STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396082	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Lane Post Acute LLC	1619 East Boot Road East Goshen West Chester, PA 19380

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. 41765 Based on a review of the facility's policy, clinical records review, and staff interview, it was determined that the facility failed to monitor behaviors and potential side effects for residents receiving anti-psychotic medications (psychiatric drugs used to treat symptoms of psychosis, like hallucinations and delusions) for two of five residents reviewed (Residents 18 and 25). Findings include: A review of the facility's policy titled Psychotropic Medications, with an effectivity date of January 14, 2025, revealed residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record. The medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. Further review of the same policy revealed that residents who receive an antipsychotic medication will have an Abnormal Involuntary Movement Scale (AIMS- A test used to assess and monitor involuntary movements) test performed per facility policy. A review of Resident 18's diagnosis list includes bipolar disorder (A disorder associated with mood swings ranging from depressive lows to manic highs) and Major Depression. A review of Resident 18's physician's order dated April 24, 2025, revealed an order of Abilify (An anti-psychotic medication) 10mg one tablet two times daily. Clinical records review failed to reveal behaviors and medication side effects monitoring were being done while the resident was taking Abilify from April 24, 2025, until May 16, 2025. A review of Resident 35's diagnosis list includes bipolar disorder and generalized anxiety disorder. A review of Resident 35's physician's order dated April 17, 2025, revealed an order of Chlorpromazine HCl 50 mg (An anti-psychotic medication) one tablet at HS (hours of sleep). Clinical records failed to reveal behaviors and medication side effects monitoring was being done while the resident was taking Chlorpromazine from April 17, 2025, until May 12, 2025. (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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted with the Director of Nursing on May 16, 2025, at 1:00 p.m., confirmed behavior and medication side effects monitoring were not done for Resident 18 and 35 while receiving an antipsychotic medication. The facility failed to ensure Residents 18 and 35 were monitored for behaviors and medication side effects while receiving an anti-psychotic medication. 28 Pa. Code 211.5(f) Clinical records Previously cited 4/19/24 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services Previously cited 4/19/24

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 41765 Based on a review of the facility's policy, clinical records review, and staff interview, it was determined that the facility failed to thoroughly investigate allegations of staff being rough to the resident while providing care for one of the 19 residents reviewed (Resident 62). Findings include: A review of the facility's policy titled Abuse, Neglect and Exploitation, implemented on March 17, 2025, revealed that an investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occurs. Written procedures for investigations include the following: Identifying staff responsible for investigation; Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might know about the allegation; Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and the cause; and Providing complete and thorough documentation of the investigation. A review of Resident 62's diagnosis list includes Spinal Stenosis (The narrowing of one or more spaces within your spinal canal that cause symptoms like back or neck pain), and lumbar disc degeneration (A condition of the discs between vertebrae with loss of cushioning, fragmentation and herniation related to aging). A review of Resident 62's Admission Minimum Data Set (MDS- A standardized assessment tool that measures health status in long-term care residents) dated May 1, 2025, revealed resident's cognition was intact. The same MDS revealed resident required partial/moderate assistance with rolling in bed and was dependent on transfers. A review of the facility documentation, Grievance Form dated May 1, 2025, revealed the following: Pt (patient) stated no medication given for upset stomach. On admission, pt stated 2 (two) CNA (certified nursing assistant) were rough when trying to take (his/her) weight and roll in bed. The same documents revealed that the concern was resolved on May 2, 2025, with a grievance official follow up EMAR (electronic medical record) printed to show medication was given to help with stomach pain. DON (Director of Nursing) and guest services present at the care conference to address concerns, Pt also paired care for care. A review of the clinical records and the facility's investigation revealed that the resident's concern for not receiving the medication was addressed, however, a resident report regarding two staff being rough during care was not thoroughly investigated. The investigation report failed to reveal a statement from the two alleged staff and other potential witnesses were taken to determine the presence of abuse. An interview conducted with the Nursing Home Administrator on May 16, 2025, at 9:07 a.m., confirmed statements were not taken from the two staff who were allegedly rough to the resident during care until May 15, 2025, after the surveyor asked for it. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure allegation of staff being rough to the resident during care was thoroughly investigated. 28 Pa. Code 211.5(f) Clinical records Previously cited 4/19/24 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services Previously cited 4/19/24

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765 Based on a review of the facility's policy, clinical records review, and staff interview, it was determined that the facility failed to ensure skin impairment identified from admission was thoroughly assessed and wound care recommendations from the wound physician were followed for one of four residents reviewed (Resident 59). Findings include: A review of the facility's policy titled Pressure Injury Prevention and Management, implemented on January 14, 2025, revealed that the facility should establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment. Licensed nurses will conduct a full body skin assessment on all residents upon admission/readmission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. Clinical records review revealed Resident 59 was admitted to the facility on [DATE], with a diagnosis of progressive supranuclear ophthalmoplegia (A late-onset neurodegenerative disease involving the gradual deterioration and death of specific volumes of the brain), generalized weakness, and urinary tract infection. A review of the admission skin assessment dated [DATE], revealed Right heel pressure. The skin assessment failed to reveal the wound stage, size, appearance, drainage, odor, and condition of the surrounding area of the skin. A review of the physician's order dated April 23, 2025, revealed an order to cleanse the right heel wound with normal saline, apply Medihoney (A dressing that aids and supports debridement and a moist wound healing environment in acute and chronic wounds and burns) and cover with dressing every other day. An interview with the Assistant Director of Nursing (ADON), licensed Employee E4 was conducted on May 15, 2025, at 1:30 p.m. Employee E4 reported that the admitting nurse is responsible for the wound assessment. The ADON reported that assessment should include the wound's stage, measurements, appearance, and drainage and documented on the resident's medical records. Employee E4 confirmed that Resident 59's right heel wound identified on admission was not comprehensively assessed until seen by the wound physician for a consult on April 25, 2025, two days after admission. A review of the wound physician's consult dated April 25, 2025, revealed right heel wound was identified as an Unstageable Pressure Ulcer (Obscured full-thickness skin and tissue loss) measuring 2.4 x 2.0 x 0.1 cm. (centimeters) with 50% slough (Is a non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed). A treatment to cleanse the wound with saline, apply medical grade honey, and cover with foam dressing daily and as needed was ordered by the wound physician. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the May 2025, Treatment Administration Record (TAR) revealed Resident 59's right heel unstageable wound treatment was not done on April 26, and 27, 2025, despite the wound physician's order to do the treatment daily and as needed. An interview with the ADON on May 16, 2025, at 10:00 a.m., revealed facility follows the wound physician's recommendations for wound treatment and puts it as an order. The ADON confirmed that the wound physician's recommendation made on April 25, 2025, to change the treatment daily and as needed instead of every other day was not followed missing two days of wound treatment to the right heel unstageable wound. The facility failed to ensure Resident 59's right heel wound was comprehensively assessed, and the recommendation of the wound physician was followed. 28 Pa. Code 211.5(f) Clinical records Previously cited 4/19/24 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services Previously cited 4/19/24

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47968 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to follow physician orders and adequately monitor significant weight changes for three of eight residents reviewed for nutrition (Residents 18, 36 and 37). Findings include: Review of facility policy, Weight and Weight Change Management, last revised date unknown, revealed: Resident weights will be obtained to provide a baseline and an ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident. Each resident will be weighed monthly or more frequently as deemed necessary by physician orders, Dietician, or IDT (interdisciplinary team) recommendation. Clinical records review revealed Resident 18 was admitted to the facility on [DATE], with diagnosis of Congestive Heart Failure (CHF-A weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs), Chronic Kidney Disease (CKD-Gradual loss of kidney functions which can result to renal failure), and right leg bimalleolar fracture (A serious ankle injury that involves breaks in both the medial and lateral malleolar bones). A review of Resident 18's physician's order dated April 24, 2025, revealed an order for a daily weight one time a day, ensuring wheelchair weight is subtracted before inputting the weight. A review of the weight and vitals revealed the following weights: 204 pounds on April 25, 2025, 204.2 pounds on April 26, 2025, 203.4 pounds on April 27, 2025, 204.1 pounds on April 28, 2025, and 204.4 pounds on April 29, 2025, which revealed a stable weight from April 25 until April 29, 2025. On May 3, 2025, the resident's weight was 247.8 pounds. A reweigh was done which also revealed 247 pounds, a 43.4 (21.23%) significant weight gain in four days. A review of the dietitian's progress notes dated May 5, 2025, revealed the resident with a weight gain of 40 pounds, reweight also showing +40 pounds. The notes also revealed that RD (registered dietitian) checked wheelchair weight alone and it's 47.4 #. Weight gain x 1 (one) day most likely due to not subtracting wheelchair weight when inputting weights obtained. RD spoke to the nurse for the resident today and emphasized subtraction of wheelchair weight/clarification from CNA (certified nursing assistant) if the subtraction was completed or not before inputting into the system. Spoke to MD (physician) about weight gain and made aware of weight change most likely r/t (related to) wheelchair weight being included. An interview with the Dietitian, licensed Employee E3 conducted on May 15, 2025, at 11:30 a.m., confirmed that the significant weight gain was due to the wheelchair not subtracted before inputting the weight into the system. The dietitian reported that the current daily weights (240 + pounds) documented in the weights and vitals were all with a wheelchair. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with an Occupational therapist (A healthcare provider that helps people to improve their daily living tasks and activities), Employee E5 was conducted on May 16, 2025, at 11:00 a.m. Employee E5 reported providing treatment and rehabilitation services for Resident 18. Employee E5 reported that she/he took the resident's weight on May 16, 2025, and it was 244 pounds without a wheelchair. An interview was conducted with the Director of Nursing on May 16, 2025, at 1:00 p.m. The DON was unable to provide a valid explanation of the 40 + pounds significant weight change in four days. The facility failed to ensure Resident 18's weight was appropriately monitored and addressed. Review of Resident 36's face sheet revealed medical diagnoses that include, Progressive Bulbar Palsy (damage to cranial nerves responsible for controlling muscles for speech, swallowing and facial movement), Sever Protein Calorie Malnutrition (insufficient energy, fat protein and nutrients), Amyotrophic Lateral Sclerosis (ALS - loss of muscle control), Acute Respiratory Failure with Hypoxia (lack of oxygen in blood), Dysarthria (speech disorder) and Anarthria (loss of muscle control for speech). Review of Resident 36's clinical records revealed a care plan dated March 10, 2025, documenting Resident 36 is at nutritional/hydration risk secondary to need for Enteral (nutritional intake via tube) feeding and flushes to maintain nutritional status. Inability to meet established nutritional needs with PO (by mouth) diet, history of prior need for mechanical altered diet with thickened liquids, history of altered lab values, history of inadequate PO intake, and increased risk for clinical changes including weight, skin and lab changes. Review of Resident 36's physician orders revealed an order dated May 1, 2025, for weekly weights for four weeks with an end date of May 29, 2025. Per the physician orders Resident 36 should have been weighed on May 1, 2025, May 8, 2025, May 15, 2025, and May 22, 2025. Review of Resident 36's physician orders revealed an order dated April 24, 2025, for NPO (nothing by mouth) diet, NPO texture, NPO consistency. Further review of Resident 36's physician orders revealed an order dated May 2, 2025, for Enteral Feed four times per day via Bolus Feeding Tube (tube syringe used to provide nutrition). Nutren 2.0 (a nutrition formula), 220cc 4 times per day, every 6 hours, total volume 880cc per 24 hours, providing 1760 kcals, 74grams protein, 609cc free water, per 24 hours. Review of Resident 36's weights on May 15, 2025, at 12:35 p.m., revealed one weight dated May 1, 2025, at 1:29 p.m. where the resident was recorded as weighing 134.9 lbs. Further review of Resident 36's weights on May 16, 2025, at 11:15 a.m., revealed a recorded weight dated May 16, 2025, at 10:49 a.m., where the resident was recorded as weighing 137.4 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Dietary staff Employee E3 on May 15, 2025, at 12:40 p.m., Employee E3 stated nursing staff is responsible for resident's weights. Employee E3 confirmed Resident 36 was not weighed on May 8, 2025, as ordered. Employee E3 stated he/she had no clarification why Resident 36 was not weighed. Employee E3 confirmed there was no documented explanation as to why Resident 36 was not weighed on May 8, 2025. Employee E3 stated the nursing supervisor was notified of Resident 36's missing weight the following day, May 9, 2025. Employee E3 confirmed Resident 36's next scheduled weighing was May 15, 2025. Interview with the DON on May 16, 2025, at 11:30 a.m., when the above was mentioned, the DON confirmed Resident 36's physician orders for weekly weights were not followed. Review of Resident 37's diagnosis list revealed diagnoses but not limited to dementia (irreversible, progressive degenerative disease of the brain, resulting in loss of reality contact and functioning ability), anxiety disorder (feelings of persistent anxiety), muscle weakness and depression. Review of Resident 37's physician orders revealed an order dated May 7, 2025, for weekly weight for four weeks with an end date of June 4, 2025. Review of Resident 37's clinical record revealed that weights were obtained as follows: April 30, 2025 - 113.2 pounds and May 14, 2025 - 101.0 pounds. Revealed a significant weight loss of 12.2 pounds. Further review of Resident 37's clinical record failed to reveal that any weights were obtained on May 7, 2025. The above-mentioned information was conveyed to the Director of Nursing on May 16, 2025, at approximately 1:00pm. 28 Pa. Code 211.5(f) Clinical Records 28 Pa. Code 211.12(d)(1)(5) Nursing Services 28 Pa Code: 211.10(c) Resident care policies

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 52707 Based on clinical records review and staff interviews, it was determined that the facility failed to follow physician orders regarding administration of nutrition for one of two residents reviewed (Resident 317). Findings include: Review of Resident 317's Medical Diagnosis revealed, unspecified protein-calorie malnutrition and chronic respiratory failure (a long-term condition where the lungs cannot adequately exchange oxygen and carbon dioxide, leading to low blood oxygen levels or high carbon dioxide levels). Clinical record review that patient was admitted to facility on May 8, 2025 with a tracheostomy (a surgical procedure where an opening (stoma) is created in the neck to access the trachea (windpipe), allowing for easier breathing) and PEG tube (a thin, flexible tube inserted directly into the stomach through the abdominal wall). Review of Resident 317's physicians order revealed an order dated May 8, 2025 for Enteral Feed Order one time a day Continuous Tube Feeding: Product: Nutren 1.5 At 60 ML/ Hour via PEG tube x 20hours/day Total Volume: 1200 mL (milliliter) Up at 4 pm Down when total volume has been infused. Review of resident 317's medication administration record (MAR) for May 2025 revealed Resident 317 received a total Nutren 1.5 volume on May 9, 2025 of 60 ml, on May 10, 2025 of 1320 ml, on May 11, 2025 of 3405 ml and on May 12, 2025 of 565ml. Interview with licensed nurse Employee E4 confirmed that tube feeding order was not being documented correctly. The facility failed to ensure Resident 317's physician order regarding continuous tube feeding for the total volume of 1200 ml was followed. 28 Pa. Code 211.5(f) Clinical Records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52707 Based on clinical records facility policy review and staff interviews, it was determined that the facility failed to follow physician orders for oxygen for one of one residents reviewed. (Resident 317) Findings include: Review of Facility policy titled Tracheostomy Care, undated, revealed the following: The facility will provide necessary respiratory care and services, such as oxygen therapy, treatments, mechanical ventilation, tracheostomy care and/or suctioning. And tracheostomy care will be provided according to the physicians orders, comprehensive assessment and individualized care plan such as monitoring for resident specific risks for possible complications, psychosocial needs as well as suctioning as appropriate. Review of resident 317's Diagnosis list revealed, chronic respiratory failure with hypoxia (Respiratory failure is a condition where there's not enough oxygen or too much carbon dioxide in your body. It can happen all at once (acute) or come on over time (chronic). Review of Resident 317's physician orders revealed Trach Collar (trach collar is a medical device used to deliver oxygen therapy to patients who have a tracheostomy tube in place.) 28% humidified oxygen. Concentrator (condenses room air into pure oxygen) set at 2L/min Observation of Resident 317 on May 15th, 2025, at 09:53 AM revealed the resident was not receiving physician ordered two liters of oxygen. Interview with Registered Nurse (RN) E-6 at 10:12 am, revealed the resident was last seen at 7:15 am. When asked if the trach setup was the same it was revealed to be the same. Upon request E-6 [NAME] order and recited it back. The facility failed to ensure Resident 317's tracheostomy collar with 28% humidified oxygen medication order was followed. 28 Pa. Code 211.5(f) Clinical Records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 41765 Based on clinical records review and staff interview, it was determined that the facility failed to ensure medications were made available for one of the 19 residents reviewed (Resident 18). Findings include: A review of Resident 18's diagnosis list includes bipolar disorder (A disorder associated with mood swings ranging from depressive lows to manic highs), Major Depression, and Sleep Apnea (A potentially serious disorder in which breathing repeatedly stops and starts). A review of Resident 18's physician's order dated April 23, 2025, revealed an order of Armodafinil 250 mg (A medication that treats sleepiness from narcolepsy, sleep apnea, or night shift work) one tablet one time a day for sleep disorder. A review of the April 2025, Medication Administration Record revealed Armodafinil medication was not administered to Resident 18 on April 24, 25, 26, 27, and 28, 2025. A review of the nursing progress notes dated April 25, 2025, at 8:52 a.m., revealed Armodafinil medication was still on order from the pharmacy, the physician was notified. A review of the nursing progress notes dated April 26, 2025, at 9:25 a.m., revealed Armodafinil medication was on order from pharmacy. A review of the nursing progress notes dated April 27, 2025, at 10:44 a.m., revealed Armodafinil medication was not available. A clinical records review revealed that the physician was not notified of the missed medication on April 26, 27, and 28. An interview conducted with the Director of Nursing on May 16, 2025, at 1:00 p.m., confirmed Armodafinil medication was not administered to Resident 18 on the above-mentioned dates due to unavailability of the medication from the pharmacy. The facility failed to ensure Resident 18's Armodafinil medication was made available timely for the resident. 28 Pa. Code 211.5(f) Clinical records Previously cited 4/19/24 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services Previously cited 4/19/24

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51168 Based on observations and staff interviews, it was determined that the facility failed to store food in a sanitary manner. Findings include: Observations in the walk-in freezer on March 15, 2025, revealed that there was a large accumulation of ice on the fans and ceiling extending down to the food boxes on the top shelf. Interview with the Dietary Director on March 15, 2025, at 11:40am confirmed the ice buildup and stated, it is cleaned up after lunch. Observation in the walk freezer on March 16, 2025, at 9:08am revealed accumulation of ice on the fan still present ice on the fans and on ceiling. Interview with the Nursing Home Administrator on March 16, 2025, at 1:15 confirmed the above statement. 28 Pa. Code: 201.18(b)(3) Management 28 Pa. Code 211.6(f) Dietary services