the baseboards were lose and the walls were wavy and scuffed with dark marks. Observation in room [ROOM NUMBER] revealed that the baseboards were lose and the walls were scraped with dark marks. Observations on the 3rd Floor [NAME] Unit revealed PTECC/HVAC wall units in rooms [ROOM NUMBERS] that the bottom panel was missing or lose on the floor exposing dangerous sharp edges and internal parts. Observations on the 1st Floor East unit the door to the employee bathroom was broken and lose and the metal door frame was disconnected from the floor causing the entire unit to move when pushed on. Observations during a tour of the boiler room on December 3, 2025, at 11:50 a.m. with the Maintenance Director, Employee E12 and the Regional Maintenance Manager, Employee E13 revealed standing water covering most of the floor all the way to the doorway threshold entering the hall outside the kitchen. Interview with the Maintenance Director revealed that the hot water holding tank had been leaking and the facility was planning on replacing it. He was unsure how long the leaking had<br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | been going on. Observation of the 3 [NAME] nursing unit on December 1, 2025, at 11:02 a.m. revealed that the central shower room was undergoing renovations. The toilet, shower and bath fixtures had been removed from the room, and the flooring had been removed, exposing concrete flooring. There were multiple deep holes in the floor in the area where the toilet had been removed as well as in the center of the room. Multiple ceiling panels had fallen and were caved in. Continued observation of the 3 [NAME] shower room revealed that the construction area was unsecured. Interview on December 1, 2025, at 11:20 a.m. Resident R45 stated that a week ago he went into the 3 [NAME] shower room to use the toilet when he noticed that all of the fixtures were removed. The resident stated that now he has to use a shower room on another nursing unit. Interview on December 2, 2025, at 9:32 a.m. Employees E25 and E26, nurse aides, confirmed that the 3 [NAME] shower room was under construction and that the doors to the room have been left unsecured. The employees confirmed that residents have to use shower rooms on other units due to the construction. Interview on December 4, 2025, at 9:23 a.m. Employee E12, Maintenance Director, confirmed that the 3 [NAME] shower room was under construction for repairs and renovations due to leaks. Observation of the East Stairwell on December 5, 2025, at 10:33 a.m. revealed that the roof access door was open, which would allow weather elements and pests to enter the building. Continued observation of the East Stairwell and interview with the Nursing Home Administrator on December 5, 2025, at 10:45 a.m. confirmed that the roof access door should not be left open. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.14(a) Responsibility of licensee |

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| | 395893 | A. Building<br>B. Wing | 12/22/2025 |

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| Care Pavilion Nursing and Rehabilitation Center | 6212 Walnut Street<br>Philadelphia, PA 19139 |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>Based on review of facility documentation, clinical record review and interviews with residents and staff, it was determined that the facility failed to assist residents to access Alcoholics Anonymous (AA)/ Narcotics Anonymous (NA) resources for one of 42 residents reviewed (Resident R63). Findings include:Interview on December 1, 2025, at 11:54 a.m. revealed that Resident R63 wanted to attend AA/NA meetings and that none were available at the facility. Review of Resident R63's care plan, dated June 12, 2025, revealed that the resident had or had the potential for ineffective coping related to history of substance use disorder (medical condition in which there is uncontrolled use of a substance despite harmful consequences). Interventions included encouraging support available and listed resources such as Alcoholics Anonymous. Review of the Facility Assessment, dated April 16, 2025, revealed that 55% of the facility population had a history of mental illness, including diagnosis of substance use disorder. Interview on December 4, 2024, the Director of Nursing (DON) confirmed that the facility does not offer AA or NA meetings to residents. The DON stated that the facility offers a Peer Program. Review of peer review documentation revealed that AA/NA meetings are not offered as part of the program. 28 Pa Code 201.18(b)(1) Management |

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| F 0576<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents have reasonable access to and privacy in their use of communication methods.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical record, review of facility policy and interview with staff and residents, it was determined that the facility failed to ensure that postal mail was delivered in timely manner for one of 42 residents reviewed. (Resident R128)Review of facility's undated policy on Mail and Package Handling revealed that under section Policy Statement: It is the policy of Care Pavilion Rehabilitation & Nursing to ensure that all residents and facility mail and packages are handled in a secure and respectful manner and distributed timely. Section Procedure: #1. Mail Arriving in Envelopes: All incoming mail that arrives in envelopes, including USPS, UPS, FedEx, and other courier deliveries, must be directed to the Business Office immediately upon receipt. #3. Resident Mail Handling: Once resident mail arriving in envelopes is sorted, the Business Office will deliver it directly to the Recreation Department for distribution. The Recreation Department is responsible for organizing and ensuring that each resident receives their mail in a respectful, timely and private manner. Review of Resident R128's clinical record revealed that Resident R128 was admitted to the facility on [DATE], with diagnoses of Schizoaffective Disorder, and Type 2 Diabetes Miletus. Review of Resident R128's MDS (minimum data set, a federally required resident assessment completed at a specific interval) dated May 1, 2025, section C0500 BIMS (brief interview for mental status) score revealed that Resident R128's BIMS score was 14 suggesting that Resident R128 was cognitively intact. Interview with Resident R128 conducted on December 1, 2025, at 10:53 AM revealed that has not been getting (his/her) mails. Further, Resident R128 revealed that (he/she) has been expecting a mail from the Social Security Administration and that (he/she) has not received the mail yet. Further Resident 128 also revealed that (he/she) called the Social Security Administration office and spoke with a social security representation with facility social worker present to follow-up of the letter. Resident R128 was told by social security representation that they mailed (him/her) the letter two weeks ago. Resident R128 revealed that (he/she) never got it. Interview with Employee E31, Director of Therapeutic Recreation conducted on December 4, 2025, at 2:36 p.m. revealed that mail is delivered to the front desk and then it gets delivered to activities with no set time frame. Further, Employee E31 revealed that resident's mail is placed in boxes in their office and when the boxes are full, the mails are sorted out and that is when the mails and delivered to the residents. Further interview with Employee E31, Director of Therapeutic Recreation confirmed that resident's mail is not delivered to the residents as soon as it is received because there is no daily resident mail delivery schedule and there is no specific resident mail delivery day. 28 Pa. Code 201.2(a) Resident's right |

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| F 0606<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Not hire anyone with a finding of abuse, neglect, exploitation, or theft.<br><br>Based on review of facility policies, personnel files and interviews with staff, it was determined that the facility failed to obtain criminal background checks as required for one of five personnel files reviewed for newly hired staff (Employee E19). Findings include: Review of facility policy Abuse dated June 1, 2025, revealed that the facility will screen employees prior to working with residents and that screening components include verification of references, certification and verification of license and criminal background check. Review of Employee E19's personnel file revealed that the employee was hired on October 1, 2025, as a nurse aide. Continued review revealed that a Pennsylvania Criminal Record Check was not completed until December 1, 2025, at 4:58 p.m., after the file was requested by state surveyors. Additionally, reference checks were not completed for the employee. Continued review of Employee E19's personnel file revealed that the employee had not resided in the state of Pennsylvania for at least two years and that the employee attested to having criminal charges in another state. Further review revealed that the facility did not obtain a Federal Criminal Record Check as required. Interview on December 4, 2025, at 12:36 p.m. Employee E20, Human Resources Director, confirmed that the State and Federal criminal record checks were not completed as required. 28 Pa Code 201.19(8) Personnel policies and procedures |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>Based on review of facility documentation and interviews with staff, it was determined that the facility failed to notify the Office of the State Long-Term Care Ombudsman of facility initiated transfers and discharges as required for three of three months reviewed (August, September and October 2025). Findings include: During Entrance Conference with the Nursing Home Administrator on December 1, 2025, at 10:15 a.m. evidence of facility initiated transfer and discharge reports to the State Long-Term Care Ombudsman were requested. During an interview with Employee E15, Regional Director of Operations, on December 4, 2025, at 1:10 p.m. evidence of facility initiated transfer and discharge reports to the State Long-Term Care Ombudsman were requested again. Interview on December 4, 2025, at 1:20 p.m. the Nursing Home Administrator stated that the previous Director of Social Work left the facility in September 2025 and confirmed that the facility did not have evidence that notices were sent to the Office of the State Long-Term Care Ombudsman of facility initiated transfers and discharges for August, September and October 2025, as required. 28 Pa Code 201.14(a) Responsibility of licensee |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>Based on review of facility policies, clinical record review and interviews with staff, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) accurately reflected the resident's diagnoses and medical conditions for two of 42 residents reviewed (Residents R81 and R296). Findings include: Review of facility policy MDS 3.0 Completion dated reviewed December 2025, revealed, Persons completing part of the assessment must attest to the accuracy of the section they completed by signature and indication of the relevant sections. Review of progress notes for Resident R81 from November 4 through 11, 2025, revealed that the resident received hospice services and wound treatments to (his/her) foot. Review of Resident R81's wound consultant note, dated October 31, 2025, revealed that the resident had arterial ulcers [wounds caused by inadequate blood flow] to (his/her) right great, second and third toes. Review of Resident R81's Significant Change MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated November 11, 2025, revealed that the assessment was not coded to reflect the resident's hospice and vascular wounds. Interview on December 2, 2025, at 1:40 p.m. Employee E21, Assessment Coordinator, confirmed that Resident R81's hospice and vascular wounds were not coded on the resident's November 11, 2025, Significant Change MDS assessment. Review of Resident R296's quarterly Minimum Data Set (mds- a federal mandated assessment tool for all residents) dated November 14, 2025, revealed that the resident entered the facility August 11, 2025 with a cognition assessment brief interview of mental status (BIMS) score of 11 indicating moderate cognitive impairment, the resident has diagnosis of anxiety and suicide ideation. Review of Residents R296's clinical record revealed resident's diagnoses of schizophrenia (Chronic mental disorder causing a distorted view of reality, affecting how a person thinks, feels, and behaves), (alcohol use), suicide ideation (Thoughts or contemplation about ending one's own life) and anxiety disorder (Mental health condition marked by excessive, persistent, and disproportionate fear, wary, and dread that significantly interferes with daily life) dated August 13, 2025. Review of Resident R296's physician orders revealed that resident has been treated with the medications Ononzapine 10 mg to be given twice a day related to schizophrenia since August 11, 2025 and Risperdone 1 mg to be given a bedtime daily related to schizophrenia since August 11, 2025. Residents' physician records revealed that Resident R296 is actively being treated for schizophrenia with the medication Olonzipine 0.5 milligrams. Interview with Assessment Coordinator, Employee E21 on December 4, 2025 at 12:45 p.m. revealed that she's familiar with the resident and confirmed that the resident has a diagnosis of schizophrenia but did not meet the facility criteria after recent CMS audit therefore the diagnosis was taken off his minimum data set. This employee was unable to produce guidelines that she felt the resident did not meet criteria and also could not determine how this determination was made. 28 Pa Code 211.12(d)(1)(5) Nursing services 28 Pa Code 201.14(a) Responsibility of licensee |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility policies and staff interview it was determined that the PASRR (Preadmission Screening and Resident Review) was not appropriately completed according to the resident assessment for three of four residents reviewed (Residents R13, R19 and R10). Findings include: The PASRR (Preadmission Screening Resident Review) was created in 1987 through language in the Omnibus Budget Reconciliation Act (OBRA) and it has three goals: to identify individuals with mental illness and/or intellectual disability, to ensure they are placed appropriately, whether in the community or in a nursing facility, and to ensure they receive the services they require for their mental illness or intellectual disability. The PASRR Level 1 must be completed on all persons who are considering admission to a Medicaid certified nursing facility. A Level II PASRR evaluation must be completed if the Level 1 PASRR determined that the person is a targeted person with mental illness or an intellectual disability. The Level II PASRR would determine if placement or continued stay in the requested or current nursing facility is appropriate. Review of Resident R10's Annual MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated October 1, 2025, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including anxiety disorder (intense, excessive, persistent worry or fear), depression (mood disorder characterized by low mood, a feeling of sadness, and a general loss of interest in things), bipolar disorder (also known as manic depression, is a mental illness that brings severe high and low moods and changes in sleep, energy, thinking, and behavior) and alcohol abuse. Review of Resident R10's PASRR, dated April 30, 2015, revealed that the assessment did not include the resident's diagnoses of anxiety, depression, bipolar or alcohol abuse. Interview on December 4, 2025, at 10:30 a.m. Employee E22, Admissions Director, confirmed that Resident R10's PASRR assessment was not updated to include the resident's diagnoses of anxiety, depression, bipolar and alcohol abuse. Review of Resident R13's quarterly Minimum Data Set (MDS- a federal mandated assessment tool for all residents) dated October 3, 2025, revealed that the resident entered the facility December 6, 2016, with diagnosis including non-traumatic brain dysfunction (brain damage from internal causes), dementia (decline the mental ability severe enough to interfere with daily life involving memory loss, thinking, reasoning and problem solving issues), anxiety, depression (mood disorder causing persistent sadness, loss of interest, and affecting how you think, feel, and handle daily activities), and psychotic disorder (severe mental illness involving a loss of contact with reality characterized by symptoms like delusions, hallucinations, and disorganized thinking). Review of the resident's Pennsylvania Preadmission Screening (PASRR) Level 1 form January 1, 2025, revealed that resident does not have a mental disorder. Review of resident R19's Minimum Data Set (MDS- a federal mandated assessment tool for all residents) dated October 2, 2025 revealed that this resident entered the facility January 1, 2024, with diagnosis of depression and psychotic disorder. Review of resident's PASRR level 1 form dated September 26, 2024, revealed that resident does not have a mental disorder. 28 Pa Code: 211.10(c) Resident care policies 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.5(f)(v) Medical records |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>Based on observations, review of facility policies, clinical record review and interviews with staff, it was determined that the facility failed to develop a baseline care plan within 48 hours of a resident's admission to the facility that included the minimum healthcare information necessary to properly care for a resident for one of 42 residents reviewed (Resident R375). Findings include: Review of facility policy, Baseline Care Plan, Comprehensive Care Plan and Ongoing Care Plan Updates dated October 1, 2024, revealed, The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care. Observation on December 1, 2025, at 11:28 a.m. revealed that Resident R375 was resting in bed. The resident had a tracheostomy (a surgically created hole in your trachea that allows for breathing) that required respiratory care, including suctioning, oxygenation, assessment, care and maintenance. Continued observation on December 2, 2025, at 11:58 a.m. with Employees E23 and E24, wound nurses, revealed that Resident R375 had a pressure ulcer to his sacrum. Review of progress notes for Resident R375 revealed a nurses note, dated October 24, 2025, at 6:42 p.m. which indicated that the resident was admitted to the facility from the hospital and that the resident had a tracheostomy and pressure injury on his sacral area at the time of his admission. Review of Resident R375's care plan, initiated November 3, 2025, revealed that no care plan had been developed that included the resident's care needs for his tracheostomy, respiratory care or sacral pressure ulcer. Interview on December 4, 2025, at 1:55 p.m. the Director of Nursing confirmed that no care plan had been developed for Resident R375's tracheostomy, respiratory and sacral pressure ulcer care needs. 28 Pa Code 211.10(c)(d) Resident care policies 28 Pa Code 211.12(d)(1)(5) Nursing services |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policies, clinical record reviews and interviews with staff, it was determined that the facility failed to update resident care plans related to hospice care, life code status, vascular wounds and tube feedings for two of 42 residents reviewed (Residents R81 and R336). Findings include: Review of facility policy, Baseline Care Plan, Comprehensive Care Plan and Ongoing Care Plan Updates dated October 1, 2024, revealed, Nursing staff will update the care plan related to physician's orders and/or changes in care needs. The nursing staff will initiate and/or update acute care plans for the resident as they are warranted. Observation on December 1, 2025, at 1:35 p.m. revealed Resident R81 was resting in bed. The resident's right foot was gangrenous (death of body tissue due to lack of blood flow). Review of progress notes for Resident R81 from August 15, 2025, through December 2, 2025, revealed that the resident received hospice services and wound treatments to his foot. Review of active physician orders for Resident R81 revealed an order, dated November 18, 2025, for hospice care. Continued review revealed on order, dated September 5, 2025, for DNR status (do not resuscitate - do not perform lifesaving interventions in the event the resident has no pulse and had stopped breathing). Review of Resident R81's wound consultant note, dated November 26, 2025, revealed that the resident had arterial ulcers [wounds caused by inadequate blood flow] on the first through fourth digits on his right foot and that the wound appeared gangrenous. Review of Resident R81's care plan, dated January 6, 2021, revealed that the resident had both DNR and Full Code (allows for all interventions needed to restore breathing or heart functioning, including chest compressions, a defibrillator and insertion of a breathing tube) listed on his care plan. Continued review of Resident's R81's care plan, dated December 29, 2020, revealed that the resident had potential for skin impairment. There was no indication on the care plan that to reflect that the resident's right foot had arterial ulcers on the first through fourth digits and that the wound was gangrenous. Further review of Resident R81's care plan revealed that there was no care plan developed to specifically meet the resident's needs related to hospice care. Interview on December 5, 2025, at 10:25 a.m. the Director of Nursing confirmed that Resident R81's care plan had not been updated related to the resident's wounds, hospice needs or to accurately reflect the resident's current code status. Review of Resident R336's clinical record revealed the resident was admitted to the facility on [DATE], for multiple conditions including dysphagia (swallowing difficulties), oropharyngeal phase (difficulty initiating a swallow and can result in health complications, particularly aspiration pneumonia). Review of Resident R336's August 28, 2025, physician's orders revealed the resident had an enteral feeding order for Glucerna 1.2 (or equivalent dayshift AC) enteral liquid via feeding pump at 65 ml/hr until total volume of 1300 ml has infused every dayshift, and document total volume infused. Review of Resident R336's clinical record revealed a care plan for enteral nutrition for Nepro (a therapeutic nutrition product specifically designed for individuals on dialysis and is suitable for tube feeding) at 70 ml/hr. for 15 hours, initiated on November 27, 2023. Interview on December 1, 2025, at 1:50 p.m. with Employee E3, Licensed Nurse, revealed that she checked the August 27, 2025, order for Resident 336's tube feeding and confirmed that care plan should be updated to reflect the order of Glucerna 1.2 at 65 ml/hr. via the feeding pump. 28 Pa Code 211.10(c)(d) Resident care policies 28 Pa Code 211.12(d)(1)(5) Nursing services |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical record, interview with staff it was determined that the facility failed to ensure that residents are provided with services to maintain and prevent further deterioration of range of motion for two of 42 residents reviewed. (Resident R260 and Resident R16) Review of Resident 260's clinical record revealed that Resident R260 was admitted to the facility on [DATE], with diagnoses of hemiplegia/hemiparesis following unspecifies cerebrovascular accident. Review of Resident R260's MDS (minimum data set, a federally required resident assessment completed at a specific interval) dated September 26, 2025, revealed a BIMS (Brief Interview of Mental Status) score of 15 suggesting that Resident R260 was cognitively intact. Review of occupational therapy discharge note dated October 10, 2025, revealed that resident's last day of service was September 3, 2025 and recommended to continue to wear splint as established. Further review of the discharge note revealed that there were no specification of the days and time that the splint was to be on and off. Review of physician's orders revealed no orders for splinting or palm guard. Further Review of Resident R260's clinical record revealed no documented evidence that Resident R260 was provided with a splint after occupational services ended on September 3, 2025. Observation on Resident R260 conducted on December 1, 2025, at 10:31AM revealed that Resident R260's left elbow was in a flexed position. Further, Resident R260 was not wearing any splint, or brace. Interview with Resident R260 conducted at the time of the observation revealed that he could not move is arm and that nobody puts a splint on him. Interview with Director of Rehab Employee E11, conducted on December 4, 2025, at 12:03PM revealed that resident had a palm guard and that palm guard is used to prevent further contractures and it protects the skin. Interview with Occupational Therapist Employee E33 conducted on December 4, 2025, at 2:15PM revealed that Resident R260 requires palm guard to prevent contractures and to protect the integrity of the skin/prevent skin breakdown. Further interview with Employee E33 revealed that Resident R260's last day of Occupational Therapy services was on September 3, 2025. Further Employee E33 also revealed that she discharged Resident R260 on October 6, 2025, instead of September 3, 2025, when she ended occupational therapy services to Resident R260. Further Employee E33 also revealed that she did not write the discharge notes and the discharge recommendations until October 6, 2025. Further interview with Employee E33 confirmed that Resident R260 was not provided with a palm guard from September 3, 2025, until October 6, 2025. Review of the December 2025 physician orders for Resident R16 included the diagnoses of quadriplegia (a symptom of paralysis that affects all limbs and body of an individual from the neck down); epilepsy (a seizure disorder); dysphasia (difficulty swallowing); and cerebral infarction (a type of stroke). Review of the resident's Occupational Therapy notes and Occupation discharge summaries also indicated that the resident had contracture (a type of scarring in your soft tissues that causes them to tighten and stiffen and can reduce an individual's flexibility and range of motion) in both his right and left hand. Review of the resident's person-centered plan of care included a plan of care dated June 4, 2025 for the resident's acute pain related to the resident's chronic disability and the resident's disease process. The person-centered plan of care nursing staff would record and treat the resident's existing conditions which may increase pain and discomfort. Such existing conditions included arthritis, osteoporosis, ulcers and contractures. Review of the resident's clinical record did not show evidence of any treatments or services to maintain or improve the Range of Motion (ROM) and mobility of the resident to prevent, to the extent possible, any further declines in the resident's ROM or mobility. During an interview with the facility's Occupational Therapist, Employee E20 on December 5, 2025 at 12:46 p.m. regarding the resident's contractures and any treatments or services related to the residents' right- and left-hand contractures. Review of the resident's most recent date of services for Occupational Therapy, October 24, 2025 through November 19, 2025 was reviewed with the<br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Occupational Therapist. One of the long-term goals that was listed on the resident's discharge summary was for the resident to wear a resting hand splint on his right and left hand for up to 8 hours Patient will safety wear a resting hand splint on left hand and right hand for up to 8 hours w/minimum s/s of redness, swelling, discomfort or pain. During the interview, the Occupational Therapist reported that she did not document the proper discharge plan for the resident, and that she mistakenly omitted the application of right and left hand splits for the resident when he was discharged from therapy on November 19, 2025. 28 PA Code 211.10(c) Resident care policies 28 PA. Code 211.12(d)(1)(5) Nursing services |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility documentation, and interviews with residents and staff, it was determined the facility failed to provide adequate supervision to Resident R284 with a diagnosis of alcohol dependency upon return from a leave of absence (Resident R284). The facility failed to ensure that a resident was properly secured during transportation to an outside appointment which resulted in the resident sliding out of the transportation van. (Resident R12) Findings include: Findings include:Review of facility policy title Substance Use Disorder (SUD) dated October 24, 2022, revealed under POLICY: To ensure the preservation of every resident's right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. With this policy Focus Health Network affirms a commitment to maintain a drug-free environment for the health and safety of individuals in the facility but recognizes that residents with a history of substance use disorder may be at increased risk for illegal or prescription drug overdose if the resident continues using substances while residing in the nursing home. Continued review of policy under section revealed Definition: Substance use disorder (SUD) is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment. Further review of same policy, under section titled Facility Assessment: revealed Assessment of residents with history of Substance Use Disorder, Interventions to prevent substance use-family/resident counselling. Upon admission, the facility will educate residents and their responsible party on the Substance Use Disorder (SUD) policy. Review of Resident R284's clinical record revealed, Resident R284 was admitted to the facility on [DATE], with diagnosis of Alcohol Dependence with withdrawal, Hypertension (high blood pressure), prostate cancer and history of falling, Review of Resident R284's physician's note dated September 30, 2025, revealed Resident R284 had a history of alcohol use disorder and to continue Naltrexone (prescription medication use to treat alcohol disorders) for alcohol consumption cessation. Review of Social Worker's documentation for Resident R284 dated October 1, 2025, revealed Resident R284 mentioned (he/she) has a history of drinking alcohol. Review of Resident R284's admission Minimum Data Set assessment dated [DATE], revealed the resident was assessed with a BIMS score of 15, which indicated the resident was cognitively intake and was able to make needs known. Review of Resident R284's care plan dated September 30, 2025, revealed the resident had behavior problem of ETOH (alcohol) abuse r/t (related) physical aggression, verbal aggression. Continue review of the resident's care plan did not include a care plan or interventions related to education/counseling resident/family related to substance use during a leave of absence and/or on the facility's policy on substance use. Review of Resident R284's nursing notes revealed on November 7, 2025, at 10:46 a.m. Resident R284 went on an escorted leave of absence with family member in stable condition. Review of facility documentation titled Release of Responsibility for Leave of Absence revealed the following: Resident R284's name, date of November 7, 2025, Time was 10:46am. Expected return at approximately: November 7, 2025, time: 10:46am. Further review of the form revealed Resident R284's handwritten name/signature dated November 7, 2025, and an illegible escort signature dated November 7, 2025. Further, there was no time indicated on the signatures. Review of Resident R284's nursing note dated November 8, 2025, time stamped 6:50 a.m. revealed Resident R284 was received in bed, slept most of the shift, no with no complaints of pain or discomfort. Review of Resident R284's incident fall documentation dated November 8, 2025, at 2:44 p.m. revealed the nurse was notified by resident's roommate that Resident R284 was on the floor. Nurse came into room and seen resident sitting on the side of bed with cut on (his/her) forehead. Resident had a cup in (his/her) hand which contained beer, sitting on the floor was a bag that contained six cans of beer, four were opened. Resident state (he/she) was sitting on the side of bed when (he/she) started to fall asleep and fell and hit (his/her) head. Resident R284 sustained a<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | laceration on the forehead. Further four empty cans of beer and one small empty bottle of unknown liquid was found with resident. Further, resident had a smell of alcohol. Resident R284 did not tell staff how he got the alcohol. Continued review of the fall incident documentation revealed that a skin assessment was completed and the cut on the resident's scalp was cleaned with normal saline and dressing applied. Resident's vitals signs were taken and 911 (Emergency Medical Services) called. Resident was admitted to the local hospital. Additional review of the fall incident documentation indicated Resident R284 was alert and oriented to place, people and time. The Resident was independent with transfer and ambulation was found at baseline. Resident was last seen by staff during rounds around 2pm in stable condition in the room. Resident was out on approved LOA (leave of absence) with family a day prior. Immediate intervention was provided by nursing staff. Diagnostic imaging done at hospital positive for C1 (first cervical vertebra) fracture. Review of Resident R284's clinical record revealed no documented evidence Resident R284 was assessed upon return from leave of absence, or any further supervision of the resident with a history of alcohol dependency upon return from leave of absence. Interview with Director of Nursing (DON), Employee E2 conducted on December 22, 2025, at 2:04 p.m. revealed that the Release of Responsibility for Leave of Absence form was completed by the nurse on the unit and given to the front desk. Further. DON, Employee E2 revealed that there is no logbook at the front desk to sign residents in and out. Further interview with DON, Employee E2 revealed that resident returned from the escorted leave of absence on the same day, November 7, 2025. Interview with Resident R284 conducted on December 2, 2025, at 1:34 p.m. confirming fallen on November 8, 2025. The resident did not disclose the events that led to the fall or reason for falling. Review of the facility's policy titled Facility's Wheelchair Transportation Safety Policy undated, requires multiple procedures to ensure resident safety during transport. Staff responsible for transportation must undergo appropriate training, and driver motor-vehicle records must be checked upon hire and annually. Vehicles must be equipped with emergency communication devices, maintained according to manufacturer guidelines, and inspected routinely with documented checklists. Before loading a resident, staff must visually inspect equipment, ensure safety straps are intact, and park on a flat, unobstructed area. During loading, the staff must ensure that the wheelchair is fully on the lift platform, resident's hands remain on their lap, brakes are engaged, and safety restraints are applied before raising the lift. Once inside the vehicle, wheelchairs must be secured using the manufacturer-specified restraint system compatible with the resident's chair. The vehicle must not move until all wheelchairs are fully secured and seatbelts are fastened. Review of Resident's R12's quarterly Minimum Data Set (MDS -a federal mandated assessment tool for all residents) dated September 2, 2025, revealed that the resident was admitted to the facility on [DATE]. The resident was assessed with a Brief Interview of Mental Status (BIMS) score of 15 indicating this resident was cognitively intact. Continued review of the MDS revealed that the resident was wheelchair dependent and required partial assistance for sit-to-stand and supervision for transfers. Resident R12's diagnosis of anxiety and an absence of left leg below the knee. Review of the documentation submitted to the State Survey Agency revealed that on July 16, 2025, at approximately 2:00 p.m., Resident R12 was accompanied with a nursing assistant out on an appointment. On the return back to the facility, the contracted transportation driver hit a bump leading to the resident partially sliding out of the wheelchair. According to escort the wheelchair was only partially locked. Resident was transported to the hospital noting that there were no bone fractures. Interview with Resident R12 on December 2, 2025, at approximately 1:15 p.m. revealed that on July 16, 2025, (she/he) was coming back to the facility in the contracted transportation van, and (she/he) did not have a safety belt, and (his/her) wheelchair was not secured. The driver hit a bump, and (she/he) fell, out of the wheelchair landing with the wheelchair on top of (her/him). Resident R12 described being in excruciating pain, and demanding be taken to the hospital. Interview on December 3, 2025, at 10:15 a.m. with Nursing assistant, Employee E34, confirmed she was with the resident and she was seated in the front seat of the transport van, when the driver hit a pothole and the wheelchair (continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | moved. Resident R12 partially slid off the wheelchair. The van driver immediately stopped the van and secured the resident back in the wheelchair and brought the resident back to the facility. Nursing assistant, Employee E34 confirmed she has since gone on appointments outside the facility with this resident and has not been educated since the incident on any safety protocols or wheelchair safety securing or transport protocol. Review of the facility documentation dated July 16, 2025, revealed that the transportation company confirmed reviewing a video of the incident and determined that the driver did not properly secure the resident and was at fault. 28 Pa. Code 201.14(b) Responsibility of Licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.21(c) Use of Outside Resources 28 Pa. Code 201.29 (a) Resident Rights 28 PA. Code 211.12(d)(1)(3)(5) Nursing services |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, a review of facility policies and staff interviews, it was determined that the facility failed to provide adequate nutritional care related to enteral nutrition for two out of 35 sampled residents reviewed (Resident R336 and R86).The findings include: Review of the facility policy Enteral Feeding. Revised July 23, 2019, stated, The physician is responsible for ordering the traditional nutrient, volume, rate, time, flushes, and tube care for the enteral feeding in consultation with the dietician. The licensed nurse is responsible to assure patency of the feeding tube, administration of nutritional products and medications per physician orders, assessment of the tube and skin site, and documentation of the enteral feeding process. Review of Resident R336's clinical record revealed the resident was admitted to the facility on [DATE], for multiple conditions including dysphagia, oropharyngeal phase (difficulty initiating a swallow and can result in health complications, particularly aspiration pneumonia). Review of Resident R336's August 28, 2025, physician's orders revealed the resident had an enteral feeding order for Glucerna 1.2 (or equivalent DiabetiSource AC) enteral liquid via feeding pump @ 65 ml/hr. until total volume of 1300 ml has infused every day shift, and document total volume infused. Observation of Resident R336 on the initial tour of facility on December 1, 2025, at 1:35 p.m. revealed that the bottle of formula hanging on the pole and hooked up to the pump was Glucerna 1.5, but it was not being delivered to the resident by the feeding tube pump which was turned off and the feeding tube hanging from the pump. Interview on December 1, 2025, at 1:50 p.m. with Employee E3, Licensed Nurse, revealed that she had unhooked the feeding tube earlier before lunch for care and the nurse aide assigned to the resident was to come and get her to restart the feeding, but that she did not and she never restarted the feeding. She could not say how long the resident went without the feeding. When asked about the discrepancy with the order verses the formula hanging, she checked the order in the computer and confirmed that the Glucerna 1.5 that was hanging was the wrong formula and that it should be Glucerna 1.2 that was in the order. Employee did not know why the wrong formula was hanging but thought that the Glucerna 1.2 was not available and that the nurse on the previous shift must have used this. When asked what should have been done, Employee E3 said that they should have called the physician. Review of Resident R86's clinical record revealed the resident was admitted to the facility on [DATE], for multiple conditions including adult failure to thrive (syndrome characterized by weight loss, decreased appetite, poor nutrition, and inactivity, often accompanied by other symptoms such as dehydration and depressive symptoms) and protein calorie malnutrition (when the body does not receive enough protein and calories to maintain proper health and functioning. It can lead to muscle loss, fat loss, and impaired bodily functions). Review of Resident R86's August 28, 2025, physician's orders revealed the resident had an enteral feeding order for Jevity 1.5 continuous feed via feeding pump at 85 ml/hr. for 15 hours until a total volume of 1275 ml is infused. Observation of Resident R86 on the initial tour of facility on December 1, 2025, at 1:15 p.m. revealed that the resident was not hooked up to the tube feeding formula. Interview on December 1, 2025, at 1:50 p.m. with Employee E3, Licensed Nurse, revealed that she had unhooked the feeding tube so that Resident R86 could go downstairs to smoke. When asked how long the resident was without the feeding, she said that this is an ongoing problem that the resident wants to move around. She asked the resident if she could hook up the tube feeding and the resident stated that he wanted to be put back into bed first. Employee E3 got a nurse aide to help Resident R86 back into bed and hooked him back up at 2:05 p.m. She again indicated that she was unsure how long the resident was not receiving his feeding. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 211.12(d)(2) Nursing services |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policies, clinical record review and interviews with staff, it was determined that the facility failed to provide adequate treatment, assessment and monitoring for the care and maintenance of midline catheter line in accordance with professional standards of practice for one of one residents reviewed for intravenous care (Resident R375). Findings include: Review of facility policy, IV Policy and Procedures dated May 4, 2020, revealed that intravenous catheters should be assessed frequently for complications, use aseptic/sterile technique during care of IV catheters, assess insertion site and dressing condition every shift, monitor infusions, measure external catheter length every seven days and assess catheter for patency. Observation on December 1, 2025, at 11:28 a.m. revealed that Resident R375 had a right upper extremity midline catheter (a thin soft tube inserted in a vein in the arm used to administer intravenous medications). Documentation on the midline catheter dressing revealed that the midline dressing was last changed on November 13, 2025. Review of progress note for Resident R375 revealed a practitioner note, dated November 19, 2025, which indicated that the resident was hospitalized from [DATE] to November 18, 2025, and was readmitted to the facility with recommendations to continue intravenous antibiotics until November 24, 2025, for pneumonia (lung inflammation caused by bacterial or viral infection). Review of Resident R375's hospital records, dated November 18, 2025, revealed that the resident had a midline catheter inserted on November 13, 2025, and to remove the catheter after antibiotic therapy is completed. Review of Resident R375's Medication Administration Records for November 2025, revealed that the resident received Micafungin (antifungal medication) intravenously from November 19 through 24, 2025. Continued review revealed that the resident received Zerbaxa (antibiotic medication) intravenously from November 18 through 22, 2025. Further review of Resident R375's clinical record revealed no evidence of any physician orders for the care, maintenance or assessment of the midline catheter. Observation and interview with Employee E7, unit manager, on December 1, 2025, at 2:45 p.m. confirmed that Resident R375's right upper extremity midline catheter was dated November 13, 2025, and that there were no orders for the use, care and maintenance of the catheter. 28 PA. Code: 211.10 (c)(d) Resident care policies 28 PA. Code: 211.12(d)(1)(5) Nursing services |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on observation and staff interviews, it was determined that the facility failed to ensure the proper functioning of an oxygen concentrator for one of one resident review receiving respiratory therapy. (Resident R357) Findings include:Observation of Resident R357 conducted on December 1, 2025, at 10:15 AM revealed that Resident R357 was in bed with nasal canula connected to an oxygen concentrator. Further, O2 concentrator was running at 2.5 liters/min.Further observation revealed that the oxygen concentrator indicator with an image of a wrench was lighted red. and the indicator with an image of an arrow pointing down next to a symbol O2 was lighted yellow. Follow-up observation with Employee E2, DON conducted on December 3, 2025, at 11:00AM, revealed that Resident R357 was on 2.5liters of O2 via oxygen concentrator further, an indicator with an image of a wrench was lighted red. and the indicator with an image of an arrow pointing down next to a symbol O2 was lighted yellow. Interview with DON Employee E2 conducted at the time of the observation confirmed that the oxygen concentrator indicator with an image of a wrench was lighted red. and the indicator with an image of an arrow pointing down next to a symbol O2 was lighted yellow. Employee E2 confirmed that the redlight indicator should not be on and that the that the oxygen concentrator needs to be serviced.Further Employee E2 revealed that they do not have a full-time respiratory therapist and that the nurses on the unit are responsible for making sure that respiratory equipment is in working order at all times including oxygen concentrators. 28 Pa. Code 211.12(d)(1) Nursing services |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>Based on review of facility documentation, review of personnel files and interviews with staff, it was determined that the facility failed to ensure that nursing staff have the appropriate competencies and skills sets necessary to care for residents' needs for three of three newly hired nursing staff reviewed (Employees E19, E27 and E28). Findings include: Review of Facility Assessment, dated April 16, 2025, revealed, Competencies are based on current standards of practice and may include knowledge and a test, knowledge and return demonstration, knowledge and observed ability, knowledge and observed behavior and annual performance evaluation. Competencies are based on the care and services needed by the resident population. Competencies are verified upon orientation, least annually and as needed. Review of personnel files revealed that Employee E19 was hired by the facility on October 1, 2025, as a nurse aide. Continued review of personnel files revealed that Employee E27 was hired by the facility on August 6, 2025, as a nurse aide. Continued review of personnel files revealed that Employee E28 was hired by the facility on October 29, 2025, as a licensed nurse. Further review of personnel files revealed that no skills competency evaluations were available for review at the time of the survey for Employees E19, E27 and E28. Interview on December 4, 2025, at 11:20 a.m. Employee E20, Human Resources Director, revealed that the skills competencies evaluations were the responsibility of the facility's staff educator and that that employee was no longer at the facility. Employee E20 confirmed that the skills competency evaluations for Employees E19, E27 and E28 were not available for review at the time of the survey. 28 Pa Code 201.20(a) Staff development 28 Pa Code 211.12(d)(5) Nursing services |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on review of clinical records, observations and interviews with staff, it was determined that the facility failed to ensure an adequate supply of medications for one of 42 residents reviewed. (Resident R31) Findings include: Review of Resident R31's physician orders revealed an order for amlodipine besylate tablet 10 milligrams (mg), with instructions to administer one tablet by mouth once daily for hypertension and to hold the medication if systolic blood pressure is less than 110 mmHg. The medication order dated was August 4, 2020.Review of Resident R167's physician orders revealed an order for amlodipine besylate tablet 10 mg, with instructions to administer one tablet by mouth once daily for hypertension. The order dated was November 2, 2020.Observation on December 3, 2025, at 9:25 a.m., on the second-floor nursing unit revealed Licensed nurse, Employee E32 preparing medication administration. While preparing medications for Resident R31, it was identified that Resident R31 did not have the prescribed medication amlodipine available in the resident's medication supply. Licensed nurse, Employee E32 was observed searching the medication cart for another resident with the same medication. Employee E32 then removed the medication amlodipine from Resident R167'smedication card, placed it into the medication cup, and administered it to Resident R31.Interview with Licensed nurse, Employee E32 conducted at the time of the observation revealed the employee stated that he frequently borrows medications from other residents when a resident's medication is not available, as long as the medication and dose are the same. Employee E32 stated this practice is acceptable for non-narcotic medications and that only narcotic medications are excluded from this practice.28 Pa. Code 201.209(a)(5)(6) Staff Development 28 Pa. Code 211.9 (a)(1) Pharmacy Services28 Pa. Code 211.12(d)(1)(2) Nursing Services |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain dental services for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical records, staff and resident interviewed, it was determined that the facility failed to ensure that residents receive routine and emergency dental services for one of 42 residents reviewed. (Resident R128) Review of Resident R128's clinical record revealed that Resident R128 was admitted to the facility on [DATE], with diagnoses of but not limited to Schizoaffective Disorder, Type 2 Diabetes Miletus, Further, Resident R128's MDS (minimum data set, a federally required resident assessment completed at a specific interval) dated May 1, 2025 section C0500 BIMS (brief interview for mental status) score revealed that Resident R128's BIMS score was 14 suggesting that Resident R128 was cognitively intact. Review of Resident R128's MDS (minimum data set, a federally required resident assessment completed at a specific interval) dated May 1, 2025, section L0200 Dental, A. Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose) was coded NO, B. No natural teeth or tooth fragment(s) (edentulous) was coded NO, C. Abnormal mouth tissue (ulcers, masses, oral lesions, including under denture or partial if one is worn) was coded NO, D. Obvious or likely cavity or broken natural teeth was coded NO, E. Inflamed or bleeding gums or loose natural teeth was coded NO. F. Mouth or facial pain, discomfort or difficulty with chewing coded NO. Observation on Resident R128 conducted on December 1, 2025, at 10:04 AM revealed that he has missing teeth, some of teeth present were brownish in color. Interview with Resident R128 conducted at the time of the observation revealed that he has a lot of missing teeth and that some of his teeth were broken. Further Resident R128 revealed that needs to see a dentist because he has not seen a dentist in three years. Review of Resident R128's clinical record revealed no documented evidence of dental assessment. 28 Pa. Code 211.15 Dental services |

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| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Dispose of garbage and refuse properly.<br><br>Based on observations and interviews with staff, it was determined that the facility did not ensure that that trash was properly disposed of in the receiving and dumpster area.Findings include: An initial tour of the Food Service Department was conducted on December 1, 2025, at 9:40 a.m. with Employee E8, Food Service Director, (FSD) which revealed a 50-gallon trash can in the corner near the door to the department that did not have a cover, and it was full of kitchen trash. Observation during a follow up visit to the kitchen on December 2, 2025, at 12:10 p.m. revealed the trash can in the corner near the door with no cover and filled with trash. A tour of the receiving area was conducted on December 3, 2025, at 12:05 p.m. with FSD and Maintenance Director (MD), Employee E12 which revealed the following: Observations in the receiving area revealed that the compacting dumpster was full and could not be used. Further observation in the parking lot revealed that staff were putting kitchen trash and housekeeping trash including dirty briefs in the open construction dumpster. Interview with the FSD and MD on December 3, 2025, at 12:15 p.m. confirmed the above findings. Interview with the Administrator on December 3, 2025, at 1:40 p.m. revealed that the facility had contacted the trash company and confirmed that the facility only has once a week pick up for the trash compactor that services the entire facility with a current census of 370 residents, and that this is not sufficient for their current needs. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(3) Management |

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|---|---|---|---|
| | 395893 | A. Building<br>B. Wing | 12/22/2025 |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.<br><br>Based on clinical record review and interviews with staff, it was determined that the facility failed to ensure a resident's hospice services were accurately reflected in the clinical record for one of two residents reviewed for hospice (Resident R81). Findings include: Review of progress notes for Resident R81 from August 15, 2025, through December 2, 2025, revealed that the resident received hospice services. Continued review of Resident R81's progress notes revealed that there were no notes regarding the resident's clinical condition or choice related to the election of hospice services. Review of physician orders revealed no physician orders for hospice care from September 5, 2025, until November 18, 2025. The above findings were reviewed with the Director of Nursing on December 5, 2025, at 10:25 a.m. 28 Pa Code 211.5(f)(i)(ii) Medical records |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policies, observations, and staff interviews, it was determined that the facility failed to ensure proper infection control practices were followed during wound care for 1 of 2 residents observed for wound care (Resident R88). Review of facility policy titled Blood or Body Fluid Exposure dated July 2016 revealed that the policy requires that all blood and body fluids be treated as potentially infectious, and that staff wear appropriate protective equipment (gloves, gowns, masks, occlusive bandages) when performing tasks with potential exposure. Any employee exposure must be reported immediately to the Infection Preventionist (or designee), and appropriate cleaning, reporting, and counseling procedures must be followed. In this instance, performing wound care in a communal dining area without appropriate precautions failed to prevent potential transmission of infectious material, compromising both resident safety and staff protection. Review of facility policy titled Infection Control dated March 2020 revealed that all blood and body fluids be treated as potentially infectious and that staff use appropriate personal protective equipment (PPE) when performing tasks with potential exposure. Additionally, the policy mandates coordination by the Infection Preventionist, adherence to CDC guidelines, proper handling of occupational exposures, and maintenance of resident safety and privacy. Providing wound care in a communal dining area failed to follow these infection control procedures, exposing other residents and staff to potential infectious material and compromising resident safety and privacy. Review of R296's quarterly Minimum Data Set (a federal mandated assessment tool for all residents) dated November 14, 2025, revealed that the resident was admitted on [DATE]. The resident's BIMS assessment (brief interview of mental status) score of 11, indicating that the resident has moderate cognitive impairment. Continued reviewed of the resident's clinical record revealed that the resident was diagnosed with anxiety and suicide ideation. On December 1, 2025 at 10:35 a.m. on the 4th floor social/dining room, Resident R296 was seated in a chair with three other residents at the table, with 16 additional residents present in the room. Licensed nurse, Employee E16 was observed providing wound care to the resident foot, which was observed actively bleeding during the procedure. During interview with Licensed nurse, Employee E16, on December 1, 2025, at 10:50 a.m. confirmed that she was providing care to Resident R 296, whose foot was actively bleeding. She stated that the wound was first noticed when she arrived for her shift at 7:00 AM. Employee E16 reported that she had a disagreement with the overnight nurse, who was responsible for providing wound care overnight, but instructed her that she needed to provide the care. The employee confirmed that she cleaned the resident's bleeding foot in the dining room. During interview with Director of Nursing, Employee E2 On December 2, 2025, at approximately 10:00 AM, revealed that he was made aware of the incident. He reported that Resident R296 was sitting in a chair when his foot began bleeding and refused to go to his room for care. The DON confirmed that wound care is not to be performed in the dining room and that the facility has protocols prohibiting care in public areas. He also stated that employees have been educated on proper infection prevention and control measures. 28 Pa. Code 201.20(a) Staff Development 28 Pa. Code 211.12 (d)(1)(2) Nursing Services |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep all essential equipment working safely.<br><br>Based on observation and interview with staff, it was determined that the facility did not ensure that essential equipment was in a safe and functioning manner related to the dish machine sanitizer pump not operating and keeping the machine out of service for two days causing the facility to serve meals on disposable paperware. Findings include: Observations during the initial tour of the kitchen on December 1, 2025, at 9:40 a.m. with Employee E8, Food Service Director (FSD), which revealed that the dish machine final rinse gage was reading 120 degrees. The FSD indicated that the dish machine was a chemical sanitizing low temperature machine. Testing of chemical sanitizing dish machine revealed that no sanitizer was present in the final rinse confirming that the machine was not sanitizing the dishes that were being run through. The FSD could not get the machine to pump the sanitizing chemical into the rinse water and the machine. The FSD attempted to reach the rep from the chemical company to have them check the machine, but they could not come out the same day. The facility switched to serving residents on disposable dishware and silverware. Interview with the FSD on December 1, 2025, at 9:40 a.m. confirmed the above findings, and that he was not certain how long the machine was operating without sanitizer. Interview with the Administrator on December 1, 2025, at 10:15 a.m. confirmed that the dish machine was not working, that the dishware could not be properly sanitized and that he instructed the FSD to serve on disposable paperware. Observation during a follow up visit to the kitchen on December 2, 2025, at 12:10 p.m. revealed that the dish machine was still out of service. The facility failed to maintain the dish machine in proper working order. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(1) Management 28 Pa Code 201.18(b)(3) Management |

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| F 0924<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Put firmly secured handrails on each side of hallways.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews with staff, it was determined that the facility failed to ensure that handrails were safe and properly secured for one of seven nursing units reviewed (3 [NAME] nursing unit). Findings include: Tour of the 3 [NAME] nursing unit on December 2, 2025, at 9:32 a.m. revealed the following:The railings by the elevator across from room [ROOM NUMBER] were missing endcaps; The railing by the clean linen room was missing endcaps;The railing by the dining room across from room [ROOM NUMBER] was missing endcaps.Endcaps or finishings on handrails are required for safety and to prevent snagging. The above findings were reviewed with Employee E12, Maintenance Director, on December 4, 2025, at 9:23 a.m. Observation on December 4, 2025, at 9:42 a.m. revealed that the handrail by the elevator in the lobby area was falling off from the wall. The Nursing Home Administrator confirmed the finding at the time of the observation. 28 Pa Code 205.9(a) Corridors |

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| F 0940<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop, implement, and/or maintain an effective training program for all new and existing staff members.<br><br>Based on review of facility documentation, review of personnel files and interviews with staff, it was determined that the facility failed to develop, implement, and maintain an effective training program for five of five newly hired staff (Employees E19, E27, E28, E29 and E30). Findings include: Review of Facility Assessment, dated April 16, 2025, revealed, The staff training and education program is designed to ensure knowledge competency for all staff. Continued review revealed, Every staff member has knowledge competency in: abuse, neglect, exploitation and misappropriation; resident rights; identification of condition change; Behavior management, Identification of changes in condition, Substance Use Disorders and Trauma Informed Care and resident preferences. Additional knowledge competencies for all staff include dementia management, infection transmission and prevention, immunization, QAPI, and OSHA hazard communication. Hand hygiene return demonstration competencies and observed knowledge competencies for emergency response are also required. Review of personnel files revealed that Employee E19 was hired by the facility on October 1, 2025, as a nurse aide. Continued review revealed no evidence of any training related to: resident rights, behavior management, identification of changes in condition, substance use disorders, trauma informed care, resident preferences, communication, dementia management, infection control, hand hygiene, QAPI, OSHA hazard and emergency response. Review of personnel files revealed that Employee E27 was hired by the facility on August 6, 2025, as a nurse aide. Continued review revealed no evidence of any training related to: resident rights, behavior management, identification of changes in condition, substance use disorders, trauma informed care, resident preferences, communication, dementia management, infection control, hand hygiene, QAPI, OSHA hazard and emergency response. Review of personnel files revealed that Employee E28 was hired by the facility on October 29, 2025, as a licensed nurse. Continued review revealed no evidence of any training related to: resident rights, behavior management, identification of changes in condition, substance use disorders, trauma informed care, resident preferences, communication, dementia management, infection control, hand hygiene, QAPI, OSHA hazard and emergency response. Review of personnel files revealed that Employee E29 was hired by the facility on September 17, 2025, as a housekeeper. Continued review revealed no evidence of any training related to: resident rights, behavior management, identification of changes in condition, substance use disorders, trauma informed care, resident preferences, communication, dementia management, infection control, hand hygiene, QAPI, OSHA hazard and emergency response. Review of personnel files revealed that Employee E30 was hired by the facility on September 9, 2025, as a maintenance technician. Continued review revealed no evidence of any training related to: resident rights, behavior management, identification of changes in condition, substance use disorders, trauma informed care, resident preferences, communication, dementia management, infection control, hand hygiene, QAPI, OSHA hazard and emergency response. Interview on December 4, 2025, at 11:20 a.m. Employee E20, Human Resources Director, revealed that the education for newly hired staff were the responsibility of the facility's staff educator and that that employee was no longer at the facility. Employee E20 revealed that whatever trainings are in the files for Employees E19, E27, E28, E29 and E30 are what is available for review at the time of the survey. 28 Pa Code 201.20(a) Staff development |