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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396144	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Exton Post Acute	501 Thomas Jones Way Exton, PA 19341

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident’s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of guidelines for Cardiopulmonary Resuscitation (CPR), facility's policies, staff interviews and residents' clinical and hospital records, it was determined the facility failed to ensure that code status was documented on the residents clinical record delaying the decision to provide life sustaining measures such as CPR for one of five residents reviewed (Resident CL1), creating a situation in which the residents were placed in Immediate Jeopardy related to failure to perform life sustaining interventions.Findings include: Review of the American Health Association (AHA) Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care, published on [DATE], revealed the AHA recommends all potential rescuers to initiate CPR unless a valid, Do Not Resuscitate (DNR) order was in place; if there were obvious clinical signs of irreversible death present, including rigor mortis (stiffness of the limbs and body that develops 2 to 4 hours after death and may take up to 12 hours to fully develop), dependent lividity (reddish-blue discoloration of the skin resulting from the gravitational pooling of blood in the lower lying parts of the body in the position of death), decapitation (separation of the head from the body), transection (division by cutting across the body), or decomposition (decay); or if initiating CPR could cause injury or peril to the rescuer. Review of facility's policy titled Emergency Procedure-Cardiopulmonary Resuscitation and Basic Life Support, dated 2001, revealed If an individual (resident, visitor, or staff) is found unresponsive and not breathing normally, a staff member who is certified in CPR for healthcare provider/BLS (Basic Life Support) will administer CPR unless: it is known that a do not resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exist for that individual; or there is obvious signs of irreversible death (e.g. Rigor mortis). If the resident's DNR status is unclear, CPR will be initiated and continued until it is determined there is a DNR or a physician's order not to administer CPR. Review of Resident CL1's emergency room hospital records dated [DATE], revealed Resident CL1 admitted for diagnosis of Acute respiratory failure with hypoxia (critical condition where the lungs cannot adequately transfer oxygen to the blood), and Atrial Fibrillation (A-fib is an irregular heartbeat). The same records revealed Code Status: Full Code. Review of Resident CL1's Encounter notes by attending physician dated [DATE], signed at 10:26 p.m., revealed Resident CL1 was admitted from the hospital with a diagnosis of Acute respiratory failure with hypoxia. The same note revealed Code Status - Full code: Patient has elected Full Code status, indicating they wish to receive all possible life-saving interventions, including CPR, defibrillation (lifesaving medical procedure that uses a controlled electrical current to stop a life-threatening, chaotic heart rhythm, allowing normal heart rhythm to restore), advanced airway management, and other aggressive treatments. Review of Resident CL1's physician's order dated [DATE], revealed an order for BIPAP (Bilevel Positive Airway Pressure - noninvasive device that helps people breathe by delivering pressurized air through a mask at two distinct pressures: high for inhalation (IPAP) (continued on next page)

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

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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Management 28 Pa. Code 201.18(e)(3) Management 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on clinical review and staff interview, it was determined that the facility failed to follow a physician's recommendations for one of five residents reviewed (Resident CL2).Findings: A review of Resident CL2's admission notes dated February 3, 2026, at 7:53 p.m., revealed the resident was admitted with a diagnosis of COVID (Coronavirus disease- A contagious disease caused by the coronavirus SARS-CoV-2), shingles (A painful, blistering skin eruption caused by the reactivation of the chickenpox virus). The resident had a fall and required rehab. The same notes revealed the resident was incontinent of bowel and bladder. A review of Resident CL2's Physical Medicine and Rehab notes dated February 5, 2026, at 9:18 p.m., revealed resident was admitted with altered mental status, COVID, Shingles, Encephalopathy (A reversible, non-structural brain dysfunction caused by systemic metabolic issues such as organ failure or infection) and BPH (Benign prostatic hyperplasia- A non-cancerous enlargement of the prostate gland caused by age related hormones changes). Plan and assessment for BPH revealed as follows: recommend monitoring urine output and PVRs (post-void residual- the amount of urine remaining in the bladder immediately after urination). A review of Resident CL2's physician orders failed to reveal an order of urine output and PVR monitoring. An interview with the Director of Nursing on February 17, 2026, at 1:00 p.m., revealed that nursing was not aware of the physiatrist's (A medical doctor who specializes in helping people regain function after surgery, a stroke, or an injury) recommendations; therefore, they were not communicated with the primary physician. The DON confirmed that the physiatrist's recommendations for urine output monitoring and PVR were not followed. The facility failed to ensure Resident CL2's Physician's recommendations for urine and PVR monitoring were followed. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa Code 211.5(f) Clinical Records

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on clinical records review and staff interview, it was determined that the facility failed to follow a blood work order in a timely manner for one of five residents reviewed (Resident CL2)Findings include: A review of Resident CL2's Nurse Practitioner's (NP) notes dated February 4, 2026, at 9:36 a.m., revealed a resident with a diagnosis of Metabolic Encephalopathy (A reversible, non-structural brain dysfunction caused by systemic metabolic issues such as organ failure or infection), and behavioral disturbances. A review of Resident CL2's physician order dated February 4, 2026, revealed an order for CBC (Complete blood count- A blood test that measures amounts and sizes of your red blood cells, hemoglobin, white blood cells and platelets) and CMP (Comprehensive Metabolic Panel- A routine blood test measuring 14 different substances to evaluate kidney/liver function, blood sugar, and electrolyte imbalance) on February 5, 2026. A review of Resident CL2's February 2026 Treatment Administration Record (TAR) revealed that the order for CBC and CMP was done on February 4, 2026. A review of Resident CL2's Laboratory Results revealed that Resident CL2's CBC and CMP ordered for February 5, 2026, were not done until February 11, 2026. February 11, 2026, blood works revealed the following: WBC (white blood cell) was 16.8 (normal range 3.5-11), Creatinine was 2.86 (normal range 0.60 -1.5), and BUN (blood urea nitrogen) was 79 (normal range 8-23). A review of Resident CL2's physician's order dated February 11, 2026, revealed an order for Sodium Chloride 0.45%. Use 2 liters intravenously (administer through a vein) one time only for hydration for 1 day at 80ml/hr. x 2 liters. An interview with the Director of Nursing was conducted on February 17, 2026, at 1:00 p.m. The DON reported that the blood work order for February 5, 2026, was not put into the laboratory system and therefore was not done. The missed blood work was not identified until February 10, 2026, during an audit. The DON confirmed that the laboratory ordered for February 5, 2026, was not followed timely manner. The facility failed to ensure Resident CL2's orders for CBC and CMP were timely followed. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa Code 211.5(f) Clinical Records

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on a review of their job descriptions it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) did not effectively manage the facility to ensure that Cardiopulmonary Resuscitation was provided in accordance with the facility policy and procedures to residents that are a full code. Findings include: Review of the job description for the NHA revealed the administrative authority, responsibility and accountability of directing the activities and programs in the center. Review of the job description for the DON revealed planning, develop, organize, evaluate, and direct the nursing service department, as well as its programs and activities, in accordance with current rules, regulations, and guidelines that govern the nursing care facilities. The findings in this report identified that the facility failed to ensure that CPR was provided in accordance with the facility policy and procedures as a resident was a FULL CODE. The NHA and DON failed to fulfill their essential job duties that the federal and state guidelines and regulations were followed. Refer to F678 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 207.2(a) Administrator's Responsibility 28 Pa. Code 211.12(d)(1)(5) Nursing Services 28 Pa. Code 211.12(d)(2)(3) Nursing Services