| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 396082 | A. Building<br>B. Wing | 05/07/2026 |

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

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|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on staff and resident interview, observation, and clinical record review, it was determined that the facility failed to monitor a resident's skin after the application of an elastic wrap for one out of six residents reviewed (Resident 37).Findings include: A review of Resident 37's admission Minimum Data Set (MDS - a mandatory assessment of a resident's condition and care needs) dated April 20, 2026, revealed Resident 37 was moderately cognitively impaired and relied on staff for substantial assistance with personal care. Resident 37's diagnoses included pneumonia (a lung infection), acute respiratory failure (a condition where the lungs cannot provide enough oxygen to the blood), pulmonary hypertension (a type of high blood pressure affecting the blood vessels in the lungs and the right side of the heart), and cardiomyopathy (enlargement of the heart muscle). Resident 37 was receiving diuretic medication (removes excess fluid from the body), opioid medication (a narcotic pain medication), antiplatelet medication (medication to prevent blood clots), anticonvulsant medication (medication to control seizures), and continuous oxygen therapy.During resident interview and observation on May 4, 2026 at approximately 10:30 a.m., Resident 37 noted their left wrist had been x-rayed on May 3, 2026 because of pain. An elastic bandage was observed wrapped around the left wrist. Review of physician orders dated May 3, 2026, revealed an order for an x-ray of the left hand and wrist.Review of nursing progress notes dated May 4, 2026 revealed no fracture present.On May 6, 2026 at approximately 11:30 a.m. the elastic bandage was noted to be wrapped around Resident 37's wrist. When asked who placed the bandage, Resident 37 stated I don't know, someone who works here. This has been on for days now.Interview with Employee 4 on May 6, 2026 at approximately 12:45 p.m. revealed that they were aware that Resident 37 had an x-ray of the wrist, but they did not place a bandage on the wrist.Interview with the DON on May 6, 2026 at approximately 1:00 p.m. revealed that they were not aware that Resident 37 had an elastic bandage on the wrist and that there was no order to place the bandage or monitor the skin underneath the bandage. During observation at approximately 1:10 p.m., the DON removed the elastic bandage from the Resident 37's wrist to reveal a plastic identification bracelet on the left wrist that had been under the elastic bandage. The DON cut the plastic identification bracelet off Resident 37's wrist to reveal reddened, intact skin.The facility failed to ensure that Resident 37's skin was monitored after the placement of an elastic bandage over a plastic identification bracelet. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services |

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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on observation, review of facility policy, and clinical record review, it was determined that the facility failed to ensure physician orders for oxygen for one out of six residents reviewed (Resident 25).Findings include:Review of facility policy titled Oxygen Administration, undated, revealed the following: Oxygen is administered under orders of a provider, except in the case of an emergency where the resident [is] exhibiting signs and symptoms of respiratory distress.Review of Resident 25's admission Minimum Data Set (MDS - a mandatory assessment of a resident's condition and care needs) dated March 11, 2026 revealed Resident 25 was moderately cognitively impaired and totally dependent on staff to complete care needs. Resident 25's diagnoses included lung cancer and chronic respiratory failure (a condition where the lungs cannot deliver oxygen to the blood). Resident 25 was receiving antianxiety medication, hypnotic medication (medication for sleep), anticoagulant medication (medication to prevent blood clots), antibiotic medication (medication to treat infections), opioid medication (narcotic pain medication) and oxygen therapy.Observation of Resident 25 on May 4, 2026 at approximately 11:30 a.m. revealed the resident receiving 4 liters per minute (LPM) of oxygen via a nasal canula (N/C - tubing that delivers oxygen directly into the nostrils delivered by an oxygen concentrator (a machine that delivers supplemental oxygen). The oxygen tubing was labeled April 28, 2026.Review Resident 25's physician orders for March 2026 revealed an order dated March 31, 2026 to admit the resident to hospice but no orders for oxygen therapy.A nursing progress note dated March 6, 2026, at 4:28 a.m. revealed: oxygen on at 4.5L via N/C no distress noted.A nursing progress note dated March 19, 2026 at 02:14 a.m. revealed Oxygen increased to 5L via N/C.A nursing progress note dated April 3, 2026 at 3:06 a.m. revealed: Oxygen on at 2L via N/C.A nursing progress note dated April 21, 2026, at 3:08 a.m. revealed: Oxygen in place via N/C 4L sleeping at present time.A nursing progress note dated April 29, 2026, at 3:04 AM revealed: Oxygen on at 4L via N/CA nursing progress note dated May 1, 2026 at 1:04 a.m. revealed: Oxygen on at 4L via N/C and HOB (head of bed) elevated for comfort.Review of Resident 25's physician orders effective May 4, 2026 revealed no orders for oxygen.Review of nursing progress notes dated May 6, 2026 at 12:19 p.m. revealed: Received n/o (new orders) to titrate (adjust levels) oxygen as needed. Placed on 6L/min with good results.The facility failed to ensure a physician's order for oxygen was entered into the Medication Administration Record prior to administering continuous oxygen. 28 Pa. Code 211.5(f) Clinical Records Previously cited 5/16/2528 Pa. Code 211.12(d)(1)(3)(5) Nursing ServicesPreviously cited 5/16/2025 |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on a review of clinical records and staff interviews, it was determined that the facility failed to ensure that medications ordered by physicians were available for two of 19 residents reviewed (Residents 4 and 5).Findings Include:<br><br>A review of Resident 4's readmission notes dated April 8, 2026, at 10:28 p.m., revealed the resident was readmitted with a left hip fracture, post ORIF (Open Reduction and Internal Fixation- A two-part surgical procedure used to treat severe, displaced bone fractures by realigning the bone and securing it with hardware) to the left hip.<br><br>A review of Resident 4's physician's order dated April 8, 2026, revealed Heparin Sodium (anticoagulant) injection solution one ml (milliliter) subcutaneously (medication injected into the fatty tissue layer between the skin and muscle) every eight hours for DVT (Deep Vein Thrombosis- blood clot in the deep vein) prevention.<br><br>A review of Resident 4's April 2026 Medication Administration Record (MAR) revealed Heparin was not administered on the following dates/times: April 27, 2026, at 6:00 a.m., 2:00 p.m., and 10:00 p.m., and on April 28, 2026, at 6:00 a.m.<br><br>A review of Resident 4's nursing progress notes dated April 27, 2026, at 5:40 a.m., revealed: medication is not available in cart, reordered from pharmacy 4/26/26.<br><br>A review of Resident 4's nursing progress notes dated April 27, 2026, at 3:08 p.m., revealed Resident missed the Heparin at 2 pm, notified [name of nurse practitioner], called pharmacy to send it stat (immediately), not available in Pyxis (automated medication storage).<br><br>A review of the nursing progress notes dated April 28, 2026, at 5:37 a.m., revealed: Medication (Heparin) has not been received from pharmacy.<br><br>A review of Resident 4's progress notes revealed that physicians were not notified of the missed Heparin doses on April 27, 2026, at 6:00 a.m. and 10:00 p.m., and April 28, 2026, at 6:00 a.m.<br><br>An interview with the Director of Nursing, conducted on May 6, 2026, at 1:00 p.m., confirmed that Heparin medications were not administered to the resident due to the medication being unavailable from the pharmacy.<br><br>The facility failed to ensure Resident 4's medication to prevent blood clots was available for administration.<br><br>A review of Resident 5's physician orders dated March 23, 2026, at 9:00 p.m., revealed an active order for: Penicillin V Potassium Oral Tablet 500 MG (Penicillin V Potassium) Give 1 tablet by mouth two times a day for Osteomyelitis (a bone infection) for 6 Months.<br><br>A review of Resident 5's April 2026 and May 2026 Medication Administration Record (MAR) revealed Penicillin V Potassium was not administered on the following dates/times: April 28, 2026, at 9:00 a.m., and 9:00 p.m., April 29, 2026, at 9:00 a.m., and 9:00 p.m., April 30, 2026, at 9:00 a.m., and 9:00 p.m., May 1, 2026, at 9:00 a.m., and 9:00 p.m., May 2, 2026, at 9:00 a.m., and 9:00 p.m., May 3, 2026, at (continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 9:00 a.m., and 9:00 p.m., May 4, 2026, at 9:00 a.m.<br><br>A review of Resident 5's nursing progress notes dated April 28, 2026, at 9:20 a.m., revealed: medication not available - awaiting delivery from pharm. supervisor made aware and at 8:22 p.m., awaiting delivery via pharm.<br><br>A review of Resident 5's nursing progress notes dated April 29, 2026, at 9:55 a.m., revealed: waiting on pharm delivery and 9:03 p.m., Medication on order.<br><br>A review of Resident 5's nursing progress notes dated April 30, 2026, at 12:11 p.m., revealed: not available in cart, notified pharmacy, stated that they need a new doctors order for a refill, notified supervisor who is contacting (Doctors name).<br><br>A review of Resident 5's nursing progress notes dated May 1, 2026, at 10:26 a.m., revealed: awaiting refill from ordering physician and at 9:37 p.m., awaiting refill from Physician.<br><br>A review of Resident 5's nursing progress notes dated May 2, 2026, at 11:36 a.m., revealed: medication not refilled and at 10:11 p.m., medication on order.<br><br>A review of Resident 5's nursing progress notes dated May 3, 2026, at 9:57 a.m., revealed: medication on order.<br><br>A review of Resident 5's nursing progress notes dated May 4, 2026, at 11:25 a.m., failed to reveal any notes stating why the medication was not administered at 9:00a.m.<br><br>A further review of Resident 5's nursing progress notes dated May 3, 2026, at 4:40p.m., revealed: Called pharmacy to inquire about status of Penicillin script. Pharmacy stated they needed a new script. Note left for (Doctors name) requesting a new script for Penicillin.<br><br>An interview with the Director of Nursing conducted on May 06, 2026, at 1:54 p.m., confirmed medication was not administered to the resident due to the medication being unavailable from the pharmacy.<br><br>The facility failed to ensure Resident 5's medication to help treat osteomyelitis by killing the bacteria that are causing the bone infection was available for administration.<br><br>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the facility's policy, clinical records review, observations, and staff interviews, it was determined that the facility failed to practice infection control prevention and management for one of two residents reviewed (Resident 71).Findings:A review of the facility's policy titled Transmission-Based (Isolation) Precautions, revised on March 16, 2026, revealed that facility staff will apply Transmission-Based Precautions, in addition to standard precautions, to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission. The same policy revealed, healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination). A review of Resident 71's hospital's Summary Report dated April 30, 2026, revealed resident had Sepsis (The body's extreme reaction to an infection, without prompt treatment can lead to organ failure, tissue damage and death) from sacral pressure injury, and C. diff (Clostridium Difficile) colitis (Inflammation of the colon due to toxins released by the bacteria, leading to severe diarrhea, cramping and fever.) The same note revealed Post Hospital Care Requirement- Infection Control: Contact Isolation required due to C. diff and MDRO-GNR (Multi-Drug-Resistant Gram-Negative Rods- are bacteria resistant to multiple antibiotics, posing significant risk) status. A review of Resident 71's census revealed the resident was readmitted to the facility on [DATE]. A review of Resident 71's physician order dated May 4, 2026, revealed Contact precautions: r/t (related to) VRE (Vancomycin-resistant enterococci - are bacteria that have developed resistance to the antibiotic vancomycin) in wound / C-Diff (+) . An observation conducted on May 4, 2026, at 1:00 p.m., revealed a PPE supply outside the resident's room and a sign on the door indicating STOP CONTACT PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry, Discard gloves before room exit. Put on a gown before room entry. Discard gown before room exit. An observation conducted on May 7, 2026, at 9:00 a.m., revealed Employee E5 and E6 were both in the resident's room, the following were observed: Employee E6 standing at resident's bedside, talking and examining the resident. Employee E6 was observed only wearing a surgical mask. Further observations revealed Employee E5, who was only wearing gloves, was observed taking garbage from the resident's room, leaving the room without taking off their gloves or washing their hands, pushing a cart in the hallway with clean linens on top, with the left hand still carrying the plastic with garbage taken from the resident's room, then entered the soiled room. An interview was conducted with Employee E5 on May 7, 2026, at 9:05 a.m. Employee E5 reported that they don't need to wear a gown since they only repositioned the residents in bed and removed the trash. Employee E5 also reported that there were no signs indicating that gowns needed to be worn when entering the room. The surveyor showed the sign (contact precaution) posted on the resident's door to Employee E5. After the interview, Employee E5 was observed entering the resident's room without wearing PPE when the Assistant Director of Nursing, Employee E3, stopped and talked to the employee. Employee 5 was observed putting on gowns and gloves after conversing with Employee E3. Additional observations revealed Employee E6 left the room without washing hands, used the wall hand sanitizer across the resident's room to clean their hands, then walked in the hallway. An interview with Employee E6 on May 7, 2026, at 9:15: a.m., was conducted. Employee E6 reported cleaning their hands with alcohol-based sanitizer located across the resident's room, then washing their hands afterwards. Employee E6 confirmed that they did not wash their hands before leaving the resident's room. The above information was conveyed to the Director of Nursing (DON) on May 7, 2026, at 9:30 a.m. The facility failed to ensure infection<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | control prevention and management were implemented for a resident on contact precaution for positive C-diff.28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services |