STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396078	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Horsham Center for Jewish Life	1425 Horsham Road North Wales, PA 19454

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record reviews and interviews with staff, it was determined that the facility failed to revise resident care plans timely for four of thirty-five residents reviewed. (Residents R221, R222, R306, and R312)Findings Include: Review of facility policy titled, Care Planning-Interdisciplinary Team undated states, Policy Statement-The interdisciplinary team is responsible for the development of resident care plans. Policy Interpretation and Implementation 1. Resident care plans are developed according to the timeframes and criteria established by 483.21 Review of resident clinical record for Resident R221 revealed the resident was admitted to the facility on [DATE]. Resident R221 had a care conference held on October 31, 2025. The next care conference was not held until April 7, 2026. The time in between care plans was over five months. Review of resident clinical record for Resident R222 revealed the resident was admitted to the facility on [DATE]. Resident R222 had a care conference held on September 30, 2026. The next care conference was not held until March 17, 2026. The time in between care plans was over five months. Review of resident clinical record for Resident R306 revealed the resident was admitted to the facility on [DATE]. Resident R306 had a care conference held on October 23, 2026. The next care conference was not held until April 9, 2026. The time in between care plans was over five months. Review of resident clinical record for Resident R312 revealed the resident was admitted to the facility on [DATE]. Resident R312 had a care conference held on September 30, 2025. The next care conference was not held until April 7, 2026. The time in between care plans was over five months. Interview held with the Director of Social Services Employee E22 on April 8, 2026 at 9:40 a.m. confirmed that the social work team had gotten off track with holding care conference timely. 28 Pa Code 211.10 (d)Resident Care Policies

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observations and staff interview it was determined that the facility did not to prominently display and maintain facility daily staffing hours as required for three days (April 6, April 7, April 8). Findings Include: Observation of the front lobby reception desk revealed a nurse staff posting from Monday March 23, 2025. A tour was taken with the Director of Social Services Employee E22 on April 8, 2026 at 10:30 a.m. revealed the lobby reception desk nurse staff posting was still from Monday March 23, 2025. A tour of the A1 unit revealed nurse staffing posting from April 7, 2026 no PPD or census was listed. A tour of C3 unit revealed nurse staffing posting from April 7, 2026 with no PPD or census. The Director of Nursing confirmed on April 8, 2026 at 11:15 a.m. that the person in charge of posting the nurse staffing was new and was unaware of how to complete the appropriate posting. The previous staff in charge has not been employed for approximately three weeks. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18 (b)(3)(e)(1) Management

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, and resident interviews, it was determined that the facility failed to provide food and drink that was palatable and served at the proper temperature for twelve of thirty five residents reviewed (Residents R5, R12, R22, R151, R119, R144, R188, R223, R257, R113, R128 and R322).Findings include: During the initial tour of the facility on April 6, 2026, the following resident interviews were obtained on units C1 and D1: Interview on Unit C1 with Resident R5 at 10:28 a.m. revealed that she does not like the food, particularly during Passover when she cannot eat the matzoh as it exacerbates her irritable bowel syndrome. Interview with the nurse aide, Employee E9, outside Resident R5's room revealed that the kitchen is very strict with Passover meals. Interview on C1 with Resident R188 at 10:35 a.m. revealed that she didn't like the food, thought it could be better, it's not edible, it's tasteless, not warm enough, that it was much better a year or so ago. Interview on Unit C1 with Resident R322 at 10:39 a.m. revealed that the food is really bad, the coffee is horrible and they only give you one tiny creamer, you don't always get what you ask for, the portions are too small too. Interview on Unit C1 with Resident R151 at 10:41 a.m. revealed that she did not like the food, the portions were too small, today she got a few grapes and a piece of pineapple for a fruit bowl, the meat and fish were overcooked, the vegetables are overcooked and too soft and the soup is too thin or mushy with a few carrots. Interview on Unit D1 with Resident R12 at 10:45 a.m. revealed that she does not always get enough to eat, the food is so bad that I often can't eat it, they cut the salad into big chunks that I can't chew, they used to shred the carrots now they are hard chunks. Interview on Unit D1 with Resident R223 at 10:52 a.m. revealed that the food is very bad, it's cold, it's just terrible, I end up eating snacks. Interview on Unit D1 with Resident R257 at 10:58 a.m. revealed that he did not like the food, it is not hot and tastes bad, don't get me started. Interview on Unit D1 with Resident R144 at 11:03 a.m. revealed that he did not like the food, it was not hot and the portions are too small. Interview on Unit D1 with Resident R113 at 11:09 a.m. revealed that she did not like the food, some things are overcooked, and the other night we had chicken that was raw, just disgusting how can you eat something like that that is not even cooked, I am surprised no one got sick. Observations during a test tray (Resident Tray Assessment) conducted by the Food Service Director (FSD), Employee E24 on April 7, 2026, at 12:15 p.m. revealed that the carrots were served at 128 degrees, below the acceptable range on greater than 130 degrees and the apple juice was at 33 degrees and was semi-frozen with ice throughout making it difficult to drink. The carrots were very bland and the manicotti, specially prepared for Passover had a hard leathery tasting shell that did not have a good flavor. The mushroom soup, which had a temperature of 141 degrees, below the acceptable range of greater than 150 degrees had an odd taste and the mushrooms were processed into tiny bits that gave a poor mouth feel. Interview with the FSD on April 7, 2026, at 12:25 p.m. confirmed the results of the test tray. Interview on Unit D1 in the dining room with Resident R113 on April 8, 2026, at 1:09 p.m. revealed that last night we had chicken that was raw, just disgusting how can you eat something like that that is not even cooked, I am surprised no one got sick. She had several pictures of the chicken that was clearly not cooked. Review of the posted menu showed that chicken with wine and mushrooms was served for supper on April 7, 2026. Interview on Unit D1 dining room with Resident R228 on April 8, 2026, at 1:11 p.m. revealed that she too was served raw chicken on her tray for supper the night before. She was upset and said that another resident at her table ate the chicken and she hoped that she did not get sick. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 211.6(f) Dietary services

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observations and interviews with residents and staff, it was determined that the facility failed to ensure that essential equipment related to medication refrigerator on unit D3 and ice and water dispenser on unit C1 were in a safe and working condition for use by residents and nursing staff on two of twelve nursing units.Findings include: Interview with Resident R13 on Unit C1 on April 6, 2026, at 11:15 a.m. during the initial tour revealed that he had not had ice in his water for the last few days. Interview with Resident R188 on Unit C1 on April 6, 2026, at 11:19 a.m. during the initial tour revealed that she had not had ice since last Friday, April 3, 2026, and she was upset, I can't drink warm water. Interview with Resident R322 on Unit C1 on April 6, 2026, at 11:28 a.m. during the initial tour revealed that she had not had ice for three days, and why can't they get ice from the kitchen? Observation on Unit C1 on April 6, 2026, at 11:40 a.m. revealed three maintenance workers were wheeling the ice and water dispenser on a cart down the hall saying that they were taking it to be repaired. Multiple observations on Unit C1 from April 6, 2026, through April 9, 2026, revealed that there was no ice and water dispensing machine. Interview with the Unit Manager, Employee E6, on April 9, 2026, at 12:40 p.m. confirmed that the ice and water machine was taken on April 6, 2026, for repair and that they had not had a working ice machine since last week. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(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. Based on observations, resident interviews, and review of facility policy, it was determined that the facility did not maintain a dignified environment for three of thirty-five residents observed (Resident R151, R194, R312) and on three of twelve dining rooms (C1, D1, D2). Findings Include: Review of facility policy titled, Homelike Environment undated states, Policy Statement-Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. 2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: .i. comfortable sound levels . 3. The facility staff and management minimizes, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting. On April 6, 2026 lunch observation was made on second floor A-pod dining room at 12:02 p.m. and the lunch plates were being served on trays to the residents. Staff were seen setting down the entire tray in front of the residents and not removing the tray from the table. All residents in the dining room were served on trays. There was no music on in the dining room. On April 7, 2026 lunch observation was made on second floor A-pod at 12:22 p.m. and the lunch plates were still being served on trays to the residents. There was no music on in the dining room. On April 8, 2026 lunch observation was made on second floor A-pod at 12:12 p.m. and the lunch plates were still being served to the residents on trays. During lunch service there were sixteen residents present in the dining room. There was no music on in the dining room. Resident council meeting was held on April 7, 2026 at 10:00 a.m. with nine awake, alert, and oriented residents. Two residents during resident council stated that they had been washed with a pillowcase due to not having any wash cloths. (Residents R151 and R194) During resident council on April 7, 2026 at 10:14 a.m. Resident R151 who has a BIMS (Brief Interview for Mental Status) score of 15 from a MDS (Minimum Data Set) completed January 13, 2026 stated, I had to get washed with a pillowcase today and we should not have to live like this, there is always a shortage on towels and linens. Resident R151 also stated, the food here is awful, the portion sizes are small, and the way they serve the food to use on trays is disrespectful, we aren't asking for a steak dinner or anything, we just want better customer service. During resident council on April 7, 2026 at 10:16 a.m. Resident R194 who has a BIMS (Brief Interview for Mental Status) score of 15 from a MDS (Minimum Data Set) completed March 16, 2026 stated I have been washed with a pillowcase before and it is degrading. They tell us we are only allowed to have two towels a day. During resident council on April 7, 2026 at 10:34 a.m. Resident R312 who has a BIMS (Brief Interview for Mental Status) score of 15 from a MDS (Minimum Data Set) completed March 25, 2026 stated we used to have two alternatives and now there is only one. You are given a tray of food, slammed down on the table, and told that is all there is. They always just say, the kitchen is closed, the kitchen is closed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dining observation on April 6, 2026, at 12:50 p.m. in the C1 dining room revealed that the staff passed the resident lunch trays leaving the physical tray on the table along with the insulated domes which were tipped upside down on the table and had lids and other disposable paperware stacked on top. The trays remained for the duration of the meal. Dining observation on April 6, 2026, at 1:15 p.m. in the D1 dining room revealed that the staff passed the resident lunch trays leaving the physical tray on the table along with the insulated domes which were tipped upside down on the table. The trays remained on the table for the duration or the meal. Dining observation on April 7, 2026, at 12:23 p.m. in the D2 dining room during the test tray evaluation revealed that the staff passed the resident lunch trays leaving the physical tray on the table along with the insulated domes which were tipped upside down on the table and had lids and other disposable paperware stacked on top. The trays remained for the duration of the meal. Dining observation on April 8, 2026, at 12:56 p.m. in the C1 dining room revealed that the staff passed the resident lunch trays leaving the physical tray on the table along with the insulated domes which were tipped upside down on the table. Dining observation on April 8, 2026, at 1:07 p.m. in the D1 dining room revealed that the staff passed the resident lunch trays leaving the physical tray on the table along with the insulated domes which were tipped upside down on the table. The trays remained on the table for the duration or the meal in both dining rooms.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on a review of the clinical record, facility documentation, observations, and interviews with staff and residents, it was determined that the facility failed to provide Activities of Daily Living (ADL) assistance for one of 35 resident records reviewed (Resident R271).Findings included: Review of Resident R271's Admission's MDS (an assessment of resident's needs) dated January 13, 2026 once admitted to the facility revealed the resident was alert and oriented, and was admitted with one Stage III pressure ulcer (Full thickness tissue loss, slough may be present but did not obscure the depth of tissue loss) and six pressure areas known but not stageable due to coverage of wound bed by slough and/or eschar (dead tissue). The MDS indicated that the resident's functional capabilities were fully dependent upon staff for all activities of daily living that included toileting, showering/bathing, dressing, and needed substantial maximal assistants with personal hygiene.Observation and interview with Resident R271 on April 6, 2026, at 11:30 a.m. revealed the resident appeared unkept, with facial hair on upper lip and hair that appeared unwashed matted and oily. When asked if nursing staff offered the resident a shower the resident indicated she did not because she was unable to stand so she received bed baths instead. When asked the last time the resident's hair was washed, the resident indicated she had not had her hair washed since being admitted to the facility almost three months ago.Review of Resident R271's care plan indicated the resident was unable to perform activities of daily living (ADLs) due to activity intolerance, initiated on admission, dated January 14, 2026. Interventions included, Interview on April 8, 2026, at 4:00 p.m. with the Assistant Director of Nursing (ADON) Employee E7 for the facility's C&D Tower, Unit Manager, Licensed Nurse, Employee E27 for Resident R271 in the facility's A1 unit, and ADON for Tower A &B Employee E28 was told about the above conversation with Resident R271and that the resident was unaware the staff could accommodate the resident in showering. During the interview it was confirmed that documentation revealed in the past 30 days revealed only bed baths were given between the times of March 10 and April 4, 2026. There was no evidence showers were offered nor if the resident refusing them. In addition, there was no further documentation that revealed Resident R271's hair had been washed since being admitted to the facility. The staff was given an opportunity to reveal documentation that showed otherwise. During the remaining survey no additional documentation was received. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code: 211.12(d)(1)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews with resident and facility staff, review of hospital documentation resident clinical documentation and facility policies, it was determined that the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, to ensure facilities identify and provide needed care and services to maintain appropriate care for one resident's indwelling foley catheter and failed to assess and reassess the foley catheter to determine appropriate indications of use for one of 35 residents reviewed (Resident R271)Findings include:Review of the facility's policy titled Urinary Continence and Incontinence -Assessment and Management revised August 2022 states, Physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function Indwelling urinary catheters will be used sparingly, for appropriate indications only.If a resident is admitted from the hospital with a newly placed indwelling catheter the attending physician and staff will evaluate the potential for removing it and the rationale for its original placement.The physician and staff will address treatable causes or contributing factors such as changing medication, treating pain, providing adaptive equipment to help with mobilized individualsThe physician will identify situations in which an indwelling urethral are indicated and will document why other alternatives are not feasible.Indwelling catheters shall not be used as a substitute for nursing care of the resident with urinary incontinence.If a catheter is used the physician and staff will document the clinical indications for use of the catheter and utilize standardized tools to document its ongoing need. If an indwelling catheter is needed, staff will monitor and report complications such as evidence of a symptomatic infection. Review of Resident R271 clinical records revealed the resident was hospitalized on [DATE], for generalized weakness, poor mobility, diagnosed with heart disease, Type 2 diabetes (lack of insulin), multiple pressure ulcers (wounds develops when sustained pressure on bony area reduces blood flow often combined with immobility, fragile skin, moisture or traction), urinary retention (unable to completely empty bladder) , and used an indwelling foley catheter (a tube inserted into the bladder to continuously drain urine when a person cannot urinate naturally). Hospital discharge instructions received by the facility on January 13, 2026, when the resident was admitted to the facility instructed the resident, in two weeks, to follow-up with a Urologist for an outpatient void trial to remove the resident's foley catheter (a test to confirm that a patient can spontaneously urinate after an indwelling Foley catheter is removed to prevent potential complications that could include overdistended bladder (muscle damage) and urinary tract infections). Review of Resident R271's Admission's MDS (an assessment of resident's needs) dated January 13, 2026, revealed the resident was alert and oriented, admitted with multiple pressure ulcers, one Stage III pressure ulcer (Full thickness tissue loss, depth of wound known) and six unstageable pressure wounds, (covered in slough and/or escar (dead tissue) incapable of determining the depth of the wounds. The same MDS indicated Resident R271 had poor bed mobility, incontinent of bowel, fully dependent upon staff for activities of daily living (ADL) that included toileting, showering/bathing, dressing, and needed substantial maximal assistants with personal hygiene.Review of wound specialist, Nurse Practioner (NP) Employee E29 initial assessment, dated January 14, 2026, noted Resident R271 with wounds located on the bilateral feet, pressure ulcers over numerous areas of the buttocks, thighs, and back. The specialist noted all prevention measures were discussed with staff that included, ongoing pressure reduction, turning, repositioning and to ensure the resident's urinary foley catheter securement device is in place to prevent pressure (a pressure injury from a Foley catheter is a type of medical device-related pressure injury (MDRPI). It occurs when the catheter or its securement device exerts sustained pressure or traction on the delicate mucosal tissue and surrounding perineal skin, leading to tissue breakdown.Review of attending physician note dated January 19, 2026, stated Resident R271 was admitted to the facility for rehabilitation and ongoing management of medical (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conditions after hospitalization for generalized weakness secondary to morbid obesity, dehydration, and multiple wounds, The same note stated a 'Foley placed in hospital secondary presumed obstructive uropathy. Recommended TOV (Trial of Void) patient refused. Will reattempt.Continue review of Resident R271's physician notes dated January 26, February 3, 11,13, 19,27, March 6, 16, and 27 2026 includes and references the note written on January 19, 2026, that states 'Foley placed in hospital secondary presumed obstructive uropathy. Recommended TOV patient refused. Will reattempt but no evidence the physician spoke again to the resident regarding the voiding trial. Further review of Resident R271's clinical file revealed on March 20, 2026, nursing progress note stated the resident's foley was Out (dislodged). The same note indicated upon inspection of resident's vaginal area a small, non-bleeding, notch like wound was found on the resident's right labia. Her vaginal area was also pink and presented with an appearance consistent with a vaginal yeast infection; resident stated, ?It did itch and burn at times.' At that same time during the Wound NP rounds he examined the vaginal wound and was to write a wound note with order recommendations. During that time Resident R271 agreed to try TOV and successfully voided three times in the nurses presence.Review of the Wound NP progress note dated March 20, 2026, reported a new wound found on Resident R271's labia identified upon removal of indwelling urinary catheter. Wound documentation describes the resident's Right labia wound primary etiology a pressure ulcer/Injury Stage/Severity, Unstageable Wound, Sized: 0.8 cm x 0.9 cm x 0.2 cm. Wound has 10% granulation (new tissue with active healing) , 90% slough (dead tissue that can impede recovery in a wound, that may be surgically removed for optimal wound recovery called debridement). Pressure ulcer of the right labia is related to prior indwelling catheter. Patient has an unstageable pressure ulcer with necrotic tissue (slough/eschar) present which prevents accurate depth assessment.March 23, 2026. wound note from Nurse Practioner Employee E30 noted Resident R271 was now incontinent of urine and described the pressure ulcer of the right labia related to Resident R271's prior indwelling catheter. Wound was assessed measuring: 0.8 cm x 0.9 cm x 0.2 cm. Wound Base, 50% granulation, 50% slough. The note indicated Resident R271 was in pain and refused wound debridement to rt labia wound. Per facility policy if a resident is admitted from the hospital with a newly placed indwelling catheter the attending physician and staff will evaluate the potential for removing it and the rationale for its original placement. During an interview with Resident R271 on April 6, 2026, at 11:30 a.m. the resident laughed when the surveyor asked why the foley catheter was placed. I have no idea. When surveyor informed the resident that the resident refused initially to have the foley catheter taken out, the resident smiled and said, I have no idea what I said when I first got here (facility) I was confused and not focused because I was just discharged from the hospital. The resident confirmed she had not spoken to the physician about having a voiding trial done to see if the resident needed the foley, Reviewing the progress note with Resident R271 on March 20, 2026, when the foley was found dislodged, the nurse noted that the resident complained that the foley Iitched and burned Per facility policy If an indwelling catheter is needed, staff will monitor and report complications., When asked if the foley gave her pain and discomfort, and what was done about it, the resident responded, Yes, it did, especially around the time if fell out. The resident stated, I asked the aide to look and see if she saw anything down there, she told me it looked red and she would tell the nurse. But the nurse never came back. Nursing never looked down there and the only aide that did was the one who saw the redness, but she no longer works here. Nursing sure did look when it fell out. All the nurses were in my room looking, even the wound care doctor saw. Review of the resident's nursing note revealed no evidence or noting of discomfort pertaining to the foley.Interview on April 8, 2026, at 4:00 p.m. with the Assistant Director of Nursing (ADON) Employee E7 for the facility's C&D Tower, Unit Manager, Licensed Nurse, Employee E27 for Resident R271 in the facility's A1 unit, and ADON for Tower A &B Employee E28 was told the above conversation with Resident R271 and the surveyors findings in the clinical chart. The three staff members were asked when the resident was asked again after January 19, 2026, when the resident refused to have the foley taken out and the physician would ?reattempt this (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conversation again with the resident. Surveyor offered to receive additional information to validate a reattempt, but no further correspondence was received during the survey. The unit manager stated the resident had many wounds for a reason why the foley catheter was not discontinued and the surveyor indicated the facility's policy is that and Indwelling catheters shall not be used as a substitute for nursing care of the resident with urinary incontinence. When reviewing the notes during the time the foley dislodged they were unaware the wound specialist classified the wound was from a pressure injury due to the foley. The unit manager stated she was one of the nurses that saw the area after the foley dislodged, It looked like a yeast infection, it was white. The surveyor read the wound report noting that the area was 90% slough, not yeast and that mucosal membrane pressure injuries from a medical device such as a foley may occur when the placement of the xx or the foley tube is not positioned correctly leading to cause pressure and pulling at the site which may not show typical signs, instead, they can present with pain, swelling, and bleeding, leading to soft clots that resemble slough. Further review of Resident R271's clinical records show no evidence nursing was monitoring and assessing the skin integrity of the surrounding area of the foley catheter. The wound specialist noted that pressure interventions were discussed with the staff and to ensure the resident's urinary foley catheter securement device is in place to prevent pressure. The securement device was documented as being used with the indwelling foley catheter but there is no evidence the integrity of the skin surrounding the foley had ongoing monitored and assessed for correct placement and positioning to prevent pulling and or pressure to the foley site. Review of the facility's policy titled, Prevention of Pressure Injuries, revised April 2020 states, the purpose of the procedure is to provide information regarding identification of pressure injuries risk factors and interventions for specific risk factors. The policy states to Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. The same policy states for device -related pressure injuries review and select medical devices with consideration to the ability to minimize tissue damage, including size, shape, its application and ability to secure the device. Monitor regularly for comfort and signs of pressure related injuries. Evaluate, report and document potential changes in skin. Review of Resident R271's clinical records revealed a care plan developed for the indwelling catheter, with goals the resident would remain free from catheter related trauma dated January 14, 2026. Interventions included to position catheter bag and tubing below the level of the bladder (to prevent urine backflow and prevent infections) and Check tubing for kinks each shift (so urine can flow easily). Ensure foley catheter tubing is secured by securement device (to aid in preventing unnecessary movement or pulling) Monitor and document urine intake and output. Monitor/record/report to physician signs and symptoms of urinary tract infections (UTI). Per the facility policy and during the time Resident R271 used the foley catheter the facility failed to assess the resident as a risk for developing device related injuries related to the use of the foley catheter and failed to develop and place preventive measures and ongoing monitoring and assessment of the resident's skin integrity surrounding the foley for pressure injuries, Monitor/record/report to physician signs and symptoms of ongoing skin assessments, and to monitor the foley tubing and securement device for proper positioning to avoid devise related injuries. Further review of Resident R271's care plans revealed the facility developed a care plan for foley catheter and/or device related injuries only after the pressure injury was found and the foley catheter was removed. Review of facility provided informaton dated April 9, 2026, revealed Type: Physician / Medical Provider Progress On follow up of visit on 3/27/26, resident again refused foley in place voiding trial and wanted to keep the foley in place. Resident verbalized understanding of risk.Review of facility provided informaton dated April 9, 2026, revealed Type: Physician / Medical Provider Progress Note Text : After review of the 3/20/2026 patient's note [Nurse Practitioner] in my professional opinion after reviewing records and images, the wound is not related to pressure but rather a mucosal membrane injury. At the time wound presented all preventions were in place including catheter securement device prior to removal per staff.

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	396078	A. Building B. Wing	04/09/2026

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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 record review and staff interview, it was determined that the facility failed to monitor resident weights and implement timely interventions for significant weight loss. Resident R81. Findings include:Review of the facility's policy titled Weight Assessment and Intervention (March 2022) revealed that residents are weighed upon admission and thereafter per physician order, with weights documented in unit records and the medical record. The policy requires monitoring for unintended weight changes, with any change of 5% or more reweighed for confirmation and, if verified, prompt notification of the dietitian. Significant weight loss is defined as 5% in one month (greater than 5% considered severe). The interdisciplinary team is responsible for evaluating causes, including medical conditions and medications, and developing an individualized care plan with goals, interventions, and ongoing monitoring. Interventions are based on resident needs, preferences, and clinical factors, including nutritional status, functional ability, swallowing issues, medications, and advance directives. Review of the facility's policy titled Change in Resident Condition or Status (undated) revealed that the facility is required to promptly notify the resident's attending physician and representative of any significant change in the resident's physical, mental, or emotional condition. A significant change is defined as a major improvement or decline that is not expected to resolve without intervention and requires interdisciplinary review and potential revision of the care plan. The policy also requires nursing staff to document all changes in the resident's medical record and to complete a comprehensive assessment in accordance with OBRA regulations and MDS guidelines when a significant change occurs.Review of Resident 81's admission Minimum Data Set (MDS-a federal mandated assessment tool for all residents) assessment dated [DATE], revealed that resident R81 was readmitted to the facility on [DATE], following a fall with injury. The resident was originally admitted on [DATE]. The resident has a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. The resident is wheelchair dependent and requires total assistance for sit-to-stand and chair-to-bed transfers, maximum assistance for showering, partial assistance for dressing, and is dependent for toileting.Resident R 81's diagnoses include anemia (a condition characterized by a decreased number of red blood cells or hemoglobin, resulting in reduced oxygen delivery to tissues), congestive heart failure (a chronic condition in which the heart is unable to pump blood effectively), renal insufficiency (impaired kidney function affecting the body's ability to filter waste and maintain fluid balance), vertebral fracture (a break in one or more bones of the spine), and seizure disorder (a neurological condition characterized by recurrent seizures due to abnormal electrical activity in the brain).Continued review of resident R81's admission MDS, dated [DATE], revealed a Nutritional assessment that indicates the resident weighed 186 pounds and is 66 inches in height. The MDS reflects a weight gain of greater than 5% in the past one month and/or greater than 10% over the past six months. The resident was also noted to hold food in her mouth and report difficulty and/or pain with swallowing, which may indicate dysphagia (difficulty swallowing).Continued review of resident R81'2 MDS Medication review indicates the resident is prescribed an anticonvulsant (used to control or prevent seizures), a diuretic (used to reduce excess fluid by increasing urine output, commonly prescribed for heart failure), an antidepressant (used to treat mood disorders such as depression), and antibiotics (used to treat or prevent bacterial infections).Review of Resident R81's nutrition assessment dated [DATE], revealed the resident was on a regular diet with thin liquids and receiving Ensure Plus at breakfast. The resident's height was documented as 66 inches, with a weight of 195 pounds and a BMI of 30.2. Meal intake was reported as greater than 50% for all meals. The assessment indicated no chewing or swallowing difficulties. However, this documentation is inconsistent with the resident's MDS assessment and other clinical records, which identified the presence of chewing and swallowing difficulties. This discrepancy reflects conflicting documentation regarding the resident's actual nutritional and swallowing (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	status.Continued review of resident R81's nutritional assessment indicated a weight gain of 4.5% over 30 days and 24% over 180 days. The registered dietitian identified increased nutritional needs related to higher metabolic demands and noted a physician-ordered weight loss regimen. The dietitian determined no new nutritional interventions were required, stating that the current diet was adequate to meet needs, with continued monitoring of weight, labs, medications, skin status, and oral intake. The summary further indicated that weight fluctuations were likely related to fluid shifts associated with congestive heart failure and edema, with continued monitoring recommended. The assessment was completed by the registered dietitian and documented on February 12, 2026. Review of Resident R81's dysphagia screening dated March 4, 2026, revealed that the resident exhibited signs of swallowing impairment, including loss of food or liquids from the mouth during eating or drinking, pocketing of food in the cheeks, residual food remaining in the mouth after meals, and coughing or choking during meals or when taking medications. The resident was determined to require a mechanically altered diet with ground texture and thin liquids. The screening also recommended skilled speech therapy evaluation and treatment due to aspiration risk associated with a regular diet. Review of physician orders for Resident R81, dated January 17, 2026, revealed an order for daily weights with instructions to notify the provider for a weight gain of greater than 2 pounds in one day or greater than 5 pounds over one week, in the morning, related to the resident's diagnosis of congestive heart failure. Further review of the resident's clinical record and staff interview revealed that this order was not followed. Review of physician orders dated February 11, 2026, revealed an order for weekly weights to be obtained every Thursday for four weeks. Further review of the resident's clinical record and staff interview revealed that this order was not followed. Review of the resident R 81's clinical record revealed the following documented weights over the last 90 days:January 31, 2026: 184.8 pounds (wheelchair scale)February 2, 2026: 184.5 pounds (wheelchair scale)February 3, 2026: 183.1 pounds (wheelchair scale)February 4, 2026: 186.6 pounds (wheelchair scale)February 5, 2026: 186.3 pounds (wheelchair scale)March 27, 2026: 141.2 pounds (Hoyer lift scale)April 1, 2026: 0 pounds (last documented weight; weights noted as discontinued without a written order or documentation from the dietitian) Review of Resident R81's care plan revealed that the resident is identified as having an actual or potential nutritional problem related to multiple diagnoses, including congestive heart failure, pulmonary conditions, atrial fibrillation, lymphedema, osteoarthritis, hypothyroidism, chronic kidney disease, epilepsy, anemia, vitamin D deficiency, hyperlipidemia, hypertension, and malnutrition. The care plan, initiated January 19, 2026, included interventions for a mechanically altered diet, monitoring and reporting signs and symptoms of dysphagia (difficulty swallowing, including pocketing, choking, coughing, drooling, holding food in the mouth, and refusal to eat), and monitoring for signs of malnutrition and significant weight loss greater than 3 pounds in one week. Additional interventions included dietitian referral for evaluation and recommendations and provision of nutritional supplements as ordered.The care plan was updated on February 17, 2026, to include supplementation, and on March 31, 2026, to reflect hospice services with an expectation of weight loss.Further review of the care plan revealed no evidence of updated or revised interventions specific to the resident's significant and ongoing weight loss, despite documented clinical decline. There was no indication that interventions were adjusted to address continued nutritional deterioration or that new measures were implemented to reflect the resident's changing condition.Review of the resident's clinical record, progress notes including nursing notes, dietary notes, and physician documentation, revealed inconsistent and fragmented documentation regarding the resident's nutritional status and intake. A nursing note dated February 12, 2026, indicated the resident weighed 195 pounds, with weight gain attributed to edema, and reported meal intake greater than 50%. A dietary note dated February 17, 2026, indicated poor meal intake. Nursing documentation dated March 19, 2026, revealed the resident did not consume dinner and refused all medications. A physician note dated March 24, 2026, indicated the resident had not been eating recently and included an order to increase medication mirtazapam. A nursing note dated March 26, (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2026, again reflected poor appetite. A dietary note dated March 30, 2026, indicated the resident's current weight reflected significant weight loss, a reweigh was requested, which was not completed, and hospice evaluation was ordered, and nutritional decline with anticipated weight loss was noted.These records indicate that throughout March 2026, the resident exhibited decreased oral intake, medication refusal, and ongoing weight decline; however, there was no consistent evidence of timely interventions, physician notification, or documented care plan adjustments in response to the resident's declining nutritional status.Interview with the registered dietitian Employee E26 and regional dietitian, it was revealed that the dietitian was not aware of the resident's physician-ordered daily and weekly weight monitoring and was not notified of the resident's significant weight loss. The dietitian stated she first became aware of the weight loss after it had already occurred and indicated that follow-up was not completed due to the resident being placed on hospice care and discontinuation of weight monitoring orders. Registered dietician employee E26 further stated that earlier weight fluctuations were attributed to fluid shifts related to edema and congestive heart failure. Although an intervention of providing mashed potatoes to increase caloric intake was implemented, there was no documented order for ongoing intake monitoring and no evidence of additional interventions or reassessment of nutritional status despite continued decline. This failure resulted in a lack of timely recognition, monitoring, and intervention for significant weight loss, indicating the facility did not ensure appropriate nutritional care and services in accordance with professional standards and physician orders.28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 211.2 (d)(10) Medical Director 28 Pa. Code 211.10 (a)(c) Resident Care Policies 28 Pa. Code 211.12 (d)(1)(5) Nursing Services

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident clinical records, facility documentation, and staff interviews, it was determined that the facility failed to ensure proper documentation was maintained to support continuity of hospice care for one resident (Resident R81) out of three residents reviewed. Findings Include: Review of the facility's policy titled Hospice Program dated July 2017 revealed that the facility maintains an agreement with a Medicare-certified hospice provider to support end-of-life care for eligible residents. The policy requires clear, timely communication and comprehensive documentation between the facility and hospice services. The facility is responsible for ensuring that hospice-related documentation is obtained, maintained, and accessible, including the hospice plan of care, election forms, physician certifications, medication information, and hospice contact information. The policy further requires that all communications with hospice providers be documented, and that the facility maintain ongoing coordination with the resident's attending physician and interdisciplinary team.Review of the facility's hospice contract further revealed that the hospice provider is responsible for completing an assessment upon admission, developing and updating the hospice plan of care, and providing the facility with current plan of care documentation. The contract also requires hospice to notify the facility of any changes in the resident's condition and to collaborate with the facility in revising the plan of care as needed.Review of Resident 82's Minimum Data Set (MDS) assessment revealed that the resident was readmitted to the facility on [DATE], following a fall with injury. The resident was originally admitted on [DATE]. The resident has a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. The resident is wheelchair dependent and requires total assistance for sit-to-stand and chair-to-bed transfers, maximum assistance for showering, partial assistance for dressing, and is dependent for toileting.The resident's diagnoses include anemia (a condition characterized by a decreased number of red blood cells or hemoglobin, resulting in reduced oxygen delivery to tissues), congestive heart failure (a chronic condition in which the heart is unable to pump blood effectively), renal insufficiency (impaired kidney function affecting the body's ability to filter waste and maintain fluid balance), vertebral fracture (a break in one or more bones of the spine), and seizure disorder (a neurological condition characterized by recurrent seizures due to abnormal electrical activity in the brain).Review of the resident's hospice communication binder revealed only a nursing sign-in sheet present. All other required hospice documentation, including the hospice plan of care, clinical notes, medication information, and related communication records, were absent.Review of Resident R81's care plan dated March 31, 2026, indicated the resident was enrolled in hospice services with a terminal prognosis related to congestive heart failure. Interventions included comfort measures, emotional support, environmental modifications, and coordination with the hospice team to address physical, emotional, and psychosocial needs.Interview with the Administrator Employee E1 on April 7, 2026, at 10:50 a.m., revealed that hospice staff typically submit documentation to the facility every two weeks. The Administrator employee E1 acknowledged that there had been no updates received in the resident's hospice plan of care and confirmed that hospice documentation and communication were not being consistently maintained or available within the facility records.28 Pa. Code (b)(1) Management28 Pa. Code 211.12 (d)(7) Medical Director 28 Pa. Code 211.12 (d)(13) 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. Based on observations, and staff interview, it was determined that the facility failed to follow acceptable infection control practices related to care and maintenance of oxygen concentrators for three of 35 residents reviewed (Resident R199, R13 and R119). Findings include: Observations during the initial tour on April 6, 2026, at 11:35 a.m. of Resident R199 room on unit C1 revealed that the filter on the oxygen concentrator was dirty having a thick whitish grey build-up on the black filter on the side of the machine. Interview with Resident R199 revealed that she uses the oxygen all the time. Follow-up observation on April 7, 2026, at 10:36 a.m. with Employee E10, LPN, revealed the filter was still dirty. A review of Resident R199's medical records revealed a March 16, 2026, physician's order to clean the oxygen concentrator filter weekly. Observations on April 6, 2026, at 11:42 a.m. of R113 room on unit C1 revealed that the filter on the oxygen concentrator was dirty having a thick whitish grey build-up on the black filter on the side of the machine. Interview with Resident R13 revealed that he uses the oxygen all the time. Follow-up observation on April 7, 2026, at 10:38 a.m. with Employee E10, LPN, revealed the filter was still dirty. Interview with Employee E10, LPN, on April 7, 2026, at 10:40 a.m. confirmed that the oxygen filters on both oxygen concentrators were dirty and that they were not cleaned as ordered. Observations on April 6, 2026, at 12:10 a.m. of Resident R119 room on unit D1 revealed that the filter on the oxygen concentrator was dirty having a thick whitish grey build-up on the black filter on the side of the machine. Interview with Resident R119 revealed that she was wearing the nasal canula connected to the oxygen concentrator, and that she only uses the oxygen when she needs it. Follow-up observation on April 8, 2026, at 10:38 a.m. with Employee E23, LPN, revealed the filter was still dirty. Interview with Employee E23, LPN, on April 7, 2026, at 12:30 p.m. confirmed that the oxygen filters on Resident R119's oxygen concentrators was dirty and that it was not cleaned as ordered. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)5 Nursing services