STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396088	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Winds Healthcare and Rehabilitation, LLC	4112 Spring Hill Road Portage, PA 15946

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that non-pharmacological interventions were attempted prior to the administration of a psychotropic medication for one of 21 residents reviewed (Resident 5). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated April 8, 2026, revealed that the resident was cognitively impaired, was taking an anti-anxiety medication, and had a diagnosis of anxiety. A psychological assessment of Resident 5, dated Physician's orders for Resident 5, dated February 19, 2026, March 1, 2026, March 24, 2026, March 27, 2026, April 14, 2026 included orders for the resident to receive 1 milligram (mg) lorazepam every six hours as needed for anxiety. A review of the medication administration records (MAR) for Resident 5, dated March, and April 2026, revealed the resident was administered 1 mg of lorazepam on March 4 at 12:28 a.m. and 12:21 p.m., March 6, March 7 at 03:03 a.m. and 4:04 p.m. and 11:00 p.m., March 9 at 4:51 p.m. and 11:05 p.m., March 11, March 12 at 10:51 a.m. and 8:31 p.m., March 13, March 15, 16, 17, 18, 19, 22, 25, 26, 28, 29, March 30 at 9:00 a.m. and 9:59 p.m., April 2, 3, 4, 16, 19, 25, 26, and 27. There was no documented evidence that non-pharmacological interventions were attempted prior to the administration of lorazepam. Interview with the Director of Nursing on May 17, 2026 at 3:22 p.m. confirmed that there were no non-pharmacological interventions attempted prior to the administration of lorazepam for the dates listed above, and there should have been. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services 28 Pa. Code 211.12(c)(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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on review of Pennsylvania's Nursing Practice Act and clinical records, as well as staff interviews, it was determined that the facility failed to clarify a provider's orders for two of 21 residents reviewed (Resident 8, 48). Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain and restore the well-being of individuals. An admission Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 8, dated April 10, 2026, indicated that the resident was severely cognitively impaired, required assistance from staff for daily care needs, and had diagnoses that included a urinary tract infection and neurocognitive disorder with Lewy bodies (a progressive brain disorder causing memory loss). Physician's orders for Resident 8, dated April 24, 2026, included an order for the resident to receive Cefepime hydrochloric acid (HCl - an antibiotic) intravenously (IV) every twelve hours for seven days. Resident 8's medical record revealed that the resident had an allergy to Keflex (an antibiotic) which is in the same drug family as Cefepime HCl. A medication order note, dated April 30, 2026, identified the possible drug allergy to Cefepime HCl.There was no documented evidence that Resident 8's allergy to the Cefepime family was clarified with the physician prior to administering the medication. A review of Resident 8's Medication Administration Record (MAR) dated April and May 2026 revealed that the resident received the Cefepime as ordered. Interview with the Director of Nursing on May 17, 2026, at 3:19 p.m. revealed that Resident's 8 medication allergy should have been clarified with the physician prior to administering the medication, and it was not. An annual MDS assessment for Resident 48, dated February 28, 2026 indicated that the resident was cognitively impaired, required assistance from staff for daily care needs, and had diagnoses that included insulin dependent diabetes. Physician's orders for Resident 48, dated March 23, 2026 included an order for the resident's bedtime Insulin Glargine to increase to 52 units/milliliter (units/ml). Physician's orders for Resident 48, dated April 7, 2026, included an order for the resident to receive 52 units/milliliter (unit/ml) Insulin Glargine at bedtime. A physician's progress note for Resident 48, dated March 31, 2026 included an order to increase the resident's bedtime insulin to 20 units/ml. A physician's progress note for Resident 48, dated April 9, 2026 included an order to increase the resident's bedtime insulin to 20 units/ml. A physician's progress note for Resident 48, dated April 28, 2026 included an order to increase the resident's bedtime insulin to 20 units/ml. A physician's progress note for Resident 48, dated May 12, 2026 included an order to increase the resident's bedtime insulin to 20 units/ml. A review of Resident 48's Medication Administration Record (MAR) dated March 2026 revealed that the resident received 36 units of Insulin Glargine at bedtime from October 5, 2025 through March 24, 2026. On March 24, 2026 the resident received 44 units of Insulin Glargine at bedtime. From March 25 through March 31, 2026 the resident received 52 units/ml of Insulin Glargine at bedtime. April 7 through 27, 2026 the resident received 16 units of Insulin Glargine at bedtime. April 28 through May 5, 2026 the resident received 20 units of Insulin Glargine at bedtime. May 7 through May 16, 2026 the resident received 16 units/ml of Insulin Glargine at bedtime. Interview with the Director of Nursing on May 17, 2026 at 12:04 p.m. confirmed that Resident 48's bedtime Insulin Glargine orders were not consistent with the physician's orders and that the orders should have been clarified with the physician to confirm which dose of Insulin Glargine the resident was to receive. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and clinical record reviews, as well as staff interviews, it was determined that the facility failed to follow physician's orders for medications and treatments for seven of 21 residents reviewed (Residents 3, 6, 12, 16, 17, 24, and 48).Findings include: A facility policy regarding medication administration, dated August 26, 2025, indicated that staff are to obtain and record vital signs, when applicable or per physician's orders. When applicable, hold medications for those vital signs outside the physician's prescribed parameters. An annual Minimum Data Set (MDS) assessment (a mandatory assessment of a resident's abilities and care needs) for Resident 3, dated May 3, 2026, revealed that the resident was cognitively intact, was dependent on staff for her daily care needs, and had a diagnosis of insulin dependent diabetes. The resident's care plan, dated October 16, 2022 indicated that the resident would be medicated per the physician's orders. Physician's orders for Resident 3, dated October 4, 2025, included for the resident to receive 10 units/milliliters (units/ml) Insulin Glargine at bedtime and to hold if the resident's blood sugar was less than 70 or greater than 400. Review of Resident 3's Medication Administration Record (MAR) dated February, March, April, and May 2026 revealed that Resident 3 received the 10 units/ml Insulin Glargine at bedtime, however, staff were not checking the resident's blood sugar to determine if the insulin should have been held per the physician's order. Interview with the Director of Nursing on May 18, 2026 at 2:24 p.m. confirmed that staff should have been obtaining a blood sugar reading from Resident 3 prior to administering the Insulin Glargine at bedtime and they were not. A quarterly MDS assessment for Resident 6, dated April 12, 2026, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, and had medical diagnosis that included heart failure and a stroke. Physician's orders for Resident 6, dated December 18, 2025, included orders for the resident to receive 25 milligrams of metoprolol tartrate (used for high blood pressure) tablet every morning and at bedtime and to hold if systolic blood pressure (SBP) less than 100 or diastolic blood pressure (DBP) less than 60. Review of the Medication Administration Record (MAR) for Resident 6, dated March and April 2026, revealed that 25 milligrams of metoprolol tartrate was administered on March 15, 2026 when the resident's SBP was 98, April 1, 2026 when the resident's SBP was 98, April 22, 2026 when the resident's SBP was 98, and April 25, 2026 when the resident's SBP was 96. Physician orders for Resident 6 dated October 25, 2025, included orders for the resident to receive a sliding scale of Humalog (insulin) and to call the medical director if the blood sugar was greater than 401 mg/dl. Review of the Medication Administration Record for Resident 6 dated March, April and May 2026, revealed that on April 3, 2026, the residents blood sugar was 419 mg/dl, April 13, 2026, the residents blood sugar was 405 mg/dl, and on May 10, 2026, the residents blood sugar was 409 mg/dl. There is no documented evidence that the medical director was notified of the resident's blood sugar being over 401 mg/dl. Dermatology consult, for Resident 6 dated April 23, 2026, included orders for right upper arm biopsy dressing to be removed in 48 hours then clean the site with peroxide, apply a layer of Vaseline and secure with dry dressing once daily for the next seven to fourteen days. A wound consult for Resident 6 dated April 27, 2026, recommended to follow the dermatology recommended treatment orders to the biopsy site of cleaning the site with peroxide, applying a layer of Vaseline once daily and secure with dry dressing. A review of Treatment Administration Records for Resident 6, dated April 28, 2026, included orders for the biopsy site to be cleansed with wound cleanser, pat dry and apply xeroform and cover with dry dressing daily. Interview with the Director of Nursing on May 18, 2026, at 12:06 p.m. confirmed that staff did not hold Residents 6 metoprolol tartrate per physician orders. She confirmed that staff should have notified the medical director of Resident 6's elevated blood sugars. She also confirmed that Resident 6's treatment to her biopsy site was not completed per dermatology and wound consultant's orders. A quarterly MDS assessment for Resident 12 dated April 30, 2026, indicated that the resident was cognitively impaired, required supervision (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with daily care needs, and had diagnoses that included coronary heart disease and high blood pressure. Physician's orders for Resident 12, dated December 18, 2025, included orders for the resident to receive 10 milligrams (mg) of Amlodipine Besylate (used for high blood pressure) every morning and to hold if the systolic blood pressure (SBP-top number) was less than 100 millimeters of mercury (mmHg) or diastolic blood pressure (DBP-bottom number) was less than 60 mmHg. Review of the MAR for Resident 12, dated April and May 2026, revealed that there was no documented evidence that the resident's blood pressure was taken prior to administering 10 mg of Amlodipine Besylate on April 28, April 29, April 30, May 2, May 3, May 4, May 5, May 6, May 7, May 8, May 9, May 10, May 11, May 12, May 13, May 14, May 15 and May 16. Physician's orders for Resident 12, dated December April 23, 2025, included orders for the resident to receive 6.25 mg of Coreg (Carvedilol) (used for high blood pressure) every day and evening shift with meals and to hold if the SBP was less than 100 mmHg or DBP was less than 60 mmHg. Review of the MAR for Resident 12, dated April and May 2026, revealed that there was no documented evidence that the resident's blood pressure was taken prior to administering 6.25 mg of Coreg (Carvedilol) on April 28 on the day shift; April 29 on the day shift; April 30 and May 2 on the day and evening shift; May 3 on the day shift; May 4, 5, and 6 on the day and evening shift; May 7, 8, and 9 on the day shift; May 10 on the day and evening shift; May 11 on the day shift, May 12 on the day and evening shift; and on May 13, 14, 15 and 16 on the day shift. Interview with the Director of Nursing on May 17, 2026, at 1:56 p.m. confirmed that there was no documented evidence that Resident 12's blood pressure was obtained and documented prior to administering Amlodipine Besylate and Coreg (Carvedilol) on the above-mentioned dates/shifts. A quarterly MDS assessment for Resident 16 dated April 29, 2026, indicated that the resident was cognitively intact, required assistance with daily care needs, and had diagnoses that included heart failure and high blood pressure. Laboratory results for Resident 16, dated March 25, 2026, revealed that the medical director ordered the resident to receive 600 milligrams of magnesium oxide twice a day and to recheck the residents' magnesium level in one week. A review of Resident 16's Medication Administration Record dated March 25, 2026, revealed that the resident was receiving 400 milligrams of magnesium oxide three times a day. There is no documented evidence that the resident magnesium oxide order was changed per physician order or that laboratory for magnesium level was obtained per physician order. Interview with the Director of Nursing dated May 18, 2026, at 12:06 p.m. confirmed that Resident 16 was receiving the incorrect dose of magnesium oxide and that a magnesium level was not checked one week later and it should have been. A quarterly MDS assessment for Resident 17, dated March 20, 2026, indicated that the resident was cognitively intact, required assistance with daily care needs, used oxygen and Bipap, and had diagnoses that included acute and chronic respiratory failure (blood does not have enough oxygen and causes difficulty breathing) and Chronic Obstructive Pulmonary Disease (COPD- chronic lung disease making breathing difficult). Physician's orders for Resident 17, dated February 21, 2026, included orders for the resident to receive 300mg/2 milliliters (ml) of Dupixent (medication used to treat COPD) inject one applicatorful subcutaneously (delivers medication into the fatty layer of tissue directly between the skin and the muscle) in the morning every 14 days for COPDA nursing note for Resident 17, dated April 20, 2026, at 9:17 a.m. revealed that the resident's Dupixent was to be refilled on April 28, 2026, as noted from the insurance. Review of Resident 17's MAR for May 2026, revealed that the residents Dupixent was discontinued on May 2, 2026. A medication audit for the resident's Dupixent revealed that the medication was discontinued by Licensed Practical Nurse 6 on May 2, 2026. A physician's note for Resident 17, dated May 7, 2026, at 3:42 p.m. revealed that the resident had chronic respiratory failure and COPD. The resident followed with a pulmonologist every three months and was to continue her Dupixent. Interview with Resident 17 on May 16, 2026, at 11:16 a.m. revealed that she was getting Dupixent for her COPD and was told it was denied. She indicated that she had been without it for about five weeks, and she is supposed to get it twice a month. She was worried because there had been several times when she has gone into complete respiratory failure and needs the Dupixent. Interview with the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Director of Nursing on May 18, 2026, at 12:01 p.m. stated that she had no idea why Resident 17's Dupixent was discontinued. She stated that the medication comes from another pharmacy and it did arrive at the facility recently. Review of the resident's MAR for April 2026 and May 2026, revealed that the resident received her Dupixent on April 18, 2026, and should have received her next doses on May 2, 2026, and May 16, 2026. Interview with Registered Nurse 7 on May 18, 2026, at 12:13 p.m. indicated that Resident 17's Dupixent was on back order, but it did come and she had placed it in the refrigerator in the medication room. She could not recall the exact day it was delivered but noted it was recent and she had no idea why it would have been discontinued. Interview with the Director of Nursing on May 18, 2026, at 2:09 p.m. indicated that Resident 17's Dupixent comes from a specialty pharmacy. She does the ordering and authorization for the medication. She indicated that she had no idea how the medication got discontinued as it was ordered by the pulmonologist and should not have been discontinued. She confirmed that the resident missed two doses of her Dupixent and plans to have the physician reorder the medication. She indicated she was going to call the specialty pharmacy as well. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 24, dated May 7, 2026, indicated that the resident was cognitively intact, had limited range of motion to her upper and lower extremities, required assistance from staff for her daily care needs, and had diagnoses that included multiple sclerosis (disease that affects the nervous system causing physical and cognitive symptoms) A physician's order, dated May 5, 2026, included an order for the resident to be weighed weekly every Wednesday for four weeks for readmission.A review of the Treatment Administration Records (TAR's) for Resident 24 for May 2026 revealed the resident's weights were not obtained as ordered. An interview with the Director of Nursing on May 18, 2026, at 12:06 p.m. confirmed that Resident 24's weights were not obtained as ordered. An annual MDS assessment for Resident 48, dated February 28, 2026 indicated that the resident was cognitively impaired, required assistance from staff for daily care needs, and had diagnoses that included rheumatoid arthritis and spinal stenosis. The resident's care plan, dated February 24, 2025 indicated that the resident had pain and that she was to be medicated per the physician's orders. Physician's orders for Resident 48, dated [NAME] 7, 2026 included an order for the resident to receive 50 milligrams (mg) Lyrica (pain medication) every 12 hours for pain. A review of Resident 48's clinical record revealed that the resident was sent to the hospital on May 3, 2026 and returned to the facility on May 7, 2026. The physician's order for Lyrica was transcribed on readmission as 50 mg Lyrica every 12 hours as needed for pain and not every 12 hours routine as was ordered. An interview with the Director of nursing on May 17, 2026 at 12:04 p.m. confirmed that Resident 48's Lyrica should have been administered every 12 hours routine for pain, however, was transcribed incorrectly. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on review of clinical records as well as staff interviews, it was determined that the facility failed to provide care for pressure ulcers in accordance with professional standards of practice, by failing to ensure that treatments and recommendations from a wound consultant were reviewed and completed for two of 21 residents reviewed (Residents 4 and 52) who had pressure ulcers. Findings include: An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated April 11, 2026, indicated that the resident was cognitively intact, required assistance with daily care needs, had limited range of motion to her lower extremity, and had a stage IV pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling). A wound consult note, dated April 27, 2026, revealed Resident 4 had a stage IV pressure ulcer to her sacrum (lower part of spine) that had undermining (occurs when tissue beneath the wound edges erodes). The recommended treatment was to cleanse the wound with wound cleanser, apply collegen particles (topical treatment that promotes healing in chronic or non-healing wounds) and calcium alginate (highly absorbent material derived from seaweed) twice a day. Physician's order, dated April 27, 2026, included an order for the Stage IV pressure ulcer on the sacrum be cleansed with wound cleanser, and collegen particles and calcium alginate be applied and covered with a dry dressing every morning and at bedtime.A wound consult note, dated May 4 and 11, 2026, revealed that Resident 4 continued to have a Stage IV pressure ulcer to her sacrum and it was recommended to cleanse the wound with wound cleanser, and apply collegen particles and Silver (Ag) fiber (antibacterial gelling fiber dressing) daily.Treatment Administration Records (TAR's) for Resident 4 for May 2026 revealed that the resident continued to receive collegen particles and calcium alginate to the Stage IV pressure ulcer on her sacrum from May 5 through May 17, 2026. There was no documented evidence that the resident received Silver fiber to the wound as recommended on May 4 and 11, 2026.Interview with the Director of Nursing on May 18, 2026, at 2:17 p.m. confirmed that the wound recommendations on May 4 and 11, 2026 were not followed. An admission MDS assessment for Resident 52 dated April 17, 2026, indicated that the resident was cognitively impaired, required assistance with daily care needs, and had diagnoses that included pneumonia, multi-drug-resistant organism and gastrostomy status. A wound consultant note, dated May 4, 2026, revealed that Resident 52 had a Stage III pressure ulcer (full thickness skin loss where subcutaneous fat is visible.) to the coccyx, and a treatment of cleansing with wound cleanser applying calcium alginate and zinc oxide paste to peri wound, secure with boarded foam change daily and as needed. Recommendations for air mattress while in bed. Observation of Resident 52 on May 18, 2026, at 9:16 a.m. revealed that the resident was lying in bed and did not have an air mattress in place. Interview with the Director of Nursing on May 18, 2026, at 11:59 a.m. confirmed that the wound recommendations on May 4, 2026, were not followed. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that professional standards of practice were followed for the care of long-term intravenous catheters for one of 21 residents reviewed (Resident 8). Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that professional standards of practice were followed for the care of long-term intravenous catheters for one of 21 residents reviewed (Resident 8). Findings include: The facility's policy regarding intravenous (IV) catheters (a thin tube placed in a vein that can be used for an extended period of time to deliver fluids and/or medications), dated April 26, 2025, revealed that the catheter was to be flushed with 5 milliliters (ml) of normal saline (salt water solution) before and after the infusion (of medication). Physician's orders for Resident 8, dated April 24, 2026, included an order for the resident to receive 2 grams (g) of Cefepime Hydrochloric acid (HCl) (an antibiotic) IV every twelve hours for seven days, and a physician's order, dated May 1, 2026, was for the resident to receive 2 grams of IV Cefepime HCl (an antibiotic) one time only. A review of resident 8's Medication Administration Records (MAR's) for April and May 2026 revealed that staff administered IV Cefepime 14 times. There was no documented evidence that Resident 8's IV catheter was flushed pre or post Cefepime administration. An interview with the Director of Nursing on May 17, 2026, at 12:06 p.m. confirmed that the nurse should have flushed the IV catheter pre and post medication administration. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain accountability for controlled medications (drugs with the potential to be abused) for five of 21 residents reviewed (Residents 4, 5, 17, 24, 37). Findings include:The facility's policy regarding disposal of discontinued controlled/narcotic medications, dated August 25, 2026, revealed that controlled/narcotic medications must be destroyed in the presence of two licensed nurses. The two nurses will count together the remaining amount of controlled/narcotic medications to be destroyed. Two nurses will sign and date the control drug record upon witnessing the destruction of the controlled/narcotic medications, logging the amount of medications destroyed. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated April 11, 2026, indicated that the resident was able to make herself understood and could understand others, was cognitively intact, required assistance with care needs, had pain frequently, received routine and as needed pain medications, was taking an opioid medication (a controlled medications used to treat pain), and had diagnoses that included arthritis.Physician's orders for Resident 4, dated December 3, 2025, included an order for the resident to receive 5 milligrams (mg) of Oxycodone (opioid medication) every four hours as needed for spinal stenosis (narrowing of the spinal canal which can cause pain). A controlled drug accountability record (tracks each dose of a controlled medication) for Resident 4's Oxycodone revealed that one tablet was signed out on the controlled drug log on January 3 at 9:40 a.m.; February 1 at 9:00 a.m.; March 1 at 8:45 a.m.; March 11 at 8:00 p.m.; March 18 at 9:30 a.m.; April 1 at 12:47 p.m.; April 6 at 8:30 a.m.; and April 18, 2026, at 10:15 p.m. There was no documented evidence in the clinical record to indicate that the signed-out doses of Oxycodone were administered to Resident 4 on the above dates and times. Interview with the Director of Nursing on May 17, 2026, at 3:22 p.m. confirmed that there was no documented evidence that staff administered the Oxycodone to Resident 4 on the dates and times mentioned above.A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated April 8, 2026, revealed that the resident was cognitively impaired and was taking a pain medication. Physician's orders for resident 5 included an order for the resident to receive 0.25 milliliters (ml) oxycodone concentrate (narcotic pain medication) every six hours as needed for pain. A review of Resident 5's oxycodone concentrate controlled drug sheet revealed that 66 doses of the drug were received by the facility and that 16 doses were administered to the resident. There was no documented evidence that the remaining 50 doses of oxycodone concentrate were destroyed. A tour of the medication room on May 18, 2026 at 10:10 a.m. with Licensed Practical Nurse 8 revealed that there was no oxycodone concentrate for Resident 5. An interview with Licensed Practical Nurse 8 on May 18, 2026 at 10:10 a.m. revealed that 50 doses of oxycodone concentrate for Resident 5 should have been destroyed when the order was discontinued, however, there was no documentation to show that they were destroyed. An interview with the Director of Nursing on May 18, 2026 at 2:19 p.m. confirmed that there was no oxycodone concentrate for Resident 5 in the facility and there was no documented evidence that the drug had been destroyed. A quarterly MDS assessment for Resident 17, dated March 20, 2026, indicated that the resident was cognitively intact, required assistance with daily care needs, had pain occasionally, received as needed pain medications, was taking an opioid medication, and had diagnoses that included fibromyalgia (chronic condition causing pain in muscles and joints throughout the body). Physician's orders for Resident 17, dated January 27, 2026, included an order for the resident to receive 50 mg of Tramadol (opioid medication) every four hours as needed for moderate to severe pain. A controlled drug accountability record (tracks each dose of a controlled medication) for Resident 17's Tramadol revealed that one tablet was signed out on the controlled drug log on March 1 at 1:00 p.m.; March 2 at 2:53 a.m.; and March 6 at 4:26 a.m. There was no documented evidence in the clinical record to (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicate that the signed-out doses of Tramadol were administered to the resident on the above-mentioned dates and times. Interview with the Director of Nursing on May 18, 2026, at 2:21 p.m. confirmed that there was no documented evidence that staff administered the Tramadol to Resident 17 on the above-mentioned dates and times. A quarterly MDS assessment for Resident 24, dated May 7, 2025, indicated that the resident was able to make herself understood and could understand others, was cognitively intact, required assistance with care needs, had pain frequently, received as needed pain medications, was taking an opioid medication (a controlled medications used to treat pain), and had diagnoses that included multiple sclerosis (disease that affects the nervous system causing physical and cognitive symptoms).Physician's orders for Resident 24, dated February 27 and April 30, 2026, included an order for the resident to receive 50 mg of Tramadol (opioid medication) every four hours as needed for moderate to severe pain.A controlled drug accountability record (tracks each dose of a controlled medication) for Resident 24's Tramadol revealed that one tablet was signed out on the controlled drug log on March 1 at 12:50 p.m.; March 14 at 1:45 p.m.; March 15 at 2:00 p.m.; March 31 (no time); April 3 at 11:19 a.m.; May 15 at 5:30 a.m.; May 9 at 2:35 a.m. and May 15, 2026, at 5:30 a.m. There was no documented evidence in the clinical record to indicate that the signed-out doses of Tramadol were administered to Resident 4 on the above dates and times. Interview with the Director of Nursing on May 18, 2026, at 12:06 p.m. confirmed that there was no documented evidence that staff administered the Tramadol to Resident 4 on the dates and times mentioned above.A comprehensive MDS assessment for Resident 37, dated April 18, 2026, indicated that the resident was understood and could understand others, required assistance for personal hygiene needs, was taking pain medication as needed, and had diagnoses that included a fracture of lower end of right tibia and anxiety disorder. Physician's orders for Resident 37, dated February 26, 2026, included an order for the resident to receive 1 milligram (mg) of Alprazolam (a controlled anxiety medication) every eight hours as needed for anxiety. Review of the controlled drug record (a form that accounts for each tablet/pill/dose of a controlled drug) for Resident 37's Alprazolam for April 2026 indicated that a dose of Alprazolam was signed out on April 4 at 9:30 p.m. and April 26 at 6:00 a.m., however, was not signed as administered on the resident's MAR. Physician's orders for Resident 37, dated March 2, 2026, included an order for the resident to receive 10-325 mg of Hydrocodone-Acetaminophen (a controlled pain medication) every six hours as needed for pain. Review of the controlled drug record for Resident 37, dated April 2026 indicated that a dose of Hydrocodone-Acetaminophen was signed out on April 26, 2026, at 6:00 a.m., however, was not signed as administered on the resident's MAR. Interview with the Director of Nursing on May 20, 2026, at 1:21 p.m. confirmed that there was no documented evidence that Resident 37 received the signed-out doses of Alprazolam and Hydrocodone-Acetaminophen on the above-mentioned dates and times. 28 Pa. Code 211.9(a)(1) Pharmacy Services.28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on review clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents were offered the COVID vaccination and that education was provided to the resident and/or representative regarding the benefits and potential risks of the COVID vaccination for three of 21 residents reviewed (Residents 1, 36, and 52) and failed to ensure that staff were offered the COVID vaccination and that education was provided to the resident and/or representative regarding the benefits and potential risks of the COVID vaccination. Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated April 22, 2026, revealed that the resident was cognitively intact and was not up to date with the COVID vaccination. Review of the immunization records for Resident 1 revealed no documented evidence that the resident was offered, received, or refused the COVID vaccine and that education was provided to the resident and/or representative regarding the benefits and potential risks of the COVID vaccination. A quarterly MDS assessment for Resident 36, dated May 6, 2026, revealed that the resident was cognitively intact and was not up to date with the COVID vaccination. Review of the immunization records for Resident 36 revealed no documented evidence that the resident was offered, received, or refused the COVID vaccine and that education was provided to the resident and/or representative regarding the benefits and potential risks of the COVID vaccination. An admission MDS assessment for Resident 52, dated April 17, 2026, revealed that the resident was cognitively intact and was not up to date with the COVID vaccination. Review of the immunization records for Resident 52 revealed no documented evidence that the resident was offered, received, or refused the COVID vaccine and that education was provided to the resident and/or representative regarding the benefits and potential risks of the COVID vaccination. There was no documented evidence that the facility offered the COVID vaccination to staff and that education was provided to staff regarding the benefits and potential risks of the COVID vaccination Interview with the Infection Preventionist/Director of Nursing on May 18, 2026, at 11:46 a.m. revealed that there was no documented evidence that Residents 1, 36 and 52 were offered, received, or refused the COVID vaccine and that education was provided to the resident and/or representative regarding the benefits and potential risks of the COVID vaccination. She indicated that she documented in her log a list of residents offered the COVID vaccine, but there was no documentation that education was provided to the resident and/or representatives. She indicated that there was no COVID policy in place and that the facility follows the CDC guidelines. She indicated that they do not offer the COVID vaccine to staff. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on review of facility documents, and staff interviews, it was determined that the facility failed to provide training on Quality Assurance and Performance Improvement (QAPI) for five of five Nurse Aides reviewed (Nurse Aides 4, 5, 6, 7 and 8).Findings include: The facility assessment, dated January 2026, indicated that all personnel, including managers, staff, and volunteers, were to receive education related to Quality Assurance and Performance Improvement (QAPI). Review of Nurse Aide 4's education record dated 2024-2025 revealed that the employee did not have training on QAPI. Review of Nurse Aide 5's education record dated 2024-2025 revealed that the employee did not have training on QAPI. Review of Nurse Aide 6's education record dated 2024-2025 revealed that the employee did not have training on QAPI. Review of Nurse Aide 7's education record dated 2024-2025 revealed that the employee did not have training on QAPI. Review of Nurse Aide 8's education record dated 2024-2025 revealed that the employee did not have training on QAPI. An interview with the Nursing Home Administrator on May 18, 2026, at 2:26 p.m. confirmed that there was no documented evidence that Nurse Aides 4, 5, 6, 7 and 8 received the facility's annual education regarding QAPI. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a) Staff development.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to inform the resident and/or resident representative in advance of the risks and benefits of psychotropic medications (medications that affect the persons mental state, emotions and behavior) and the treatment alternatives prior to initiating the administration of the medication for two of 21 residents reviewed (Residents 24 and 36).Findings include: A facility policy regarding use of psychotropic medications, dated August 26, 2025, indicated that prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase. The resident has the right to accept or decline the initiation or increase of a psychotropic medication. The facility will document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and the preferred option to accept or decline in a format the facility deems to use (written consent form, narrative note, etc.). A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 24, dated January 30, 2026, revealed that the resident was cognitively intact and did not receive psychotropic medications.A psychiatry progress note for Resident 24, dated March 2, 2026, recommended to start buspirone (an antianxiety medication) 5 milligrams (mg) twice daily for anxiety.Physician's orders for Resident 24, dated March 2, 2026, included an order for the resident to receive 5 mg of buspirone every morning and bedtime for anxiety.There was no documented evidence in Resident 24's clinical record to indicate that the resident and/or resident representative was informed in advance of the risks and benefits and treatment alternatives prior to initiating buspirone. An admission MDS assessment for Resident 36, dated May 6, 2026, revealed that the resident was cognitively intact, received psychotropic medications including antianxiety medications and antidepressant medications, and had diagnoses including adjustment disorder with mixed anxiety and depressed mood. A psychiatry progress note for Resident 36, dated May 11, 2026, recommended to start buspirone (an antianxiety medication) 2.5 milligrams (mg) twice daily for adjustment disorder with anxiety and depression. Physician's orders for Resident 36, dated May 11, 2026, included an order for the resident to receive 2.5 mg of buspirone every 12 hours for anxiety. Physician's orders for the resident, dated May 13, 2026, included an order for the resident to receive 2.5 mg of buspirone every day and evening shift for anxiety. There was no documented evidence in Resident 36's clinical record to indicate that the resident and/or resident representative was informed in advance of the risks and benefits and treatment alternatives prior to initiating buspirone. Interview with the Director of Nursing on May 17, 2026, at 2:36 p.m. confirmed that there was no documented evidence in Resident 24 and 36's clinical record to indicate that the resident and/or resident representative was informed in advance of the risks and benefits and treatment alternatives prior to initiating buspirone. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(2) Management. 28 Pa. Code 201.29(a): Resident rights.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for three of 21 residents reviewed (Residents 2, 4, 7).Findings include:The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (required assessments of a resident's abilities and care needs), dated October 2025, revealed that Section N0415B1 Antianxiety medications was to be coded if the resident took the medication during the seven-day look-back period, Section N0415F1 Antibiotic medications was to be coded if the resident took the medication during the seven-day look-back period, and Section N0415J1 Hypoglycemic medications was to be coded if the resident took the medication during the seven-day look-back period.Physician's orders for Resident 2, dated October 6, 2025, included an order for the resident to receive 0.5 milligrams (mg) of lorazepam (an antianxiety medication) every morning and at bedtime for anxiety/restlessness. A review of Resident 2's Medication Administration Record (MAR) dated March 2026 revealed that the resident received the anti-anxiety medication daily during the seven day look back period. However, A quarterly MDS assessment for Resident 2, dated March 17, 2026, revealed that Section N0145B was not coded, indicating that the resident did not receive an antianxiety medication during the seven-day look-back period. Physician's orders for Resident 4, dated October 24, 2025, included an order for the resident to have a small amount of bacitracin ointment applied to the nephrostomy tube (thin catheter that drains urine from the kidney into a bag) exit wound weekly. The resident's Treatment Administration Record (TAR) for April 2025 revealed that the resident received bacitracin to the nephrostomy tube exit wound on April 3 and 10, 2026. However, an annual MDS assessment for Resident 4, dated April 11, 2026, revealed that Section N0401F1 was not coded, indicating that the resident did not receive antibiotic medication during the seven-day look-back period. Physician's orders for Resident 7, dated November 29, 2025, included an order for the resident to receive 500 mg of Metformin hydrochloride (a hypoglycemic medication) by mouth every morning and at bedtime for diabetes. Physician's orders for Resident 7, dated June 3, 2025, included an order for the resident to receive 5 milligrams of Linagliptin (a hypoglycemic medication) every morning for diabetes. A quarterly MDS assessment for Resident 7, dated February 24, 2026, revealed that Section N0415J (Hypoglycemic) was not coded, indicating that the resident did not receive hypoglycemic medication during the seven-day look-back period. Interview with the Director of Nursing on May 18, 2026, at 2:06 p.m. confirmed that Resident 2, 4, and 7's MDS assessments were coded incorrectly.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to develop and implement an individualized care plan for two of 21 residents reviewed (Residents 24 and 36).Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 24, dated May 7, 2026, revealed that the resident was cognitively intact and received an antidepressant medication.Physician's orders for Resident 24, dated April 30 and May 11, 2026, included an order for the resident to receive 5 mg of buspirone every morning and bedtime for depression and then 2.5 mg of buspirone every morning and night for depression.Medication Administration Records (MAR's) for Resident 24 for May 2026, revealed the resident received buspirone from May 1 through May 18, 2026.There was no documented evidence that a care plan was developed to address Resident 24's depression and use of buspirone.Interview with the Director of Nursing on May 18, 2026, at 12:06 p.m. confirmed that the resident did not have a care plan developed to address Resident 24's depression and use of an antidepressant medication. An admission MDS assessment for Resident 36, dated May 6, 2026, revealed that the resident was cognitively intact, required assistance with daily care needs and had a diagnosis of malnutrition. An admission assessment for Resident 36, dated May1, 2026, revealed that the resident had upper and lower dentures. Interview with the resident on May 16, 2026, at 10:53 a.m. revealed that she did have dentures and wore them daily, but she did not have them in at the time of the interview. Observations at 10:59 a.m. revealed that the resident's dentures were in a denture cup at the sink in the resident's room. There was no documented evidence that a care plan was developed to address that Resident 36 had upper and lower dentures and wore them daily. Interview with the Director of Nursing on May 16, 2026, at 3:10 p.m. confirmed that the resident did not have a care plan developed to address Resident 36's need for dentures. 28 Pa. Code 211.11(d) Resident care plan. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for four of 21 residents reviewed (Residents 13, 16, 24 and 52).Findings include: A facility policy for Care Plan Revisions Upon Status Change dated August 26, 2025, indicated that the comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 13, dated February 15, 2026, indicated that the resident was cognitively intact, did not receive an anticoagulant, and had diagnoses that included high blood pressure and dementia. Current physician's orders for Resident 13 included an order to receive 5 milligrams (mg) of apixaban (anticoagulant) twice a day for atrial fibrillation (irregular heartbeat),.A review of the Medication Administration Records (MAR's) for Resident 13 for May 2026 revealed the resident was not receiving apixaban.The current care plan for Resident 13 indicated that the resident was receiving anticoagulant therapy (a blood thinner).An interview with the Director of Nursing on May 18, 2026, at 2:19 p.m. confirmed that Resident 13 was not receiving anticoagulant medications and the care plan should have been revised to reflect that, however it was not. A quarterly MDS assessment for Resident 16 dated April 29, 2026, indicated that the resident was cognitively intact, required assistance with daily care needs, and had diagnoses that included heart failure and high blood pressure. The current care plan for Resident 16 dated March 6, 2025, indicated that the resident was receiving anticoagulant therapy (a blood thinner). Review of the Medication Administration Record (MAR) for Resident 16 dated May 2026, revealed no documented evidence that the resident was receiving an anticoagulant medication. An interview with the Director of Nursing on May 18, 2026, at 2:18 p.m. confirmed that Resident 16 was not receiving anticoagulant medications and that the care plan should have been revised to reflect that. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 24, dated May 7, 2026, indicated that the resident was cognitively intact, had limited range of motion to her upper and lower extremities, required assistance from staff for her daily care needs, and had diagnoses that included multiple sclerosis (disease that affects the nervous system causing physical and cognitive symptoms).A physician's order, dated November 25, 2025, included an order for the resident to utilize bilateral resting hand splints two hours on and two hours off.A review of the Treatment Administration Records (TAR's) for Resident 24 for May 2026 revealed the resident was not using resting hand splints and they had been discontinued on April 8, 2026.The current care plan for Resident 24 indicated that the resident was to utilize resting hand splints on for two hours and off for two hours.An interview with the Director of Nursing on May 18, 2026, at 12:06 p.m. confirmed that Resident 24 was not utilizing hand splints and the care plan should have been revised to reflect that, however it was not. An admission MDS assessment for Resident 52 dated April 17, 2026, indicated that the resident was cognitively impaired, required assistance with daily care needs, and had diagnoses that included pneumonia, multi-drug-resistant organism and gastrostomy status. The Care plan for Resident 52 dated April 9, 2026, indicated that the resident was receiving anticoagulant therapy (a blood thinner). Review of the Medication Administration Record (MAR) for Resident 52 dated May 2026, revealed no documented evidence that the resident was receiving an anticoagulant medication. An interview with the Director of Nursing on May 18, 2026, at 2:18 p.m. confirmed that Resident 52 was not receiving anticoagulant medications and that Resident 52's care plan should have been revised to reflect that, however it was not. 28 Pa. Code 211.12(d)(5) Nursing services.

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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 review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident had dentures in place for breakfast for one of 21 residents reviewed (Resident 36). Findings include: The facility's policy regarding care of dentures, dated August 26, 2025, revealed that nursing staff will provide denture care. If a resident is unable to care for their own dentures, dentures will be cleaned for them during routine oral care. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 36, dated May 6, 2026, revealed that the resident was cognitively intact, required assistance with daily care needs and had a diagnosis of malnutrition. A physician's order for Resident 36, dated May 15, 2026, included an order for the resident to receive a regular diet, mechanical soft texture with nectar consistency liquids. An admission assessment for Resident 36, dated May 1, 2026, revealed that the resident had upper and lower dentures. Interview with the resident on May 16, 2026, at 10:53 a.m. revealed that the resident was edentulous at the time of the interview, and she indicated that she had dentures and did not have them in for breakfast that day. Observations at 10:59 a.m. revealed that her dentures were in a denture cup at the sink in the resident's room. Interview with Nurse Aide 1 at that time confirmed that she did not have her dentures in. She indicated that she probably did not need them so much before when she was on a purred diet, but her diet was upgraded the previous day to mechanical texture. Nurse Aide 1 cleaned the resident's dentures and gave them to the resident. The dentures were not in reach of the resident or accessible for her to clean or put in herself. Interview with the Director of Nursing on May 16, 2026, at 3:10 p.m. confirmed that the resident should have had her dentures in prior to her receiving her breakfast tray. Interview with the Therapy Manager on May 17, 2026, at 2:16 p.m. confirmed that when they worked with Resident 36, she typically had her teeth in. She stated that when she had been on a pureed diet, she would not have expected her to need her teeth, but since her diet was updated to mechanical on May 15, 2026, she would expect her to have to teeth in to assist her with chewing. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that the resident environment was as free of accident hazards by failing to complete safety assessments for air mattress use for three of 21 residents reviewed (Residents 4, 6, 24).Findings include: The facility's policy regarding air mattresses, dated August 26, 2025, indicated that the air mattress would be used in accordance with evidence-based practice for residents with or at risk for pressure injuries. Air mattresses would be chosen by matching the potential therapeutic benefit with the resident's specific situation. Considerations for utilizing air mattresses included: medical condition, size and weight, mobility and activity levels, need for moisture control or shear reduction, presence of pressure injuries, risk of developing a pressure injury or at high risk for additional pressure injuries, pain and discomfort, and an excessive amount of penetration of the surface. Air mattresses would be utilized in accordance with manufacturer's recommendations (including considerations for contraindications). A schedule for inspection and replacement would be established accordingly.An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated April 11, 2026, revealed that the resident was cognitively intact, had limited range of motion of the lower extremities, required assistance from staff for daily care needs, and had a pressure ulcer. The resident's care plan, dated April 10, 2024, revealed that the resident had a pressure sore and used an air mattress. There was no documented evidence that the use of an air mattress was assessed for potential safety hazards prior to the air mattress being placed on Resident 4's bed.Observations on May 18, 2026, at 8:49 a.m. revealed that Resident 4 was in bed with an air mattress in place. A quarterly MDS assessment for Resident 6, dated April 12, 2026, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included heart failure and a stroke. Physician's orders dated April 13, 2026, included an order for the resident's bed to be equipped with an air mattress. Observations on May 16, 2026, at 11:05 a.m. revealed that Resident 6's bed was equipped with an air mattress. There was no documented evidence that the use of an air mattress was assessed for potential safety hazards prior to the air mattress being placed on Resident 6's bed. A quarterly MDS assessment for Resident 24, dated May 7, 2026, revealed that the resident was cognitively intact, had limited range of motion of the upper and lower extremities, required staff assistance for daily care needs, had pressure ulcers, and had diagnoses that included multiple sclerosis (disease that affects the nervous system causing physical and cognitive symptoms). Resident 24's care plan, dated October 27, 2025, revealed that the resident had a pressure sore and used an air mattress. There was no documented evidence that the use of an air mattress was assessed for potential safety hazards prior to the air mattress being placed on Resident 24's bed.Observations on May 18, 2026, at 8:50 a.m. revealed that Resident 24 was in bed with an air mattress in place.Interview with the Director of Nursing on May 18, 2026, at 12:06 p.m. confirmed that Residents 4, 6, and 24 did not have an assessment completed regarding potential safety hazards prior to the air mattress being placed on the residents' beds. 28 Pa. Code 211.10(c)(d) Resident Care Policies.28 Pa. Code 211.12(d)(5) Nursing services.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on review of clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure nephrostomy output was monitored for one of 21 residents reviewed (Resident 4) who had a nephrostomy tube (a flexible tube inserted into the kidney to drain urine), and failed to ensure that a follow up appointment was kept for one of 21 residents reviewed (Resident 5).Findings include: An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated April 11, 2026, revealed that the resident was cognitively intact, had limited range of motion of the lower extremities, required assistance from staff for daily care needs, had nephrostomy tubes (thin catheter inserted through the skin into the kidney to allow urine to drain directly into a collection bag outside the body), and diagnoses that included renal disease and obstructive uropathy (blockage in the urinary system).Physician's orders, dated October 23, 2025, included orders for staff to empty the resident's bilateral nephrostomy tubes and record the output every shift. The resident's care plan, dated April 9, 2024, revealed that the resident's nephrostomy tubes were to be emptied every shift.A review of the Treatment Administration Records (TAR's) for February, March, April, and May 2026 revealed that the output from the nephrostomy tubes was not obtained every shift on February 5, 6, and 18, March 18, April 1 and 26, and May 3 and 8, 2026.Interview with the Director of nursing on May 18, 2026, at 2:17 p.m. confirmed that there was no documented evidence that the output from Resident 4's nephrostomy tubes were recorded every shift as ordered on the mentioned dates. A quarterly MDS assessment for Resident 5, dated April 8, 2026 revealed that the resident was cognitively impaired and had an indwelling urinary catheter (a tube inserted directly into the bladder to drain urine). Hospital discharge orders, dated January 10, 2026 included an order for the resident to complete a voiding trial (remove urinary catheter to urinate independently) by January 13, 2026 and then to follow up with urology (doctor specializing in urinary issues) on January 21, 2026 at 8:00 a.m. There was no documented evidence that Resident 5 had a voiding trial or that he attended the follow up appointment with urology as scheduled. Interview with Registered Nurse 7 on May 18, 2026 at 2:44 p.m. confirmed that the resident did not have a voiding trial and did not attend the follow up appointment with urology on January 21, 2026. Interview with the Director of Nursing on May 18, 2026 at 2:19 p.m. confirmed that Resident 5 did not attend his follow up appointment with urology. 28 Pa. Code 211.12(d)(5) Nursing Services.

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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. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders were followed for one of 21 residents reviewed (Resident 52) who had a feeding tube.Findings include: The facility policy regarding enteral tube feedings, dated August 26, 2025, indicated that prior to the administration of the tube feeding, staff were to verify the placement of the feeding tube and were to document the verification of the tube placement. The tube feed was to be flushed before and after feedings and medications. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 52, dated April 17, 2026, indicated that the resident was cognitively impaired, required assistance from staff for daily care tasks, and had a feeding tube. Physician's orders for Resident 52, dated April 14, 2026, included orders for the resident to receive Jevity 1.5 (a tube feeding formula) 237 milliliters five times a day. Observations for Resident 52 tube feed administration on May 18, 2026, at 9:18 a.m. revealed that Licensed Practical Nurse 2 gathered supplies, washed her hands applied gloves, listened for bowel sounds and then attached feeding syringe and started to pour Jevity 1.5 237 milliliters into the syringe by gravity. Interview with Licensed Practical Nurse 2 on May 18, 2026, at 9:26 a.m. confirmed that she did not check placement prior to administering the feeding and that there was no physician order for flushing the feeding tube before or after administering the feeding. Interview with the Director of Nursing on May 18, 2026, at 11:59 a.m. confirmed that there is no documentation that staff are verifying Resident 52's feeding tube placement with residual. She also confirmed there was no documentation of flushing the feeding tube before and after feedings and medications. 28 Pa. Code 211.12(d)(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. Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to administer a resident's continuous oxygen as ordered for one of 21 residents reviewed (Resident 12). Findings include: The facility's policy regarding oxygen therapy, dated August 26, 2025, indicated that oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 12 dated April 30, 2026, indicated that the resident was cognitively impaired, required supervision with daily care needs, received oxygen therapy, and had a diagnosis of coronary artery disease (CAD-a disease that limits blood flow to the heart caused by plaque buildup in the arteries). Physician's orders for Resident 12, dated May 10, 2026, included an order for the resident to receive continuous oxygen at a flow rate of 1-5 liters per minute (LPM) via nasal cannula (tubes that deliver oxygen into the nostrils) every shift and as needed. Observations of Resident 12 on May 16, 2026, at 12:04 p.m. revealed that the resident was in the dining room eating her lunch meal with an oxygen tank on the back of her wheelchair. The oxygen tank was set at 2 LPM and the tank was reading empty. An interview with Nurse Aide 1 on May 16, 2026, at 12:29 p.m. confirmed that the resident's oxygen tank was empty. Interview with Licensed Practical Nurse 3 on May 16, 2026, at that time, confirmed that the tank was empty and indicated that the resident mostly needs her oxygen at night and that her pulse oximetry (measures blood oxygen levels) usually runs in the low 90's. The resident's oxygen tank was replaced with a full tank and she was taken back to room and was placed on an oxygen concentrator. A nursing note for Resident 12, dated May 16, 2026, at 12:45 p.m. revealed that the resident's oxygen noted to be empty on her portable tank while in the dining hall. Upon checking the resident's pulse oximetry, it was determined that her pulse oximetry was ranging anywhere from 80-94% but not holding continuously. Her nail polish was removed from her finger and her pulse oximetry was obtained and ranged anywhere from 99% down to 80%. The resident's oxygen was on at 2 LPM via nasal cannula. The registered nurse was notified, and the doctor was notified. Her oxygen was increased to 3 LPM via nasal cannula and her pulse oximetry was 94% at two different times. Interview with the Director of Nursing on May 16, 2026, at 3:10 p.m. confirmed that Resident 12's oxygen tank was empty and should have been checked and replaced. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on a review of clinical records, as well as staff interviews, it was determined that the facility failed to maintain clinical records that were complete and accurately documented for one of 21 residents reviewed (Resident 17). Findings include: A quarterly MDS assessment for Resident 17, dated March 20, 2026, indicated that the resident was cognitively intact, required assistance with daily care needs, had pain occasionally, received as needed pain medications, was taking an opioid medication (a controlled medication used to treat pain), and had diagnoses that included fibromyalgia (chronic condition causing pain in muscles and joints throughout the body). Physician's orders for Resident 17, dated January 27, 2026, included an order for the resident to receive 50 mg of Tramadol (opioid medication) every four hours as needed for moderate to severe pain. Review of Resident 17's Medication Administration Record (MAR) for April 2026, revealed that the resident received 50 mg of Tramadol on April 8 at 7:39 a.m.; April 9 at 7:10 a.m.; April 10 at 6:40 a.m.; April 11 at 6:12 p.m.; April 13 at 5:04 a.m. and 10:03 a.m.; April 14 at 7:26 a.m.; April 15 at 4:16 p.m. and 10:21 p.m.; April 16 at 6:15 a.m.; April 17 at 6:30 a.m., 4:31 p.m. and 10:14 p.m.; April 18 at 3:44 a.m. and 7:53 a.m.; April 19 at 7:02 a.m. and 6:57 p.m.; April 20 at 1:27 a.m.; April 21 at 6:58 a.m. and 8:03 p.m.; April 22 at 2:12 a.m. and 6:53 a.m.; April 23 at 7:02 a.m., 11:09 a.m., 4:13 p.m., and 9:43 p.m.; April 24 at 3:31 a.m.; April 25 at 6:21 p.m.; April 27 at 3:28 p.m.; and April 28 at 5:00 a.m. However, there was no documented evidence in the resident's clinical record of a controlled medication record (a form that accounts for each tablet/pill/dose of a controlled drug) from April 8 through April 28 to verify the administration of 50 mg of Tramadol on the above-mentioned dates and times. Interview with the Director of Nursing on May 18, 2026, at 12:01 p.m. confirmed that there was no documented evidence in Resident 17's clinical record of a controlled medication record from April 8 through April 28 to verify the administration of 50 mg of Tramadol on the above-mentioned dates and times. 28 Pa Code 211.5(f) Clinical Records. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies.Findings include: The facility's deficiencies and plan of corrections for an annual survey ending July 2, 2025, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending May 18, 2026, identified repeated deficiencies related to accurate MDS assessments, creation of care plans, revision of care plans, quality care, safety/accidents, bowel/bladder incontinence and indwelling urinary catheters, maintenance of IV catheters, narcotic accountability, and infection control. The facility's plan of correction for a deficiency regarding accurate MDS assessments, cited during the survey ending July 2, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F641, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that MDS assessments were completed accurately. The facility's plan of correction for a deficiency regarding care plan creation, cited during the survey ending July 2, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F656, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that care plans were created timely. The facility's plan of correction for a deficiency regarding care plan revision, cited during the survey ending July 2, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F657, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that care plans were revised timely. The facility's plan of correction for a deficiency regarding quality care, cited during the survey ending July 2, 2025 revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that quality care was provided. The facility's plan of correction for a deficiency regarding safety / accident hazards, cited during the survey ending July 2, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F689, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that safety / accident hazards were prevented. The facility's plan of correction for a deficiency regarding bowel/bladder incontinence and indwelling urinary catheters, cited during the survey ending July 2, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F690, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that bowel/bladder incontinence and indwelling urinary catheters were treated appropriately. The facility's plan of correction for a deficiency regarding maintenance of IV catheters, cited during the survey ending July 2, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F694, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that IV catheters were maintained appropriately. The facility's plan of correction for a deficiency regarding narcotic accountability, cited during the survey ending July 2, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F755, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that narcotics were appropriately accounted for. The (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's plan of correction for a deficiency regarding infection control, cited during the survey ending July 2, 2025, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F880, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that infection control was properly maintained. Refer to F641, F656, F657, F684, F689, F690, F694, F755, F880. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.

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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 review of established infection control guidelines, facility policy, and residents' clinical records, as well as observations and staff interviews, it was determined that the facility failed to follow infection control guidelines from the Centers for Medicare/Medicaid Services (CMS) and the Centers for Disease Control (CDC) to reduce the spread of infections and prevent cross-contamination for one of 21 residents reviewed (Resident 52). Findings include: CDC guidance on isolation precautions and Implementation of Personal Protective Equipment (PPE) use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDRO's - bacteria that have become resistant to certain antibiotics, and these antibiotics can no longer be used to control or kill the bacteria), dated July 12, 2022, indicates that MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. CMS updated its infection prevention and control guidance effective April 1, 2024. The recommendations now include the use of EBP during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, in addition to residents who have an infection or colonization with a CDC-targeted or other epidemiologically important MDRO when contact precautions do not apply. The facility's policy regarding EBP, dated August 26, 2025, the facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO that is currently targeted by CDC may be considered epidemiologically important. An order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds (e.g. chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g. central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters. PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO. An admission MDS assessment for Resident 52 dated April 17, 2026, indicated that the resident was cognitively impaired, required assistance with daily care needs, and had diagnoses that included pneumonia, multi-drug-resistant organism and gastrostomy status. A wound consultant note, dated May 4, 2026, revealed that Resident 52 had a Stage III pressure ulcer (full thickness skin loss where subcutaneous fat is visible.) to the coccyx, and a treatment of cleansing with wound cleanser applying calcium alginate and zinc oxide paste to peri wound, secure with boarded foam change daily and as needed. Observations for Resident 52 tube feed administration on May 18, 2026, at 9:18 a.m. revealed that Licensed Practical Nurse 2 gathered supplies, washed her hands applied gloves, listened for bowel sounds and then attached feeding syringe and started to pour Jevity 1.5 237 milliliters into the syringe by gravity. Interview with Licensed Practical Nurse 2 on May 18, 2026, at 9:26 a.m. confirmed that Resident 52 should have had enhanced barrier precautions while completing feeding and that he did not have supplies or signage in his room. Interview with the Director of Nursing on May18, 2025, at 11:59 a.m. confirmed that Resident 52 should have had an enhanced barrier precaution sign on his door and while providing feeding via gastrostomy tube. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that each resident was offered and/or received the influenza immunization for one of 21 residents reviewed (Resident 24) and failed to ensure that each resident was offered and/or received the pneumococcal immunization for five of 21 residents reviewed (Residents 1, 5, 24, 48 and 52). Findings include: The facility's policy regarding the influenza vaccine, dated August 26, 2025, indicated that between October 1 and March 31 each year, the influenza vaccine shall be offered to residents unless the vaccine is medically contraindicated or the resident has already been immunized during that time. For those who receive the vaccine, the date of the vaccine, lot number, expiration date, person administering, and the site of the vaccination shall be documented in the resident's medical record. A resident's refusal of the vaccine shall be documented on the informed consent form and placed in the resident's medical chart. The infection preventionist and/or designee will maintain surveillance data on the influenza vaccine coverage. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 24, dated May 7, 2026, revealed that the resident was cognitively intact and was not offered the influenza vaccine. Review of the immunization records for Resident 24 revealed no documented evidence that the resident was offered, received, or refused the influenza vaccine for this year's influenza vaccination season. The facility's policy regarding the pneumococcal vaccine, dated August 26, 2025, indicated that prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series unless medically contraindicated or the resident has already been vaccinated. For those who receive the vaccine, the date of the vaccine, lot number, expiration date, person administering, and the site of the vaccination shall be documented in the resident's medical record. A resident's refusal of the vaccine shall be documented on the informed consent form and placed in the resident's medical chart. A quarterly MDS assessment for Resident 1, dated April 22, 2026, revealed that the resident was cognitively intact and was not offered the pneumococcal vaccine. Review of the immunization records for Resident 1 revealed no documented evidence that the resident was offered, received, or refused the pneumococcal vaccine. A quarterly MDS assessment for Resident 5, dated April 22, 2026, revealed that the resident was cognitively impaired and was not offered the pneumococcal vaccine. Review of the immunization records for Resident 5 revealed no documented evidence that the resident was offered, received, or refused the pneumococcal vaccine. A quarterly MDS assessment for Resident 24, dated May 7, 2026, revealed that the resident was cognitively intact and was not offered the pneumococcal vaccine. Review of the immunization records for Resident 24 revealed no documented evidence that the resident was offered, received, or refused the pneumococcal vaccine. A quarterly MDS assessment for Resident 36, dated May 6, 2026, revealed that the resident was cognitively intact and was not offered the pneumococcal vaccine. Review of the immunization records for Resident 36 revealed no documented evidence that the resident was offered, received, or refused the pneumococcal vaccine. An annual MDS assessment for Resident 48, dated February 28, 2026, revealed that the resident was cognitively intact and was not offered the pneumococcal vaccine. Review of the immunization records for Resident 48, undated, revealed no documented evidence that the resident was offered, received, or refused the pneumococcal vaccine. An admission MDS assessment for Resident 52, dated April 17, 2026, revealed that the resident was cognitively intact and was not up to date with the COVID vaccination. Review of the immunization records for Resident 52 revealed no documented evidence that the resident was offered, received, or refused the pneumococcal vaccine since admission. Interview with the Infection Preventionist/Director of Nursing on May 18, 2026, at 11:46 a.m. confirmed that Residents 24 was not offered the influenza vaccine during this year's flu season and she should have been, and confirmed that Residents 1, 5, 24, 48 and 52 were not offered a pneumococcal vaccine and that they should have been. 28 Pa. Code 201.14(a) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396088	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Winds Healthcare and Rehabilitation, LLC	4112 Spring Hill Road Portage, PA 15946

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Responsibility of Licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on a review of the facility assessment and employee education records, as well as staff interviews, it was determined that the facility failed to ensure that nurse aides completed the required annual education for three of five nurse aides reviewed (Nurse Aides 4, 6, and 7).Findings include: The facility assessment regarding education, dated January 2026, indicated that all personnel, including manager, staff (both employees and those who provide services under contract), and volunteers, indicated that the nurse aides would receive their necessary education credits annually. Review of the employee education file for Nurse Aide 4 revealed that there was no documented evidence of twelve hours of required education completed between 2024-2025. Review of the employee education file for Nurse Aide 6 revealed that there was no documented evidence of twelve hours of required education completed between 2024-2025. Review of the employee education file for Nurse Aide 7 revealed that there was no documented evidence of twelve hours of required education completed between 2024-2025. Interview with the Nursing Home Administrator on May 18, 2026, at 2:26 p.m. confirmed that there was no documented evidence that Nurse Aides 4, 6, and 7 completed the 12 hours of annual training as required. 28 Pa. Code 201.18 (b)(3)(e)(1) Management. 28 Pa. Code 201.19 Personnel policies and procedures.