STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396056	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
William Penn Care Center	2020 Ader Road Jeannette, PA 15644

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, staff interview, and observations, it was determined that the facility failed to ensure a resident with a tracheostomy (trach- a surgical created opening in the neck that provides a direct secure airway) was monitored and documented as appropriate respiratory care for one of three residents (R3) and failed to provide appropriate respiratory care for four of six residents (Residents R11, R32, R67 and R69). Findings include: Review of the facility policy Administering Medications through a Small Volume (handheld) Nebulizer last reviewed 1/6/26, indicated the purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. Obtain a physician order, review the residents care plan, current orders and diagnoses to determine resident needs, check the treatment record. Store in a plastic bag with the resident's name and date on it. Change equipment tubing every seven days. Review of the facility policy Continuous Positive Airway Pressure (C-PAP -keeps airways open when you sleep) / Bilevel Positive Airway Pressure (BIPAP- normalizes breathing by delivering pressurized air) Support last reviewed 1/6/26, indicated review the physician orders to determine the oxygen concentration and flow and the Positive End Expiratory Pressure (PEEP-pressure at the end of exhalation to prevent the collapse of small air sacs in the lungs) for the machine. Review of the facility policy Charting and Documentation last reviewed 1/6/26, indicated all services provided to the resident, progress toward the care plan goals, or any change in the residents medical, physical, functional, or psychosocial conditions, shall be documented in the residents' medical record. Documentation of procedures and treatments will include care-specific details including but not inclusive of: The date and time the procedure/treatment was provided The name and title of the individual who provided the care The signature and title of the individual documenting Review of the facility Respiratory Therapy Job description revealed assume primary responsibility for all respiratory care modalities, initiate and conduct therapeutic procedures, maintain resident records, select assemble check and operate equipment. Documents patient care services by charting patient and department records. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE], with diagnoses of traumatic brain injury, respiratory failure, and high blood pressure. (continued on next page)

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: 396056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2026
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of physician orders dated 5/22/24, indicated to administer oxygen at 10 liters per minute continuously, titrate to maintain spO2 above 90% every day and night shift. Review of Resident R3's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/12/26, indicated diagnoses were current. Section O- Special Treatments, Procedures, and Programs revealed the resident required tracheostomy care while a resident. During an interview completed on 5/6/26 at 10:18 a.m. upon asking the Director of Nursing (DON) concerning the Respiratory Therapist duties in the facility replied, respiratory remained in facility due to resident with a trach and to make sure the proper equipment is in the facility for the residents, they also change out the equipment as scheduled. During an observation on 5/6/26, at 11:24 a.m. Resident R3 was observed receiving 10 liters of oxygen via face mask to trach. The resident's pulse and oxygen saturation was being monitored. Review of Resident R3's clinical record on 5/6/26, at 11:26 a.m. failed to include evidence of monitoring and documenting the resident's respiratory rate, depth and quality each shift and as needed. During an interview on 5/6/26, at 11:32 a.m. Registered Nurse Assessment Coordinator (RNAC), Employee E6 stated, the nurses are responsible for knowing the resident's care plans and reviewing it for the specific condition they have to ensure care is monitored and documented. RNAC, Employee E6 confirmed the facility has two shifts 7 a.m. to 7 p.m. and 7 p.m. to 7 a.m. RNAC, Employee E6 stated staff should enter a nurse's note if they notice a change in their respiratory rate, depth, and quality and complete vitals each shift. RNAC, Employee E6 confirmed the facility failed to document and monitor Resident R3's respiratory rate, depth and quality each shift and as needed. During an interview on 5/6/26, at 11:43 a.m. Registered Nurse Supervisor, Employee E18 stated documenting by exception does not provide evidence Resident R3's respiratory rate, depth and quality each shift and as needed. RN Supervisor, Employee E18 confirmed the facility failed to ensure a resident with a trach was monitored and documented as appropriate for Resident R3. During an interview completed on 5/6/26, at 1:41p.m. upon asking the DON for clarification concerning respiratory duties and the completion of the Medication Administration Record (MAR) replied respiratory changes all the equipment, the nurses are signing off as completed. Review of the clinical record revealed Resident R67 was admitted to the facility on [DATE], with the diagnosis of obstructive sleep apnea (causes the breathing to pause that reduces the flow of oxygen), heart failure (the heart doesn't pump the way it should and diabetes (high sugar in the blood). Review of Resident R67's physician orders dated 4/20/26, indicated C-PAP at hour of sleep at home settings. The order failed to include what the setting was or any care of the C-PAP machine. Review of Resident R67's current care plan failed to include the C-PAP settings or any care needed for the C-PAP machine During an observation completed on 5/4/26, at 10:31 a.m. Resident R67's C-PAP mask was sitting on top of the bedside stand not stored in a bag as required. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview completed on 5/4/26, at 2:15 p.m. Registered Nurse Employee E9 confirmed that Resident R67's C-PAP mask was not stored in a bag as required. During an interview completed on 5/8/26, at 10:04 a.m. Licensed Practical Nurse (LPN) Employee E7 confirmed that Resident R67's current physician orders did not include the settings or any care for the C-PAP, and Resident R67's current care plan did not include interventions for the settings or care for the C-PAP machine. Review of the clinical record revealed Resident R69 was admitted to the facility on [DATE]. Review of Resident R69's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/19/26, indicated the diagnosis of chronic lung disease emphysema (makes breathing difficult), anemia (low iron in the blood) and high blood pressure. Review of Resident R69's physician orders dated 8/12/25, indicated Albuterol Sulfate (relaxes airway muscles to improve airflow) Inhalation Nebulization solution 1.25 milligram/3milliliter inhale 1vial orally via nebulizer four times a day related to emphysema. During an observation completed on 5/4/26, at 2:10 p.m. Resident R69's handheld nebulizer (transfers liquid medication into a fine mist) was sitting on top of the machine not stored in a bag as required. During an interview completed on 5/4/26, at 2:15 p.m. RN Employee E9 confirmed Resident R69's nebulizer was sitting on top of the machine not stored in a bag as required. Review of the clinical record revealed Resident R11 was admitted to the facility on [DATE]. Review of Resident R11's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/1/26, indicated diagnoses of high blood pressure, Chronic Obstructive Pulmonary Disease (COPD- makes it hard to breath) and anxiety. Review of Resident R11's current physician orders dated 1/21/26, indicated change nasal cannula every two weeks on Wednesday's day shift for oxygen therapy. Review of Resident R11's current physician orders dated 2/3/26, indicated oxygen at 2 liters per minute (Lpm) via nasal cannula (N/C) at bedtime daily at bedtime for low oxygen saturations with sleeping. Review of Resident R11's Medication Administration Record (MAR) for April 2026, indicated the nasal canula was documented as changed on 4/1/26, by Licensed Practical Nurse (LPN) Employee E19, on 4/15/26 was documented as changed By LPN Employee E7, and was documented as changed on 4/29/26 by LPN Employee E20. During an interview completed on 5/8/26, at 10:12 a.m. upon reviewing Resident R11's nasal canula changes for April with LPN Employee E7 confirmed the changes on 4/1/26 and 4/29/26 were completed by other LPN's, I did sign off on 4/15/26. We sign it off on the MARS, but respiratory actually does it. Review of the clinical record revealed Resident R32 was admitted to the facility on [DATE]. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R32's MDS dated [DATE], indicated the diagnosis of high blood pressure, diabetes and obstructive sleep apnea. Review of Resident R32's physician orders dated 6/28/22, indicated oxygen at 2LPM via NC continual every shift for hypoxia Review of Resident R32's physician orders dated 11/1/23, indicated to change nasal cannula every two weeks on Wednesdays for Oxygen therapy Review of Resident R32's MAR for April 2026, indicated the nasal canula was documented as changed on 4/1/26, and 4/29/26 by Registered Nurse (RN) E13 on 4/15/26 was documented as changed By LPN Employee E21. During an interview completed on 5/8/26, at 10:32 a.m. upon reviewing Resident R32's nasal canula changes for April 2026 with RN Employee E13 confirmed the changes on 4/1/26 and 4/29/26 were completed by me. The one on 4/15/26, was another nurse identified as LPN E21. RN Employee E13 further added that respiratory does the changes, the check indicates I did it, but I didn't. I don't want to check off something I didn't do, but I do go in and check to see the date it was done then I will check it, I don't know why they (respiratory) don't sign it. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, resident clinical records, and staff interview, it was determined the facility failed to ensure the coordination of hospice services with facility services to meet the needs of each resident for end of life care for three of five residents (Resident R9, R24 and R78).Findings include: Review of the facility policy Hospice Program dated 1/6/26, indicated that coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by the facility in order to maintain the resident's highest practicable physical, mental, and psychosocial well-being. Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE]. Review of Resident R9's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/12/26, indicated diagnoses of high blood pressure, heart failure (heart doesn't pump the way it should) and diabetes (high sugar in the blood). Section O- Special Treatments, Procedures, and Programs: K1- Hospice Care indicated Resident R9 received hospice while a resident. Review of Resident R9s medical record dated 12/8/25, indicated admission to local hospice with the diagnosis of hypertensive heart disease. Review of Resident R9's current care plans failed to include a care plan for hospice. During an interview completed on 5/7/26, at 12:16 p.m. Resident Nurse Assessment Coordinator (RNAC) Employee E6 stated Resident R9 went hospice with a local hospice provider and confirmed that the facility failed to implement a care plan for Resident R9's hospice needs. Review of the clinical record indicated Resident R24 was admitted to the facility on [DATE]. Review of Resident R24's MDS dated [DATE], indicated diagnoses of high blood pressure, kidney disease, and hypokalemia (low potassium levels in the blood). Review of Resident R24s medical record included a physician order to admit to hospice services dated 4/29/26. Review of Resident R24's current comprehensive care plan failed to indicate a plan of care by the facility that displayed the coordination of hospice services by failing to include contact information for the hospice agency and how to access the hospice's 24 hour on-call system. Review of the clinical record indicated Resident R78 was admitted to the facility on [DATE]. Review of Resident R78's MDS dated [DATE], indicated diagnoses of high blood pressure, kidney disease, and vitamin D deficiency. Review of Resident R78's medical record included a physician order to admit to hospice services date 4/12/2. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R78's current comprehensive care plan failed to indicate a plan of care by the facility that displayed the coordination of hospice services by failing to include contact information for the hospice agency and how to access the hospice's 24 hour on-call system. During an interview on 5/7/26, at 10:16 a.m. RNAC (registered nurse assess coordinator) Employee E11 confirmed that the facility failed to include contact information for the hospice agency and how to access the hospice's 24 hour on-call system in the plan of care and that the facility failed to ensure the coordination of hospice services with facility services to meet the needs of Residents R24 and R78. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(d) Resident care policies28 Pa. Code: 211.12(d)(3)(5) Nursing services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, observations, and staff interviews, it was determined that the facility failed to prevent cross contamination during a dressing change for one of three residents (Resident R24), failed to implement an infection control program that included a system of surveillance to identify possible communicable diseases or infections for three of 10 months (February 2026, March 2026, and April 2026) and failed to maintain a comprehensive program for water management to monitor the potential development and spread of Legionnaires (an infection of the lungs caused by bacteria, commonly spread by water) for 10 of 10 months. (July 2025 - April 2026).Findings include: Review of the facility Infection Prevention and Control Program last reviewed 1/6/26, indicated a system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all resident, staff and volunteer's visitors and other individuals providing service under a contractual arrangement based upon a facility assessment and national standards. The Infection Preventionist serves as the leader surveillance and maintains documentation of incidents, findings, and corrective actions. A water management program has been established as part of the overall infection and prevention and control program. Control measures and testing protocols are in place to address potential hazards associated with the facility's water systems. Review of the facility Water Management Program last reviewed 1/6/26 indicated the water management program will consist of including but not inclusive to the following areas: The water management program will identify the elements of a water management program. The water system will be described to show the flow of water throughout the building. A flow chart/diagram will show how the hot water is distributed throughout the building. The water management team will identify areas where Legionella could grow and spread throughout the building by marking it on the flow chart/diagram. The water management program will utilize control measures and corrective actions with the water system as identified when samples are outside of the control limits. Testing of the water will occur at three different sites every 6 months or as needed. Review of the clinical record indicated Resident R24 was admitted to the facility on [DATE]. Review of Resident R24's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/26/26, indicated the diagnosis of Peripheral Vascular Disease (PVD- blood vessels narrow, spasm or become blocked limiting oxygen delivered to the limbs), Diabetes (high sugar in the blood and high blood pressure. Review of a physician order dated 4/27/26, indicated right lateral foot, cleans with normal saline, pat dry, apply Santyl ointment, cover with dry dressing daily and as needed. During a dressing change observation completed on 5/5/26, at 9:14 a.m. Licensed Practical Nurse (LPN) Employee E2 prepared a clean area utilizing Resident R24's over bed table in which a barrier and supplies were placed. LPN Employee E2 cleansed Resident R24's foot with the normal saline, she then placed the right foot directly on Resident R24's wheelchair seat without placing a barrier, applied the Santyl ointment and dry dressing. After completion of the dressing LPN Employee E2 gathered and discarded supplies, removed the barrier on the over bed table and exited the room. During an interview completed on 5/5/26, at 9:39 a.m. LPN Employee E2 confirmed not placing a clean barrier on Residet R24's wheelchair seat prior to placing his right foot on it. LPN Employee E2 also confirmed that she failed to clean the bedside table after removing the supplies and barrier and confirmed the failure to prevent cross contamination during a dressing change. Review of the facility's Infection Control documentation failed to reveal surveillance for tracking infections for residents for three of ten 10 months (February 2026, March 2026, and April 2026). During a telephonic interview completed on 5/6/26, at 2:00 p.m. upon asking Registered Nurse RN Employee E17 concerning a system of surveillance to identify possible communicable diseases or infections stated, I have not done anything since I took over the program on 4/4/26, I have not looked at the Infection Control Binders. During an interview completed on 5/6/26, at 2:29 p.m. the Nursing Home Administrator confirmed the facility (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	failed to implement an infection control program that included a system of surveillance to identify possible communicable diseases or infections for three of 10 months (February 2026, March 2026, and April 2026). Review of the facilities Legionella water management plan that included monitoring or auditing of facility for potential Legionella failed to provide mapping of high opportunity areas where Legionella could be found in the facility water pipes. The plan also failed to include water temperature logs and evidence of preventative measures used to prevent water borne illness in areas that are not currently in use. During an interview completed on 5/7/26, at 11:19 a.m. upon asking Environmental Service (ES) and Maintenance Director (MA) Employee E23 concerning the water management plan and preventative measures revealed that the flow diagram did not include control measures or indicate what was hot or cold water. It was also revealed that Legionella testing is completed once a year. Upon asking ES MD Employee E23 concerning what the hot water tank holding temperatures should be was not able to provide an answer. ES MD Employee E23 stated, hot water for the rooms should be no more than 106 degrees and the laundry hot water temperatures are 140 degrees. Upon asking for temperature logs ES MD Employee E23 could not provide any. During an interview completed on 5/7/26, at 12:04 p.m. Maintenance Employee E24 revealed that he checks the hot water holding tanks every couple of weeks, he could not produce any logs. Maintenance Employee E24 also revealed that the water in facility rooms not being used is ran a couple of minutes and further stated we do the closed unit every two weeks. During an interview on 5/7/26, at 1:03 p.m. the Nursing Home Administrator (NHA) stated he was unable to provide the facilities Legionella water management plan that included monitoring or auditing of facility for potential Legionella and failed to provide mapping of high opportunity areas where Legionella could be found in the facility water pipes and confirmed that the facility failed to maintain a comprehensive program for water management to monitor the potential development and spread of Legionnaires (an infection of the lungs caused by bacteria, commonly spread by water) for 10 of 10 months. 28 Pa. Code: 201.14 (a) Responsibility of licensee.28 Pa. Code: 201.18 (b)(1)(e)(1) Management.28 Pa. Code: 211.10 (d) Resident care policies.28 Pa. Code: 211.12 (d)(1)(2)(5) Nursing services.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on review of the facility policy and staff interview, it was determined that the facility failed to implement an antibiotic stewardship program for 3 of 10 months (February 2026, March 2026 and April 2026).Findings include:Review of facility Infection Control Plan, Program and Committee policy last reviewed 1/6/26, indicated the facility has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. An antibiotic stewardship program will be implemented as part of the overall infection control program. Antibiotic use protocols and a system to monitor antibiotic use will be implemented as part of the antibiotic stewardship program. Review of the facility's Infection Control Program for February 2026, March 2026 and April 2026, failed to include documented evidence that antibiotic (medications used to treat infections) monitoring and ensuring appropriate usage was completed. During a telephonic interview completed on completed on 5/6/26, at 2:06 p.m. Registered Nurse (RN) Infection preventionist (IP) Employee E17 revealed that she took over the Infection Control program on 4/4/26, and stated I have been doing that as well as supervising the building, I just look at the records to see if any are reportable, I haven't been able to do it since I started, I do about 12 hours a week, I have not seen the binders. During an interview completed on 5/6/26, at 2:29 p.m. the Nursing Home Administration confirmed that the facility failed to implement an antibiotic stewardship program for 3 of 10 months (February 2026, March 2026 and April 2026). 28 Pa. Code: 211.10(c)(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy, resident interview and staff interview, it was determined that the facility failed to treat each resident with respect by failing to address a resident by their preferred name for one of eight residents (Resident R61). Review of facility policy Resident Rights dated 1/6/26, indicated that residents will be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individually. Staff shall speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnoses, or care needs. Review of clinical record revealed that Resident R61 was admitted to the facility on [DATE]. Review of Resident R61's care plan dated 11/21/25, revealed the name the resident prefers to be addressed as. Review of Resident 61's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 2/20/26, indicated diagnoses of high blood pressure, anxiety, and depression. Section A1300 D under the question Name by which resident prefers to be addressed, revealed a specific name the resident prefers to be called. During an observation and interview on 5/5/26, at 10:26 a.m. Resident R61's name tag located at the entrance of the door failed to indicate the resident's preferred name. When State Agency greeted Resident R61 by the name listed at the entrance of the door, Resident R61 stated she does like being called that and stated her preferred name. During an interview in 5/6/26, at 1:37 p.m. Activities Director, Employee E3 stated residents are asked upon admission what their name preferences are, and if a resident had a preferred nickname then it is included in their care plan. Activities Director, Employee E3 confirmed Resident R61's preferred name was listed in their care plan and indicated she was unsure who is responsible for ensuring preferred name is listed at the resident's door entrance. During an interview on 5/6/256, at 1:41 p.m. Nurse Aide (NA), Employee E4 indicated the nurses are usually responsible for placing the resident's name tag at the entrance of the door, but sometimes the aides do it. During an observation on 5/6/26, at 1:44 p.m. Resident R61's name tag at the entrance of their door failed to include the resident's preferred care name. During an interview on 5/6/26, at 1:45 p.m. the Assistance Director of Nursing, Employee E5 confirmed Resident R61's preferred name was not listed on the name tag at the entrance of their door. During an interview on 5/6/25, at 2:28 p.m. Director of Nursing confirmed that Resident R61's preferred name choice was not listed at the entrance of their door, and the facility failed to ensure that the facility respected Resident R61's preferences in their name choice.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on review of facility policy, observation, and staff interview it was determined that the facility failed to maintain the confidentiality of resident's medical information on one of four medication carts (East Medication Cart).Findings include: Review of facility policy Quality of Life - Dignity dated 1/6/26, indicated that staff shall maintain an environment in which confidential clinical information is protected. During an observation on 5/4/26, at 11:38 a.m. the East Medication Cart at the nurses station was left unattended with the computer screen open with identifiable information any passerby could see resident personal and confidential information. During an interview on 5/4/26, at 11:38 a.m. Registered Nurse Employee E9 confirmed the above observation and that the facility failed to maintain the confidentiality of residents' medical information as required. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.29(c.3) Resident Rights.28 Pa. code: 211.5(b) Medical records.28 Pa. Code: 211.12(d)(1)(3) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
William Penn Care Center	2020 Ader Road Jeannette, PA 15644

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, closed resident records and staff interview, it was determined that the facility failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for two of four resident hospital transfers (Resident R24 and Closed Resident Record CR87).Findings include: Review of facility policy Bed Hold Notice Upon Transfer dated 1/6/26, indicated that at the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addressees information explaining the return of the resident to the next available bed. In the event of an emergency transfer of a resident, the facility will provide within 24 hours written notice of the facility's bed-hold policy. Review of the clinical record indicated Resident R24 was admitted to the facility on [DATE]. Review of Resident R24's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/26/26, indicated diagnoses of high blood pressure, kidney disease, and hypokalemia (low potassium levels in the blood). Review of the clinical record indicated Resident R24 was transferred to the hospital on 3/31/26, and returned to the facility on 4/5/26. Review of Resident R24's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 3/31/26. During an interview on 5/7/26, at 11:49 p.m. Business Office manager Employee E10 confirmed that the facility failed to maintain documentation that resident or resident's representative were notified of the facility bed-hold policy for two of four resident hospital transfers (Resident R24, and R87). Review of Closed Resident Records CR87's admission record indicated he was admitted on [DATE]. Review of Closed Resident Records CR87's MDS assessment dated [DATE], indicated that he had diagnoses that included hyperlipidemia (elevated lipid levels within the blood), congestive heart failure (a progressive heart disease affecting pumping action of the heart muscles impacting circulation, swelling and shortness of breath), and a right femur fracture. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Closed Resident Records CR87's clinical nurse note dated 2/6/26, indicated staff received venous doppler results and they are indicating nonocclusive thrombus in right common femoral vein (probable blood clot). These results were immediately sent to the certified registered nurse practitioner (CRNP) and orders were obtained to increase Eliquis temporarily and repeat ultrasound. Staff then received a message from the registered nurse that the Resident CR87's daughter called in and began screaming at her because her father has a blood clot. The daughter was very rude. Staff did relay that message to CRNP. Report called to hospital. Resident CR87 was sent to hospital on 2/6/26 around 5:50 p.m. Review of Closed Resident Records CR87's emergency room transfer form dated 2/6/26, indicated information provided to EMS staff. The information did not include the facility bed hold policy. Review of Closed Resident Records CR87's clinical nurse notes, physician notes and transfer documents failed to include documented evidence that Resident CR87 or Resident CR87's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 2/6/26. During an interview on 5/7/26, at 2:30 p.m. information disseminated to the Nursing Home Administrator (NHA) and Assistant Director of Nursing (ADON) Employee E5 that the facility failed to notify the resident or resident's representative of the facility bed-hold policy at time of hospital discharge for Closed Resident Records CR87 as required. 28 Pa. Code: 201.29 (a)(c.3)(2) Resident rights.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to properly monitor weight and nutrition status by failing to obtain a monthly weight for one of eight residents (Resident R8), and failed to individualize care plans to address the resident specific nutritional concerns for two of two residents (Resident R8, and R90).Findings include: Review of the facility policy Weight Policy dated 1/6/26, indicated that ongoing monthly weight will be obtained unless otherwise directed by the physician. Monthly weights will be obtained on the date of the first scheduled shower for the month; regardless of refusal of shower. Monthly weights will be obtained by the 7th day of each month. Weights will be documented in the resident's electronic medical record. Review of the clinical record indicated Resident R8 was admitted to the facility on [DATE]. Review of Resident R8's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/5/26, indicated diagnoses of high blood pressure, peripheral vascular disease (PVD, circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and thyroid disorder. Review of Resident R8's clinical record revealed that no monthly weight was recorded for April 2026. During an interview on 5/6/26, at 1:46 p.m. Nurse Aide Employee E12 confirmed that the facility failed to obtain a monthly weight for Resident R8 in April 2026. Review of Resident R8's clinical record revealed the following physician's orders: Renal Diet (a diet for people with kidney disease), Mechanical Soft - ground meat texture to have a low fat diet for low protein dated 4/1/26. Magic Cup (a nutritionally dense ice cream) two times a day for additional nutrition with lunch and dinner dated 9/10/25. Review of Resident R8's care plan last revised on 5/7/26, indicated that resident has potential to have nutritional problems related to dysphagia (difficulty swallowing), and for requiring a mechanically altered and therapeutic diet weight loss and interventions include the following: Provide, serve diet as ordered dated 4/11/24 Provide and serve supplements as ordered dated 4/11/24. Review of Resident R8's care plan failed to include resident specific interventions for the physician ordered diet and supplements listed above. During an interview on 5/7/26, at 10:19 a.m. RNAC (registered nurse assess coordinator) Employee E11 confirmed that the facility failed to individualize care plans to address the resident specific nutritional concerns for Resident R8. Review of the clinical record indicated Resident R90 was admitted to the facility on [DATE]. Review of Resident R90's MDS dated [DATE], indicated diagnoses of high blood pressure, hypokalemia (deficiency of potassium in the bloodstream), and heart failure (a progressive heart disease that affects pumping action of the heart muscles) Section K0300 was marked that resident had loss of 5% or more in the last month or loss of 10% or more in 6 months, and is not on a physician-prescribed weight loss regimen. Review of Resident 90's clinical record revealed the following physician's orders: Regular diet, regular texture, lactose free for diet dated 4/13/26. Nutritional Juice with meals dated 4/14/26. Review of Resident R90's care plan last revised on 3/9/26, indicated interventions include the following: Serve diet as ordered dated 9/24/25 Review of Resident R90's care plan failed to include any focus to address the weight loss, and failed to include resident specific interventions for the physician ordered diet and supplements listed above. During an interview on 5/7/26, at 1:37 p.m. RNAC Employee E11 confirmed that the facility failed to individualize care plans to address weight loss, and the resident specific nutritional concerns for Resident R90. 28 Pa. Code 201.18(b)(1)(Management.28 Pa. Code 211.10(c) Resident care policies.28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to properly secure a treatment cart while not in use for one of three treatment carts (East Hall Treatment Cart), failed to properly store medications in one of two medication storage rooms (East Medication Room) and in two of four medication carts (A Hall Medication Cart and C Hall Medication Cart).Findings include: Review of the facility policy Administering Medications last reviewed 1/6 /26, indicated during administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse. When opening a multi-dose container, the date opened shall be recorded on the container. Review of the facility policy Storage of Medications last reviewed 1/6/26, indicated the nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Compartments containing drugs and biologicals shall be locked when not in use. Medications must be stored separately from food and must be labeled accordingly. During an observation completed on 5/4/26, at 9:49 a.m. the East side treatment cart was sitting in the hallway placed near room [ROOM NUMBER]. The treatment cart was unlocked and unattended. During an interview completed on 5/4/26, 9:56 a.m. Licensed Practical Nurse (LPN) Employee E14 confirmed the treatment cart placed near room [ROOM NUMBER] was left unlocked and unattended and that the facility failed to properly secure a treatment cart while not in use. During an observation completed on 5/5/26, at 9:40 a.m. the East Medication Room contained the following: A Purple Cup.A Styrofoam coffee cup.A black tote bag sitting on a chair.A black sweater, black pants and a leg rest bag hanging on the wall.Black pants and a wheelchair leg rest bag hanging on the wall. A grey blanket sitting on top of a pile of clothes in boxA light gray wheelchair cushion.A dark grey wheelchair cushion.A curved neck pillow and two blankets sitting on top of a box. A wheelchair leg rest bag sitting on the counter.The East first hall refrigerator contained 2 vials of Tubersol solution opened and not labeled with a date as required.The East second hall refrigerator contained 2 vials of Tubersol solution opened and not labeled with a date as required. During an interview completed on 5/5/26, at 9:54 a.m. LPN Employee E2 confirmed the above findings and stated, I don't know who the black tote bag or cups belong to. The blankets and clothing look like a donation and confirmed that the facility failed to properly store medications in the East Medication Room. During an observation completed on 5/5/26, at 9:56 a.m. the A hall medication cart contained the following:1 bottle of Nystatin liquid opened and not labeled with a date as required.1 bottle of Latanoprost eye drops opened and not labeled with a date as required.1 Trelegy Ellipta inhaler opened and not labeled with a date as required.The left side compartment of the medication cart contained a coffee cup, a strawberry pastry crisp bar, a bag of sliced red peppers and a personal cell phone During an interview completed on 5/5/26 at 10:03 a.m. LPN Employee E14 confirmed that above findings and stated the items in the left side compartment of the medication cart are mine and confirmed the facility failed to properly store medications in the A Hall Medication Cart. During an observation completed on 5/5/26, at 10:51 a.m. the C Hall Medication Cart contained: 2 bottles of Robitussin cough suppressant opened and not labeled with a date as required.1 bottle Milk of Magnesia opened and not labeled with a date as required.1 bottle of Miralax powder opened and not labeled with a date as required.1 bottle of lactulose liquid opened and not labeled with a date as required. During an interview completed on 5/5/26, at 10:51 a.m. LPN Employee E22 confirmed the above observations and confirmed that the facility failed to properly store medications in the C Hall Medication Cart. 28 Pa. Code: 201(a) Responsibility of licensee.28 Pa. Code: 211.9(a)(1) Pharmacy services.28 Pa. Code: 211.12(d)(1)(2)(5) Nursing services.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on a review of facility policy, facility provided documentation, and staff interviews, it was determined the facility failed to designate a consistent qualified individual(s) onsite, who is responsible for implementing programs and activities to prevent and control infections for one of 10 months (April 2026).Findings included: Review of facility Infection Control Plan, Program and Committee policy last reviewed 1/6/26, indicated the facility has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance and epidemiological investigations of exposures and infectious disease During an interview completed on 5/6/26, at 1:59 p.m. Human Resource (HR) Employee E15 revealed the former Infection Preventionist Employee E16 had resigned, with the last day of employment was 4/4/26. During a telephonic interview completed on completed on 5/6/26, at 2:06 p.m. Registered Nurse (RN) Infection preventionist (IP) Employee E17 revealed that she took over the Infection Control program on 4/4/26, and stated I have been doing that as well as supervising the building, I just look at the records to see if any are reportable, I haven't been able to do it since I started, I do about 12 hours a week. Upon asking RN IP Employee E17 concerning infection control training and certification replied, I did that so long ago, I can try to find it. Review of the facility provided certification courses for RN IP Employee E17 it was revealed that course training was completed in 2022, however there was not a certificate for the completion for Nursing Home Infection Preventionist Training Course. During an interview completed on 5/6/26, at 2:29 p.m. the Nursing Home Administration confirmed the facility failed to designate a consistent qualified individual(s) onsite, who is responsible for implementing programs and activities to prevent and control infections for one of 10 months (April 2026). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1)(e)(1) Management.28 Pa. Code: 201.19(3) Personnel records.28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.