STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395915	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitions Healthcare Allens Cove	25 Cove Road Duncannon, PA 17020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on facility policy review, observations, and resident and staff interviews, it was determined that the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for five of 16 residents reviewed (Residents 10, 15, 26, 30, and 52). Findings include: Review of facility policy, titled Resident Rights last revised February 6, 2025, read, in part, The facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. To ensure the respect and dignity of each resident during dining and to promote a home-like environment. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences. Observation during lunch meal service on March 17, 2026, at 12:47 PM, revealed a cart of beverages with two sleeves of soft plastic cups on the bottom shelf of the cart for tray meal service down the south hall. Observation of Residents 26 and 52 on March 17, 2026, at 1:20 and 1:30 PM, revealed they were eating lunch in their rooms and were served beverages with soft plastic cups on their trays. During an interview with Employee 11 (Registered Dietitian) on March 18, 2026, at 11:20 AM, the surveyor inquired about the use of soft plastic cups for tray meal service, she stated she was also wondering why the facility was not using the hard plastic cups that are easier to grasp and more homelike. During an interview with Resident 10 on March 18, 2026, at 12:44 PM, she revealed when she is served beverages in soft plastic cups, the liquid usually spurts out of the cup, so staff compensate by not filling them the whole way. This results in not getting as much to drink and the plastic cups are more difficult to hold. Observation during lunch meal service on March 18, 2026, at 12:55 PM, revealed residents down the south hall who were eating in their rooms were being served beverages in soft plastic cups on their trays. Interview with Employee 6 (Dietary Manager) on March 18, 2026, at 1:00 PM, revealed she just ordered two cases of hard plastic cups for meal service, which will be plenty to ensure all residents are served beverages in those cups during meals. During an interview with Resident 30 on March 18, 2026, at 1:07 PM, he stated he has difficulty grasping the soft plastic cups during his meals, and when he picks them up they usually squeeze in and the liquid spills all over him. During an interview with Resident 15 on March 18, 2026, at 1:10 PM, she showed the surveyor her thumb that was stained red and stated it was because she has to grab the soft plastic cup with her cranberry juice with her thumb inside to be able to pick it up. During an interview with the Nursing Home Administrator on March 19, 2026, at 11:09 AM, the surveyor revealed the concern with the use of the soft plastic cups during meal service. He revealed he would expect dining equipment to accommodate the residents' needs and preferences and promote a dignified and homelike dining experience. 28 Pa. Code 201.14 (a) Responsibility of licensee28 Pa. Code 201.29 (a) Resident rights

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395915	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitions Healthcare Allens Cove	25 Cove Road Duncannon, PA 17020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure residents received a transfer notice with the required included information upon transfer/discharge for two of three residents reviewed for hospitalizations (Residents 5 and 30). Findings include: Review of facility policy titled, Resident Discharge/Transfer from Facility, with an effective date of January 21, 2025, read, in part, Upon a transfer or discharge of a Resident, the facility must: Notify the Resident and the Resident representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to the resident/resident representative. Review of Resident 5's clinical record revealed diagnoses that included congestive heart failure (disease process that results in the decreased ability of the heart to pump blood through the body effectively) and chronic kidney disease (disease of the kidneys that affects kidney function). Review of Resident 5's clinical record revealed she was transferred to the hospital for an acute medical change in condition on October 30, 2025. Resident 5 returned to the facility on November 12, 2025. Further review of Resident 5's clinical record revealed she was also transferred to the hospital for an acute medical change in condition on November 14, 2025. Resident 5 returned to the facility on December 1, 2025. Review of available documentation failed to reveal evidence that Resident 5 was provided with a written notice of transfer for either hospitalization. Review of Resident 30's clinical record revealed diagnoses that included congestive heart failure and pressure ulcer of sacral region stage 4 (injury to the skin and underlying tissue caused by prolonged pressure on the skin). Review of Resident 30's clinical record revealed he was transferred to the hospital for an acute medical change in condition on October 9, 2025. Resident 30 returned to the facility on October 17, 2025. Further review of Resident 30's clinical record revealed he was also transferred to the hospital for an acute medical change in condition on October 22, 2025. Resident 30 returned to the facility on October 30, 2025. Review of available documentation failed to reveal evidence that Resident 30 was provided with a notice of transfer for either hospitalization. Interview with the Nursing home Administrator on March 19, 2026, at 12:38 PM, revealed he was unable to determine if transfer notices were sent for the four aforementioned hospitalizations, and he would expect the facility to provide a written notice of transfer to residents/representatives in the event of a hospitalization. 28 Pa. Code 201.14(a) Responsibility of licensee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395915	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitions Healthcare Allens Cove	25 Cove Road Duncannon, PA 17020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on personnel training record review and staff interview, it was determined that the facility failed to ensure each nurse aide was provided required in-service training, consisting of no less than 12 hours per year, which included dementia management and resident abuse prevention for four of five nurse aide employee records reviewed (Employees 1, 2, 3, and 5). Findings Include: Review of personnel information revealed Employee 1's hire date was January 5, 2024; Employee 2's hire date was November 13, 2023; Employee 3's hire date was October 12, 2024; and Employee 5's hire date was March 3, 2025. Review of facility training records failed to reveal that the aforementioned Employees completed 12 hours of required annual training in the past 12 months. Further review of facility training records failed to reveal evidence that dementia management training was completed by Employees 1, 2, and 5 within the past 12 months, or that abuse prevention training was completed by Employee 3 within the past 12 months. During an interview with the Nursing Home Administrator on March 19, 2026, at 10:06 AM, he stated he would expect the nurse aide annual training to be done every 12 months and include abuse and dementia. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.19(7) Personnel policies and procedures28 Pa. Code 201.20(a)(d) Staff development

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395915	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitions Healthcare Allens Cove	25 Cove Road Duncannon, PA 17020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure that a resident's medication regimen was free from unnecessary psychotropic medications for one of five residents reviewed for unnecessary medications (Resident 8). Findings Include: Review of facility policy, titled Use of Psychotropic medications, with a revision date of January 21, 2025, revealed It is the policy of the Facility to assess the interventional necessity of psychotropic medication prior to delivery when related to the escalation of Resident behaviors Attempt to meet needs by the care plan and/or the behavior modification program, if appropriate. Use calm, friendly approach and try to redirect thoughts. Attempt to reassure and console. Document behavior, interventions tried and effectiveness on the 'Behavioral/Interventions' Sheet. Offer PO [by mouth] PRN [as needed] medications if above steps ineffective. Review of Resident 8's clinical record revealed diagnoses that included stroke, dementia with behavioral disturbance, anxiety, and major depressive disorder with psychotic symptoms. Resident 8 was admitted to hospice on July 28, 2025. Review of Resident 8's psych consult note dated January 11, 2026, revealed the reason for the visit was for the Resident yelling out and heightened anxiety, and the chief complaint/symptoms and concerns were staff reporting an increased in anxiety levels and yelling out for help. Further review of the consult revealed a recommendation to increase Resident 8's Lexapro (antidepressant medication) to 10 mg to assist with Resident's mood and anxiety. Review of Resident 8's psych consult note dated February 3, 2026, revealed that the Resident was being seen for increased anxiety reported by nursing. Resident reported anxiety was keeping her from falling asleep and the note further stated that Resident had no overt psychosis. Further review revealed that the prior recommendation to increase the Lexapro to 10 mg was not initiated. Recommendation was again made during this visit, to increase the Lexapro to 10 mg for anxiety and also encouraged staff to utilize PRN Ativan for anxiety that is not redirectable. Review of Resident 8's physician progress note dated February 11, 2026, revealed that Resident 8 was in bed at the time of the examination and was calling out loud saying help me help me. When asked what she wanted, Resident 8 replied she wanted her husband so she can go shopping. The note further states that Resident 8 has been having agitation and episodes with calling. She is currently on 25 mg of Seroquel twice daily. Will increase it to 50 mg twice daily. Drowsy but responded to questions by opening her eyes. Further review of Resident 8's physician note on February 11, 2026, revealed under the section Assessment and Plan, the Seroquel will be increased because of repetitive calling out episodes. Review of Resident 8's physician orders revealed an order dated February 11, 2026, for Seroquel, 25 mg, take two tablets (to equal 50 mg), twice a day. Further review of Resident 8's physician orders revealed an order dated February 13, 2026, for Seroquel, 25 mg, take two tablets (to equal 50 mg), three times a day. Review of Resident 8's current physician orders revealed an order dated March 14, 2026, for Seroquel 50 mg, take one tablet three times a day. Review of Resident 8's clinical record revealed no indication for the Seroquel being increased from 50 mg twice a day to 50 mg three times a day. Review of Resident 8's physician orders revealed the Lexapro 10 mg, that was recommended by psych consult was not ordered until March 4, 2026, to start on March 5, 2026. Review of Resident 8's antipsychotic medication target behaviors revealed her target behaviors to be monitored included: yelling/calling out; continuously ringing call bell; expressing multiple complaints including stating she cannot breathe with SpO2 being 100% on room air; asking for bed covers to be taken off/put on; and removing clothing/disrobing. Staff are to document behavior noted and interventions attempted in progress note, every shift. Review of Resident 8's behavior documentation for January 2026, February 2026, and March 2026, revealed no documentation that Resident 8 displayed any of her targeted behaviors for her antipsychotic medication. Review of Resident 8's clinical record revealed no documented behaviors of Resident 8, with the exception of the two aforementioned psych consults stating the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395915	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitions Healthcare Allens Cove	25 Cove Road Duncannon, PA 17020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident was having increased anxiety and the one physician documentation of resident yelling out during his visit. There was also no documentation that any non-pharmacological interventions were attempted prior to increasing Resident 8's Seroquel. During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on March 19, 2026, at 11:05 AM, the surveyor asked if Resident 8's behavior of yelling out was an appropriate indication for the increase in her Seroquel dose, and if there were any additional behaviors documented, or any documentation of any non-pharmacological interventions that were attempted prior to increasing the Seroquel. In a follow up interview with the NHA and DON on March 19, 2026, at 12:34 PM, the NHA stated that Resident 8 does have a behavior of yelling out continuously but stated that it is not well documented by staff. He stated that staff should be documenting Resident 8's behaviors as well as any non-pharmacological interventions. The DON stated that Resident 8's Seroquel was increased due to repetitive yelling out with delusional thoughts, but he also confirmed that there is no documentation of the continuous behaviors that Resident 8 was displaying around the time the Seroquel dose was increased. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 211.2(d)(3) Medical director.28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395915	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitions Healthcare Allens Cove	25 Cove Road Duncannon, PA 17020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on facility policy review, clinical record review, select facility investigative documentation, and staff interviews, it was determined that the facility failed to have evidence that all alleged violations are thoroughly investigated and report the results of all investigations to officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident for one of two residents reviewed for abuse (Resident 9). Findings include: Review of facility policy, titled Abuse, Neglect, Mistreatment, Exploitation, and Misappropriation of Resident Property last revised June 14, 2023, read, in part, Facility staff will be trained to report any oral or written reports of alleged neglect, abuse, mistreatment, and misappropriation of resident's property. Facility staff must also report injuries of unknown etiology. Proper reporting procedures are as follows: Any report or suspicion of an incident is to be reported immediately to the charge nurse/supervisor. The administrator or his designated person will notify the Licensing and Regulatory Agency (Department of Health/DHS), Protective Services, Local Police Department, and other designated agencies as required. Steps will be taken to prevent further potential abuse by reporting all alleged violations/allegations and investigation within the required timeframes and conducting a thorough investigation of the alleged violation. Review of Resident 9's clinical record revealed diagnoses that included dementia (a condition characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities), insomnia (a sleep disorder in which you have trouble falling & staying asleep), and osteoarthritis (when protective cartilage that cushions the ends of the bones wears down over time). Review of Resident 9's clinical record revealed a nursing progress note dated January 17, 2026, that read, [Nurse Aide] came to this writer and reported that resident had large bruise on both hands, one large bruise on her left forearm and a skin tear that had a border dressing on it. Border dressing peeled back and 1 inch skin tear observed with small amount of bleeding. Resident states that [Nurse Aide] was 'too rough' and that the aide was yelling at her while providing care to resident on night shift. Witness statement gathered from roommate. Witness reports this happened yesterday, January 16, 2026, on evening shift. Treatment order placed. Resident assessed for pain, discomfort and further skin concerns. POA [Power of Attorney] contacted. Son requested follow-up information once investigation is complete. During an interview with the Director of Nursing (DON) on March 17, 2026, at 2:23 PM, he revealed he investigated the day the alleged abuse was reported on January 17, 2026, but based on the statements he collected and information gathered, it was determined the abuse allegation was unsubstantiated. He further revealed he did not notify any outside agencies of the alleged abuse and did not suspend the alleged perpetrator due to her not being there when the investigation was conducted on January 17, 2026. Also, he stated that he tried to interview Resident 9 about the incident and he was unable to get any information from her, but failed to note that in the investigation details. Review of statement from Employee 9 (Nurse Aide) on January 17, 2026, revealed I gave [Resident 9] her breakfast tray and noticed her hands had two large bruises that looked new. Reported to [Employee 10 (Registered Nurse)]. Unsure of how the bruises got on her hands. Review of statement from Employee 10 on January 17, 2026, revealed [Employee 9] informed me that resident had large purple bruises on her hands and arms. Resident stated '[employee description] hurt her.' Her roommate stated she heard her yelling at night while a nurse aide was providing care. Upon further investigation [Employee 7] and [Employee 8] have reported that resident has become combative at night yelling and hitting staff members. Review of statement written by Employee 8 on January 17, 2026, revealed Resident can be combative (hitting, kicking) with care. She can be aggressive with staff (get the hell out, I'll call my son, don't you touch me). She is difficult to redirect; demanding staff do what she wants. If it isn't possible she threatens to call her granddaughter or son. Review of statement written by the DON on January 17, 2026, revealed Resident roommate stated she believed the incident during care in which she overheard yelling occurred on January 16, 2026, involved [Employee 3 (Nurse Aide)]; however, she could not (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395915	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitions Healthcare Allens Cove	25 Cove Road Duncannon, PA 17020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	visualize at the time due to the curtain pulled while care was being provided. Review of additional statement written by the DON on January 17, 2026, revealed, This writer spoke to [Employee 3] via telephone who stated that [Resident 9] had become very combative during care, on Thursday January 16, 2025, swinging and trying to hit the caregiver at that time. Nurse aide did not notice any injury at that time. Educated nurse aide to stop providing care if resident becomes combative and reapproach later. Review of statement written by Employee 7 on January 17, 2026, revealed I worked 10-6:30 AM, Friday night into Saturday and did first rounds on [Resident 9] @ 12:00 AM (assisted with another aide) we noticed the bruises & skin tear then. I also worked Thursday into Friday when these bruises were reported. Resident has become combative/aggressive during night shift changes. During changes she refuses changes or just fights (trying to punch & kick or jump out of bed). During an interview with Employee 7 on March 18, 2026, at 5:15 PM, she revealed she went to the Licensed Practical Nurse (LPN) on duty on the night shift of Thursday into Friday to notify her of the bruises, but she doesn't remember who it was, and they told her they were already aware of the bruises and would handle it. During an interview with the DON on March 19, 2026, at 9:21 AM, he revealed, in hindsight, he should have reported the allegation of abuse and details of the investigation to the appropriate agencies. Follow up interview with the DON on March 19, 2026, at 11:08 AM, he revealed he spoke with the two LPNs on duty Thursday into Friday in response to Employee 7's statement, and both denied the bruises were reported to them, but he failed to note that in the investigation details and now does not remember who they were. No further information was provided. 28 Pa. Code 201.14 (a) Responsibility of licensee28 Pa. Code 201.18 (b)(1) Management28 Pa. Code 201.29 (a) Resident rights

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395915	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitions Healthcare Allens Cove	25 Cove Road Duncannon, PA 17020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined the facility failed to develop and implement a baseline person-centered care plan within 48 hours of a resident's admission to include the minimum healthcare information necessary to properly care for a resident and failed to provide the resident and their representative with a summary of the baseline care plan for two of 19 residents reviewed (Residents 4 and 68).Findings include: Review of Resident 4's clinical record revealed diagnoses that included hypertension (high blood pressure) and chronic kidney disease (when the kidneys are damaged and can't do their important jobs). Review of Resident 4's clinical record revealed the Resident was admitted to the facility on [DATE]. Review of Resident 4's clinical record revealed their care plan was initiated on February 17, 2026, and was completed on March 16, 2026. Further review of the Resident's care plan revealed their activities, dietary, nursing, social services, and therapy focus areas and interventions on the care plan were initiated and completed on March 16, 2026. The only care plan focus area that was initiated timely was the Resident's advanced directive care plan, initiated on February 17, 2026. Review of Resident 68's clinical record revealed diagnoses that included heart failure (a chronic condition where the heart muscle is unable to pump enough to meet the body's needs for blood and oxygen) and hypertension. Review of Resident 68's clinical record revealed the Resident was admitted to the facility on [DATE]. Review of Resident 68's clinical record revealed all of their care plan focus areas and interventions were initiated on either December 17, 2025, or December 30, 2025. Resident 4 and 68 did not have timely development and implementation of the baseline care plan. The resident and their representative were also not provided a summary of the baseline care plan. During an interview with the Nursing Home Administrator on March 19, 2026, at 11:00 AM, he confirmed that the Residents' baseline care plans were not completed within 48 hours of their admission and would expect them to be. 28 Pa. Code 211.11 (d) Resident care plan42 CFR 483.21(b) Comprehensive Care Plans

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395915	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitions Healthcare Allens Cove	25 Cove Road Duncannon, PA 17020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined the facility failed ensure that resident and resident representative were involved in developing the comprehensive care plan and making decisions about his or her care for one of 19 residents reviewed (Resident 68). Findings include: Review of Resident 68's clinical record revealed diagnoses that included heart failure (a chronic condition where the heart muscle is unable to pump enough to meet the body's needs for blood and oxygen) and hypertension (high blood pressure). Review of Resident 68's clinical record revealed the Resident was admitted to the facility on [DATE]. Review of Resident 68's clinical record revealed all of their care plan focus areas and interventions were initiated on either December 17 or 30, 2025. Review of Resident 68's clinical record failed to reveal that a care plan meeting was held with an interdisciplinary team and failed to reveal any evidence or documentation that the Resident and their Representative were invited to participate in the care planning process. During an interview with the Nursing Home Administrator on March 19, 2026, at 2:09 PM, he revealed there weas no evidence of a care plan meeting being held with the Resident or their Representative, and that the development of the comprehensive care plan should include the resident and their representative. 28 Pa. Code 211.11 (d) Resident care plan42 CFR 483.21(b) Comprehensive Care Plans

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395915	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitions Healthcare Allens Cove	25 Cove Road Duncannon, PA 17020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on clinical record review and staff interview, it was determined that the facility failed to ensure care and services are provided in accordance with professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for one of 19 residents reviewed (Resident 48). Findings Include: Review of Resident 48's clinical record revealed diagnoses that included colon cancer and bladder cancer. Review of Resident 48's physician progress note dated March 13, 2026, revealed Resident 48 was being seen due to excessive blood draining into Resident's urostomy bag (a surgically created opening in the abdominal wall that allows urine to bypass a diseased or dysfunctional bladder. It is commonly used when the bladder is removed due to cancer, birth defects, or nerve damage, allowing urine to flow continuously into an external pouching system). The note further stated that the physician spoke to Resident 48's responsible party (RP), who stated she was also going to call and speak with Resident's urologist. Further review of Resident 48's physician note dated March 13, 2026, revealed an addendum that at 4:45 PM the physician was contacted by the facility nurse, stating Resident 48's urologist called the facility and was requesting a urinalysis and culture to rule out a UTI (urinary tract infection). Review of Resident 48's nursing progress notes revealed a note dated March 13, 2026, stating that the nurse spoke with Resident 48's urologist's office and they recommended a UA C&S (urinalysis with culture and sensitivity). Review of Resident 48's physician orders revealed an order dated March 13, 2026, for a UA C&S. The order was marked as completed. Review of Resident 48's clinical record revealed no evidence that the UA C&S was collected and sent to the lab on March 13, 14, or 15, 2026. Review of Resident 48's physician progress note dated March 16, 2026, revealed A UA has not yet been collected. Review of Resident 48's physician orders revealed an order for a UA C&S ordered on March 15, 2026, with a start date of March 16, 2026. Review of Resident 48's nursing progress notes revealed a note on March 16, 2026, at 1:35 PM, stating that the UA C&S was collected. Review of a follow up physician note dated March 16, 2026, revealed the UA was suggestive of a UTI and new orders were given to start an antibiotic for treatment. During an interview with the Nursing Home Administrator (NHA) and Director of Nursing on March 18, 2026, at 1:47 PM, the NHA stated that Resident 48's UA C&S should have been collected and sent to the lab on March 13, 2026, when it was first ordered. 28 Pa. Code 201.18(b)(1) Management28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services