STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396026	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concordia at Villa St Joseph	1030 State Street Baden, PA 15005

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident clinical records, and staff interviews, it was determined that the facility failed to ensure that residents medication regimen was free from unnecessary psychotropic medication (drugs that affect a person's mental state, emotions, and behavior) for three of five sampled residents (Residents R2, R8, and Resident R9). Findings include: The facility Use of psychotropic medications policy dated 4/28/25, and last reviewed 1/1/26, indicated that a psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These medications should only be used to treat the resident's medical symptoms. For psychotropic medications, without documentation in the record explaining that the practitioner has determined that other treatments have been deemed clinically ineffective, the indication for use is inadequate. The facility Gradual dose reduction of psychotropic drugs policy dated 4/28/25, last reviewed 1/1/26, indicated that gradual dose reduction (GDR) refers to the stepwise tapering of a dose to determine if symptoms, conditions or risk can be managed by a lower dose. Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated the medication, the facility will attempt a GDR in two separate quarters (with at least one month between attempts), unless contraindicated. GDR will be documented in the clinical record. Rationale for clinical contraindications may be documented in the clinical record. Review of Resident R2's admission record indicated he was admitted [DATE]. Review of Resident R2's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 12/8/25, indicated Resident R2 had diagnoses that included Parkinson's Disease (a progressive disorder of the central nervous system which affects movement and includes tremors), diabetes (metabolic disorder impacting organ function related to glucose levels in the human body), Dementia (a condition characterized by memory loss and progressive or persistent loss of intellectual functioning), and chronic kidney disease (a loss of kidney function resulting in the swelling of feet, fatigue, high blood pressure and changes in urination). Review of Resident R2's care plans, last reviewed 1/6/26, indicated that Resident R2 uses psychotropic medications with the reason being behavioral management. Review of Resident R2's physician orders dated 6/6/25 and 6/7/25 indicated the following: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give one Seroquel 25mg in the morning for Major depressive disorder Give two Seroquel 25mg at bedtime for Major depressive disorder Review of Resident R2's physician visits dated 11/20/25, 1/27/26, and 2/25/26 indicated that Resident R2 had no behaviors and to continue his Seroquel dosage. Review of Resident R2's clinical progress notes October 2025 to March 2026 did not include any behaviors related to the use of Seroquel. During an interview on 3/4/26, at 10:23 a.m. Director of Nursing (DON) was asked about Resident R2 GDR documentation and the GDR process: I round with the psychiatrist. He retired at the end of January 2026. The Psychiatrist would see the residents after a medication adjustment, monitor the residents and discuss quarterly during the medication reduction meeting. That is our process. During an interview on 3/4/26, at 10:37 a.m. Licensed Practical Nurse Assessment Coordinator (LPNAC) Employee E7 was asked about the GDR process: we currently are going through transition. Before, a psychiatrist would come in and complete a review of medications and consider a GDR. During an interview on 3/4/26, at 11:28 a.m. Director of Nursing (DON) provided documents/email communications mentioning GDR discussion with the facility multi-disciplinary team regarding Resident R2. However, specific behaviors, a documented clinical rationale for using a psychotropic medication, or the effects should Resident R2 medications be modified was not documented. During an interview on 3/4/26, at 11:31 a.m. Licensed Practical Nurse Assessment Coordinator (LPNAC) Employee E7 was asked for Resident R2's behaviors notes and gradual dose reduction (GDR) documents and stated: I cannot find anything that you requested. During an interview on 3/4/26, at 11:40 a.m. Nurse aide Employee E8 was asked if Resident R2 had any behaviors for the past six months, and she stated: I have not seen any behaviors. Resident R2 is very sweet. Some behaviors when he first came in though. During an interview on 3/4/26, at 2:22 p.m. the Director of Nursing (DON) confirmed that the facility failed to ensure that residents medication regimen was free from unnecessary psychotropic medication and document in the resident record the reason for continued use for Resident R2 as required. Review of Resident R8 admission record indicated she was admitted on [DATE]. Review of Resident R8 admission record indicated diagnosis of unspecified mood disorder (symptoms predominate that are characteristic of a depressive disorder and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning) depression (involves a depressed mood or loss of pleasure or interest in activities for long periods of time) and anxiety disorder (excessive, frequent and unrealistic worry about everyday things). Review of Resident R8 MDS dated [DATE], indicated resident R8 has diagnoses of CAD (coronary artery disease a common type of heart disease affects the main blood vessels that supply blood to the heart), anxiety (repeated episodes of sudden feelings of intense anxiety and fear or terror that (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reach a peak within minutes), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily activities.). Review of Resident R8 clinical record MAR (medication administration record - a record documenting residents' medication) for January 2026 indicated: Alprazolam (used to relive symptoms of anxiety) Tablet 0.25 MG Give 1 tablet by mouth every 24 hours as needed for Anxiety -Start Date- 01/26/2026 1237 -D/C Date- 02/23/2026 0958 Review of the MAR indicated medication was given 1/26/26, 1/27/26, 1/28/26 and 1/30/26. Review of the MAR failed to include what behaviors Resident R8 was experiencing and other attempts to relive potential behaviors prior to Resident R8 being given the psychotropic medication. Review of Resident R8 progress notes for January 2026 failed to include a description of behaviors, or non- pharmacological interventions that were given to resident R8 prior to the psychotropic medications. Review of Resident R9 admission record indicated she was admitted on [DATE]. Review of Resident R9 MDS assessment dated [DATE], indicated Resident R9 has diagnoses of adult failure to thrive (a state of decline that is multifactorial and may be cause by chronic concurrent diseases and functional impairment), depression (causes a persistent feeling of sadness and loss of interest) and malnutrition (deficiencies, excesses, or imbalances in a person's /intake of energy and /or nutrients.) Review of Resident R9 MDS, BIMS (Brief Interview Mental Status) indicated a score of 9 (moderate impairment). Review of Resident R9 clinical record psychotropic medication informed consent dated 11/18/25, indicated: sertraline 150mg and anti-anxiety - hydroxyzine. Review of the consent form showed Resident R9 signed for the consent of the medications. During an interview on 3/5/26, at10:39 a.m. Nursing Home Administrator and Director of Nursing confirmed that the facility failed to give non-pharmacological interventions to Resident R8 and failed to have a guardian or responsible party sign for Resident R9. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.2(a)(c) Physician services. 28 Pa. Code: 211.9(a)(1)(d)(k) Pharmacy services. 28 Pa. Code: 211.12(c)(d)(5) Nursing services.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 review of clinical records and staff interviews, it was determined that the facility failed to develop and implement a baseline care plan to include instructions needed to provide effective and person-centered care of the resident for five of eight residents reviewed (Resident R21, R28, R147, and R157). Findings include: Review of the facility policy Baseline Care Plan dated 1/1/26, indicated 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 meet professional standards of quality care. Review of the admission record indicated Resident R21 admitted to the facility on [DATE], with the diagnoses of pneumonia (lung infection), Parkinson's disease (disorder of the nervous system that results in tremors), and enterocolitis due to clostridium difficile (C-diff - contagious bacteria causing severe, watery diarrhea, abdominal pain, fever, and nausea). Review of Resident R21's physician order dated 2/12/26, indicated contact precautions for C-diff. Please clarify with physician when isolation precautions can end. Review of Resident R21's baseline care plan dated 2/12/26, failed to include instructions for care and management of contact precautions for Cdiff. Review of the admission record indicated Resident R28 admitted to the facility on [DATE], with the diagnoses of atrial fibrillation (irregular heart rhythm), heart failure (heart doesn't pump blood as well as it should), and lymph edema (tissue swelling caused by an accumulation of protein-rich fluid that's usually drained through the body's lymphatic system). Review of Resident R28's MDS dated [DATE], indicated the diagnoses remain current. Review of Resident R28's physician orders dated 2/15/26, indicated:-cleanse left buttock open area with saline, apply calcium alginate (highly absorbent fiber derived from brown seaweed, used as a primary wound dressing for moderate to heavy exudating wounds) and border gauze daily in the morning.-cleanse open areas of left shin with saline, apply calcium alginate and border gauze daily.-cleanse skin tear of left upper elbow area with saline apply xeroform gauze (non-adherent dressing) and border gauze in the evening. Review of Resident R28's baseline care plan dated 2/15/26, failed to include person centered instructions for care and management of left buttock, left shin, and left elbow wounds. Interview on 3/4/26, at 1:00 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E1 confirmed Resident R21's and Resident R28's baseline care plans failed to include instructions needed to provide effective and person-centered care of each resident. Review of the clinical record indicated Resident R147 was admitted to the facility on [DATE], with diagnoses of pneumonia, anxiety disorder, and encounter for follow up after examination after (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completed treatment for conditions other than malignant neoplasm. Review of Resident R147's care plan dated 2/20/26, revealed the resident had an alteration in gastrointestinal status due to a new peg tube (A percutaneous endoscopic gastrostomy tube, is a feeding tube inserted into the stomach through the abdominal wall, used for patients who cannot eat by mouth.). On 2/23/26, a total of three days after the resident was admitted to the facility, interventions were initiated to administer tube feed per order. The care plan failed to include the physician order or size of the resident's G-Tube. Interview with the Registered Nurse Assessment Coordinator, Employee E1 on 3/3/25, at 12:50 p.m. confirmed Resident R147's physician orders for the administration of tube feeds or the size of the resident's G-Tube were not included in the resident's baseline care plan. RNAC, Employee E1 confirmed the facility failed to develop and implement a baseline care plan to include instructions needed to provide effective and person-centered for Resident R147. Review of the admission record indicated Resident R157 admitted to the facility on [DATE], with diagnoses of depression and diabetes (a condition that causes blood sugar to rise). Review of Resident R157's physician order dated 2/25/26, indicated to change incisional wound vac every 3 days. Place versatile or Adaptec or similar dressing, black sponge over the incision. Set wound vac at 80 mm/hg continuous suction. Replace knee immobilizer. Review of Resident R157's care plan dated 2/25/26, revealed the resident had pseudomonas/ candida parasitosis infection to right knee. Interventions included to apply wound vac as prescribed. The care plan failed to include the wound vac settings or order to change the wound vac. During an interview on 3/2/26, at 1:55 p.m. Licensed Practical Nurse Assessment Coordinator, Employee E7 confirmed the facility failed to ensure Resident R157's baseline care plan included wound vac settings and an order to change the wound vac. 28 Pa Code 211.10(a) Resident care policies.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, and staff interview it was determined that the facility failed to ensure residents received treatment and care in accordance with professional standards of practice and follow physician orders for three of four residents (Resident R36, R73, R157).Findings include: Interview with the Director of Nursing on 3/4/26, at 1:00 p.m. indicated the facility does not have a policy regarding quality of care or change in condition. Review of the admission record indicated Resident R36 admitted to the facility on [DATE]. Review of Resident R36's Minimum Data Set (MDS- a periodic assessment of care needs) dated 2/23/26, indicated the diagnoses of hepatic encephalopathy (a reversible serious brain dysfunction caused by liver failure where the liver cannot filter toxins, mainly ammonia from the blood), diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and liver cancer. Review of hospital discharge documentation indicated rifaximin (a broad-spectrum antibiotic used to treat diarrhea and reduce the risk of over-hepatic encephalopathy recurrence) 550 mg (milligram) by mouth twice a day from 2/5/26, through 4/5/26. Review of Resident R36's physician order dated 2/18/26, indicated rifaximin 550 mg (milligram) give one tablet by mouth every morning and at bedtime for anti-infective agent for 30 days. Review of Resident R36's Medication Administration Record (MAR) dated February 2026, indicated rifaximin 550 mg give one tablet by mouth every morning and at bedtime. The medication was not documented as ever being received by the resident. Review of Resident R36's progress note dated 2/19/26, at 2:22 p.m. indicated this writer called the pharmacy this afternoon to inquire as to why the Rifaximin 550 mg did not come from the pharmacy today. Upon research, it is noted upon admission that the medication is to be supplied by the family and ordered while he was still in the hospital. It will arrive as soon as possible and the family will bring it to us to give to resident. Review of Resident R36's progress note dated 2/24/26, indicated rifaximin remains on hold, to be supplied by the family. This writer asked resident's family for an update about the medication. It is apparently over one thousand dollars for a supply, and they are looking into the situation further. Interview on 3/4/26, at 9:59 a.m. Licensed Practical Nurse (LPN) Employee E2 indicated the family is trying to get the medication for us. Review of the admission record indicated Resident R73 admitted to the facility on [DATE]. Review of Resident R73's MDS dated [DATE], indicated diagnoses of diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), high blood pressure, and anxiety. Review of Resident R73's physician order dated 2/12/26, indicated Lispro Pen (short acting insulin) inject as per sliding scale: if 0 - 70 = 0 initiate hypoglycemic protocol; 71 - 140 = 0; 141 - 180 = 1; 181 - 220 = 2; 221 - 260 = 3; 261 - 300 = 4; 301 - 340 = 5; 341 - 999 = 6 give 6 units and recheck in 30 minutes, if still >340 contact physician. Review of Resident R73's clinical record indicated the facility failed to notify the physician of abnormal glucose levels greater than 341 as ordered on the following days:3/1/2026 16:15 383.0 mg/dL notification not documented.2/25/2026 16:00 369.0 mg/dL notification not documented.2/23/2026 19:34 394.0 mg/dL notification not documented. 2/20/2026 19:41 387.0 mg/dL notification not documented.2/19/2026 21:07 348.0 mg/dL notification not documented.2/18/2026 20:30 386.0 mg/dL notification not documented.2/14/2026 20:15 357.0 mg/dL notification not documented. Review of the admission record indicated Resident R157 admitted to the facility on [DATE], with diagnoses of depression and diabetes (a condition that causes blood sugar to rise). Review of Resident R157's physician order dated 2/25/26, indicated to change incisional wound vac every 3 days. Place versatile or Adaptec or similar dressing, black sponge over the incision. Set wound vac at 80 mm/hg continuous suction. Replace knee immobilizer. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R157's care plan dated 2/25/26, revealed the resident had psudomonous/ candida parapsiolsis infection to right knee. Interventions included to apply wound vac as prescribed. The care plan failed to include the wound vac settings or order to change the wound vac. During an interview on 3/1/26, at 10:11 a.m. Resident R157 wound vac was not on and operating. The wound vac was observed not to be plugged in. During an interview on 3/2/26, at 10:12 a.m. Licensed Practical Nurse (LPN), Employee E9 confirmed Resident R157's wound vac was not on and functioning. LPN, Employee E9 confirmed the facility failed to provide the wound vac as ordered. Interview on 3/4/26, at 11:00 a.m. the Director of Nursing confirmed that the facility failed to ensure residents received treatment and care in accordance with professional standards of practice and follow physician orders for three of four residents (Resident R36, R73, R157). 28 Pa. Code: 201.14(a) Responsibility of Licensee. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12 (d)(5) Nursing Services.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on review of facility policy, and facility documents and staff and resident interviews it was determined that the facility failed to document, resolve, and provide response to resident and/or their responsible party regarding concerns for one of five residents (Resident R142).Findings include: Review of the facility Resident and Family Grievances policy dated 1/1/26, indicated the Grievance Official is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility, maintaining the confidentiality of all information associated with grievances, issuing written grievance decisions to the resident, and coordinating with state and federal agencies as necessary in light of specific allegations. A resident or family member may voice grievances with respect to care and treatment that has been furnished as well as that which has not been furnished, the behavior of staff and other residents, and other concerns regarding their LTC facility stay. Grievances may be voiced in form of verbal complaint to a staff member. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated form or assist the resident or family member to complete the form. Forward the grievance form to the Grievance Official as soon as practicable. Review of the facility's January Resident Council Minutes dated 1/19/26, revealed Resident R142 attended the resident council meeting and expressed a concern related to maintenance. It was indicated when the heater controls are on low, the room gets very hot. Roommate opens window and Resident R142 is cold. Difficult to adjust and create a comfortable environment. During an interview on 3/2/26, at 12:02 p.m. Resident R142 confirmed she expressed a concern in January's Resident Council meeting regarding room temperatures. Review of January 2026, facility provided Grievance log failed to include Resident R142 grievance. Interview on 3/2/26, at 2:12 p.m. the Nursing Home Administrator confirmed that the facility failed to document, resolve, and provide response to resident and/or their responsible party regarding concerns for one of five residents (Resident R142). 28 Pa. Code 201.14(b) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 PA Code: 201.29(a) Resident rights.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and facility documents, clinical records, staff and family interviews it was determined that the facility failed to implement written policies and procedures to ensure a complete and thorough investigation of one of four abuse allegations (Resident R74).Findings include: Review of the facility policy Abuse, Neglect, and Exploitation, dated 1/1/26, indicated: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Identification of Abuse, Neglect and Exploitation: Possible indicators of abuse include, but are not limited to: Physical injury of a resident, unknown origin. Review of the admission record indicated Resident R74 was admitted to the facility on [DATE]. Review of the admission record diagnosis indicated: sciatica left side (nerve pain from injury or irritation to your sciatica nerve), other abnormalities of gait and mobility (gait disorders are an abnormal walking pattern with many possible causes like an injury, sore, an inner ear (balance)issue or nerve damage), and age-related osteoporosis without current pathological fracture(Bones to become weak and brittle so brittle that a fall or even mild stresses such as bending over or coughing can cause a break. Osteoporosis-related breaks most commonly occur in the hip, wrist or spine). Review of the facility documentation progress notes dated 3/1/26, indicated: Hospital nurse called at 0005 (5:00 a.m.) to report radiology report of LEFT femur broken. Resident R74 to be admitted . Review of the facility documentation indicated that Resident R74 progress notes dated 3/1/26, Pt with history of left side sciatica and inability to ambulate. Pt reports new onset worsening pain to left hip. Reports she can't move leg. She is anxious. She wants to go to hospital. Review of witness statements indicated Resident R74 was moved into bed by a sit to stand (a type of transfer device for residents) by Nurse Aide (NA) Employee E10 and afterwards complained of pain. During an interview on 3/4/26, at 12:55 p.m. NA Employee E10 indicated: I took Resident R74 to the bathroom utilizing the sit to stand lift. I took the resident back to bed with the sit to stand, placed her in the bed, afterwards she complained of pain - I notified the nurse. Review of facility provided documentation indicated witness statements from staff were completed. Further review failed to include that the facility identified the injury of unknown origin as potential neglect or that an investigation was completed to rule out neglect. During an interview on 3/5/26, at 10:46 a.m. Director of Nursing (DON) indicated that the investigation was completed, and the facility had collected the witness statements but there was no further documentation, nor could documentation be provided to show that neglect was investigated and ruled out. During an interview on 3/5/26, at 10:50 a.m. Nursing Home Administrator and DON were informed that the facility failed to implement written policies and procedures to ensure a complete and thorough investigation of one of four abuse allegations (Resident R74). 28. Pa Code 201.14(a) Responsibility of licensee.28. Pa Code 201.18(b)(1)(e)(1) Management.28. Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on review of facility policy, facility documents, clinical records, and staff interview it was determined that the facility failed to conduct a thorough investigation of an injury of unknown origin to eliminate possible neglect for one of four residents (Resident R74). Findings include: Review of the facility policy Abuse, Neglect, and Exploitation, dated 1/1/26, indicated: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Identification of Abuse, Neglect and Exploitation: Possible indicators of abuse include, but are not limited to: Physical injury of a resident, unknown origin. Review of the admission record diagnosis indicated: sciatica left side (nerve pain from injury or irritation to your sciatica nerve), other abnormalities of gait and mobility (gait disorders are an abnormal walking pattern with many possible causes like an injury, sore, an inner ear (balance)issue or nerve damage), and age-related osteoporosis without current pathological fracture (Bones to become weak and brittle so brittle that a fall or even mild stresses such as bending over or coughing can cause a break. Osteoporosis-related breaks most commonly occur in the hip, wrist or spine). Review of the facility documentation progress notes dated 3/1/26, indicated: Hospital nurse called at 0005 (5:00 a.m.) to report radiology report of LEFT femur broken. Resident R74 to be admitted . Review of the facility documentation indicated that Resident R74 progress notes dated 3/1/26, Pt with history of left side sciatica and inability to ambulate. Pt reports new onset worsening pain to left hip. Reports she can't move leg. She is anxious. She wants to go to hospital. Review of witness statements indicated Resident R74 was moved into bed by a sit to stand (a type of transfer device for residents) by Nurse Aide (NA) Employee E10 and afterwards complained of pain. During an interview on 3/4/26, at 12:55 p.m. NA Employee E10 indicated: I took Resident R74 to the bathroom utilizing the sit to stand lift. I took the resident back to bed with the sit to stand, placed her in the bed, afterwards she complained of pain - I notified the nurse. Review of facility provided documentation indicated witness statements from staff were completed. Further review failed to include that the facility identified the injury of unknown origin as potential neglect or that an investigation was completed to rule out neglect. During an interview on 3/5/26, at 10:46 a.m. Director of Nursing (DON) indicated that the investigation was completed, and the facility had collected the witness statements but there was no further documentation, nor could documentation be provided to show that neglect was investigated and ruled out. (continued on next page)

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	396026	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concordia at Villa St Joseph	1030 State Street Baden, PA 15005

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/5/26, at 10:50 a.m. Nursing Home Administrator and DON were informed that the facility failed to conduct a thorough investigation of an injury of unknown origin to eliminate possible neglect for one of four residents (Resident R74). 28 Pa Code: 201.18 (e)(1)(2) Management. 28 Pa Code: 201.29 (a)(c) Resident Rights. 28 Pa Code: 211.12 (a)(c)(d)(1)(3)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, observations, and staff and resident interviews, it was determined that the facility failed to ensure that residents with an enteral feeding tube (a tube inserted in the stomach through the abdomen) received appropriate treatment and services to prevent potential complications for one of three residents reviewed (Residents R147).Findings include: Review of [NAME] manufacture guidelines titled How to bolus feed dated 3/20, stated bolus feeding is a way of receiving a set amount of feed as required, without use of a feeding pump. This is given over a period of time, as advised by your healthcare professional, using an enteral feeding syringe. Materials required include a 60ml enteral feeding syringe, clean jug for decanting your feed, water for flushing the feeding tube before and after the feed, and the prescribed feed. Once opened, cover your feed and put it in the fridge (when not being used). Sterile feed can be used for up to 24 hours (nonsterile for up to 4 hours).1 After this time throw the feed away if you do not use it. Review of the Jevity 1.5 Cal Product Information manufacturer guidelines dated 2024, revealed Jevity 1.5 Cal is a calorically dense, high protein, fibre-fortified liquid formula proving complete, balanced nutrition for people who may benefit from increased calories and protein. It was indicated all formulated liquid diet products, regardless of administration system, require careful handling because they can support microbial growth. Follow these instructions for clean technique and proper setup to reduce the potential for microbial contamination. For tube feedings, follow health care professional instructions for flow rate, volume and need for additional fluids. Care should be taken to avoid contamination during preparation and administration. Pump feeding is recommended, use a 10Fr or larger tube. For gravity feeding, use a 12 Fr or larger tube. Review of the facility provided undated Administration of Enteral Feedings-Gastrostomy or Jejunostomy Tube (G-Tube or J-Tube) education, indicated for enteral feeding via bolus administration the formula is opened and the amount ordered is added to the tube. Open the clamp and allow the formula to flow into the stomach. Once complete, clamp the tube. Flush tube. Review of the clinical record indicated Resident R147 was admitted to the facility on [DATE], with diagnoses of pneumonia, anxiety disorder, and encounter for follow up after examination after completed treatment for conditions other than malignant neoplasm. Review of Resident R147's care plan dated 2/20/26, revealed the resident had an alteration in gastrointestinal status due to a new peg tube (A percutaneous endoscopic gastrostomy tube, is a feeding tube inserted into the stomach through the abdominal wall, used for patients who cannot eat by mouth.). On 2/23/26, a total of three days after the resident was admitted to the facility, interventions were initiated to administer tube feed per order. The care plan failed to include the physician order or size of the resident's G-Tube. Review of a physician order dated 2/24/26, indicated to administer 360 milliliters (ml) Jevity 1.5 liquid nutritional supplement via Peg Tube, bolus feed, four times a day. During an interview and observation on 3/3/26, at 12:06 p.m. Resident R147 stated I do have one complaint, I am hungry all the time. Resident R147 indicated 360 ml four times a day is not enough, it should be 400. Resident R147 stated my stomach is growling all the time. Resident R147's Jevity 1.5 was observed being administered via gravity in from the pole with tubing and dripping slowly. The resident stated, this one is very slow. 360 ml was still observed in the bag. During an interview on 3/3/26, at 12:12 p.m. Registered Nurse (RN), Employee E6 stated Resident R147's tube feeding was hung around 11:10 a.m. and stated, I came in 5 to 10 minutes ago and noticed it was not going through. RN, Employee E6 confirmed Resident R147 was not receiving his tube feed by bolus as ordered. During an interview on 3/3/26 at 12:33 p.m. RN, Employee E6 stated in the beginning the pump was used to administer Resident R147's tube feed, however the pump was not efficient. RN, Employee E6 stated it typically takes an hour for the tube feed to be administered using a bag and tubing and it attached to the pole. During an interview on 3/3/26, at 12:37 p.m. RN, Employee E6 confirmed (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident R147 tube feedings were ordered to be administered via bolus. During an observation on 3/4/26, at 11:16 a.m. Resident R147's syringe hanging on the tube feeding pole was undated and the tube feed tubing failed to have a cap attached to the end. The resident's tube feed bottle was observed sitting on the window seal. During an interview on 3/4/26, at 11:23 a.m. RN, Employee E6 confirmed the above observations. During an interview on 3/5/26, at 2:05 p.m. the Director of Nursing and Nursing Home Administrator confirmed that the facility failed to ensure that residents with an enteral feeding tube received appropriate treatment and services to prevent potential complications as required for one of three residents (Residents R147). 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.12(d)(1) Nursing services.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, staff interviews, and resident observations it was determined that the facility failed to maintain a peripheral intravenous (IV) catheter site consistent with professional standards of practice for one of three residents (Resident R29).Findings include:Review of the facility policy Intravenous Therapy dated 1/1/26, indicated the facility will adhere to accepted standards of practice regarding infusion practices. IV sites are checked every shift and as needed for signs and symptoms of infection or inflammation.Review of the admission record indicated Resident R29 admitted to the facility on [DATE].Review of Resident R29's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/12/26, indicated the diagnoses of renal insufficiency (a condition in which the kidneys lose the ability to remove waste and balance fluids), pneumonia (lung infection) and urinary tract infection.Review of Resident R29's physician order dated 2/28/26, indicated sodium chloride intravenous solution0.9 % (percent). Use 500 ml (milliliters) intravenously every shift for dehydration. To be run as a 500ml bolus (at once) and then remaining 500 mls at 75 mls/hour for a total of 1000mls.Observation on 3/1/26, at 9:35 a.m. Resident R29 was lying in bed. The left lower arm had a peripheral IV inserted. The site was not labeled with a date or time. The extension tubing connected to the IV catheter itself was not clamped off, and failed to have a cap, or injection site at the end. Blood was noted to be backed up in the extension tubing.Observation and interview with Licensed Practical Nurse (LPN) Employee E3 confirmed the appearance of the IV site, that it was not clamped off, failed to have a cap, or injection site at the end, and that blood was noted to be backed up in the extension tubing.Interview on 3/1/26, at 2:45 p.m. information was disseminated to the Director of Nursing that the facility failed to maintain a peripheral intravenous catheter site consistent with professional standards of practice for one of three residents (Resident R29).28 Pa. Code 201.18(b)(3) Management.28 Pa. Code 211.10(c)(d) Resident care policies.28 Pa. Code 211.12(d)(1)(3) Nursing services.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff and resident family interviews it was determined that the facility failed to meet residents pain needs for two of two residents reviewed (Resident R5 and Resident R159). Findings include: Review of facility policy Pain Management dated 1/1/26, indicated: The facility must ensure that pain managements provided to residents who require such services, consistent with professional standards of practice, and the residents' goals and preferences. Resident R5 was admitted to the facility on [DATE]. Review of Resident R5 MDS (minimum data set - a periodic assessment of resident needs) dated 12/11/25, indicated diagnosis of a-fibrillation (an irregular and often very rapid heart rhythm), and myelodysplastic syndrome (group of disorders caused by blood cells that are poorly formed or don't work properly.) Review of Resident R5 clinical record indicated: resident to wear below lower extremities lymphedema (swelling that happens when something affects your lymphatic system) garments during the day off at night. Review of Resident R5 clinical record progress notes dated 3/3/26, indicated: review of progress notes show resident complain of pain around 3am -lymphedema socks were still on. Review of Resident R5 clinical record to include MAR/TAR (medication administration record and treatment administrator record - forms used to documents residents' medications and treatments) failed to include lymphedema garments to be place on or off. During an interview on 3/5/26, at 10: 50 a.m. Director of Nursing (DON) stated that she just added an order on the MAR for the nurses to remove the lymphedema garments at night and that prior to her adding it during the meeting it was not indicated on the MAR/TAR. During an interview on 3/5/26, at 10:50 a.m. Nursing Home Administrator (NHA) and DON were informed that the facility failed meet Resident R5 pain needs by failing to remove lymphedema socks. Resident R159 was admitted to the facility on [DATE]. Review of Resident R159 admit record indicated diagnosis of heart failure (occurs when the heart muscle doesn't pump blood as well as it should), unspecified fracture of T11-T12 vertebra, sequela (fracture of spine), and atrial fibrillation (an irregular and often very rapid heart rhythm.) During observations on 3/1/26, from 9:57 a.m. Resident R159 was heard:crying out in pain saying, I know there's a pill you can give me for this pain, I give you permission, please ask them to give me a pill I don't want to have to feel this pain something to put me to sleep. During an interview on 3/1/26, at 10:10 a.m. Resident R159 family member indicated that Resident R159 yells out, but not typically like this - and she came in with a broken spine earlier this week. During an interview on 3/1/26, at 10:13 a.m. LPN (Licensed Practical Nurse) Employee E12, indicated that she was the only nurse on the unit, she was passing medications on the other side of the nursing unit. LPN Employee E12 was told during shift change that Resident R159 was given pain medications and she checked the MAR, and she was able to give her pain medication. Review of Resident R159 physician orders indicated: HYDROmorphone HCl Oral Liquid 1MG/ML (Hydromorphone HCl)Give 1 mg sublingually every 1 hours asneeded for moderate to severe pain/SOB/ restlessness If allergic to morphineor renal failure.For moderate to severe (4-10) pain/shortness of breath/ restlessness.*If ineffective after two 1 mg doses, thencall hospice 800.720.2557 for additional OxyCODONE HCl Tablet 10 MGGive 10 mg by mouth every 4 hours asneeded for Pain-Start Date-02/26/2026 1743 LORazepam Oral Tablet 0.5 MG(Lorazepam)Give 0.5 mg by mouth every 4 hours asneeded for terminalrestlessness/anxiety/shortness of breath*If ineffective after two 0.5 mg doses,then call hospice 800.720.2557 foradditional orders.-Start Date-02/26/2026 1749 OxyCODONE HCl Tablet 10 MGGive 10 mg by mouth every 4 hours asneeded for Pain-Start Date-02/26/2026 1743 Review of Resident R159 MAR for February 2026 indicated: Hydromorphone HCl Oral Liquid 1 MG/ML was last given at 2/28/26, at 2:44 p.m. Lorazepam Oral Tablet 0.5 MG not given on 2/28/26.Oxycodone HCl Tablet 10 MG last given at 7:38 a.m. During an interview on 3/1/26, LPN Employee E12, confirmed Resident R159 was in need of pain medication and pain medication could be given, and that during report (update on residents during shift change) (continued on next page)

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	396026	A. Building B. Wing	03/05/2026

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	previous staff indicated that pain medications were given to Resident R159. During an interview on 3/5/26, at 10:57 a.m. NHA and DON were informed that the facility failed to meet Resident R159 pain needs. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to discard expired medical supplies and ensure all drugs and biologicals were stored under proper temperature controls for one of three medication rooms. (Fontbonne Medication Room). Findings include: Review of the facility policy Medication Storage in the facility dated [DATE], indicated medications and biologicals are stored safely, securely, and properly. Medications requiring refrigeration or temperatures between 36F and 46F are kept in a refrigerator with a thermometer to allow temperature monitoring. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from stock, and disposed of. During an observation on [DATE], at 1:29 p.m. the Fontbonne Medication room contained the following expired supplies: -(3) 1ml 28g 1/2 safety syringe with needle expired [DATE] -(5) 28g 1/2 1 ml safety syringe needle expired [DATE] -(1) BD vacutainer push button blood collection set 0.6 x19mmx305 mm expired [DATE] During an observation on [DATE], at 1:29 p.m. the temperature of the medication fridge located in the Fontbonne Medication room was 48F. During an interview on [DATE], at 1:30 p.m. Licensed Practical Nurse Employee E11 confirmed that the above supplies were expired, and the medication fridge temperature was not in range as required. Interview on [DATE], at 1:37 p.m., the Nursing Home Administrator confirmed that the facility failed to discard expired medical supplies and ensure all drugs and biologicals were stored under proper temperature controls for one of three medication rooms. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.12(d)(2)(3) Nursing services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to thoroughly clean and disinfect a contact isolation room with the appropriate disinfectant for one of three residents (Resident R21). Findings include: Review of the facility policy Management of C. Difficile Infection Procedure dated 1/1/26, indicated the facility implements facility-wide strategies for the prevention and spread of Clostridioides difficile (C diff) infections. Use disposable equipment whenever possible. Thoroughly clean and disinfect with a sporicidal disinfectant (chemical disinfectants designed to destroy highly resistant bacterial and fungal spores). Review of the admission record indicated Resident R21 admitted to the facility on [DATE], with the diagnoses of pneumonia (lung infection), Parkinson's disease (disorder of the nervous system that results in tremors), and enterocolitis due to clostridium difficile (C-diff - contagious bacteria causing severe, watery diarrhea, abdominal pain, fever, and nausea). Review of Resident R21's physician order dated 2/12/26, indicated contact precautions for C-diff. Please clarify with physician when isolation precautions can end. Observation of Resident R21's room on 3/3/26, at 12:54 p.m. indicated signage of contact isolation on the closed door of the room. Interview on 3/3/26, at 12:54 p.m. Housekeeping Employee E4 indicated We scrub around the toilet and the sink really well. When asked if there was anything special required to clean a room with contact isolation due to C-diff. Interview on 3/3/26, at 12:55 p.m. Housekeeping Employee E4 further indicated we use [NAME] Facility Plus disinfectant. When asked if it contained bleach, housekeeper indicated they were not sure. Review of Midlab's EPA's (Environmental Protection Agency) Reg No. 45745-11-45745 for [NAME] Facility Plus disinfectant, the product's ability to kill on hard, non-porous inanimate surfaces, did not include effectiveness against killing Cdiff. Interview on 3/3/26, at 1:23 p.m. Environmental Services Director confirmed the [NAME] Facility Plus disinfectant was not effective against killing C-diff according to the manufacturer's EPA Reg No. 45745-11-45745 sheet. Interview on 3/3/26, at 2:45 p.m. interview with the Nursing Home Administrator information was disseminated to indicate the facility failed to thoroughly clean and disinfect a contact isolation room with the appropriate disinfectant for one of three residents (Resident R21). 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.28 (b)(e)(1) Management. 28 Pa Code: 211.10 (d) Resident care policies.

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F 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on review of facility documentation, resident and staff interviews it was determined that the facility failed to observe resident rights for four of four residents.Findings include: Review of facility policy Resident Rights dated 1/1/26, indicated: Respect and Dignity - The resident has a right to be treated with respect and dignity, including: The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences. Review of facility documentation Resident Council Minutes dated 9/22/25, indicated: Call bells DON told group to re- hit call bell if staff doesn't come back timely. During a resident group interview 3/2/26, at 11:20 a.m. residents were asked about the process for call bell's and how they are answered. Residents indicated that when they hit the call bell staff will come in and ask what they need and turn off the call bell. When asked if the resident needs have been met, they said it depends on what they need and if they need to get another staff person. When asked if the staff leave the call bell on till they see if they can meet the need the residents indicated no- they turn off the call bell and then try to meet the need. Residents were asked about the call light staying on till the staff know if they can meet the residents need - residents indicated that would be amazing if the call light could stay on till the need is met. During an interview on 3/5/26, 10:48 a.m. approximately with Nursing Home Administrator (NHA) and Director of Nursing (DON) indicated that the understanding of 9/22/25, resident council meeting and how the staff respond to call bell's is to come in turn off the call light and find out the resident needs. During an interview NHA and DON indicated that they were unclear on when the call bell light would get turned off. During an interview on 3/5/26, at 10:57 a.m. NHA and DON were informed that the facility failed to observe resident right s for four of four residents. 28 Pa. Code: 201.29(a) Resident rights.