

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395702</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/23/2026</b>
NAME OF PROVIDER OR SUPPLIER: <b>BEACON RIDGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>1515 WAYNE AVENUE INDIANA, PA 15701</b>		
STATE LICENSE NUMBER: <b>033102</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0558 SS=D	Based on a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance survey completed on April 23, 2026, it was determined that Beacon Ridge was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0558		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0558  SS=D	Continued from page 1  483.10(e)(3) Reasonable Accommodations Needs/Preferences  §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.  This REQUIREMENT is not met as evidenced by:	F 0558	This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Indiana Skilled Nursing INC dba Beacon Ridge agrees with the allegations and citations listed on the statement of deficiencies. Indiana Skilled Nursing INC dba Beacon Ridge maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Indiana Skilled Nursing INC dba Beacon Ridge written credible allegation of compliance. By submitting this plan of correction, Indiana Skilled Nursing INC dba Beacon Ridge does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Indiana	Completion Date: <b>05/29/2026</b> Status: <b>APPROVED</b> Date: <b>05/19/2026</b>

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F 0558  SS=D	Continued from page 2	F 0558	<p>Skilled Nursing INC dba Beacon Ridge reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.</p> <p>The facility is unable to retroactively correct the observation for Resident 32 and 78; when it was identified it was corrected at that time. There were no ill effects noted.</p> <p>The Director of Nursing and/or designee will re-educate current facility staff, including agency staff, on assuring the call pendants and/or tap bells are within reach. New/agency Nursing staff will be educated upon onboarding, assuring the call pendants and/or tap bells are within reach of residents.</p> <p>The Director of Nursing and/or designee will complete random audits 3 times a week for 2 weeks, weekly for 2 weeks and then monthly</p>	

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F 0558  SS=D	Continued from page 3	F 0558	for 2 months to assure the call pendants and/or tap bells are within reach.  Audit results will be reviewed by the facility Quality Assurance Performance Improvement Committee to determine compliance or need for continuation of audits.	

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F 0558  SS=D	Continued from page 4  Based on review of policies and clinical records, as well as observations and resident and staff interviews, it was determined that the facility failed to ensure that call bells were within reach for two of 40 residents reviewed (Residents 32 and 78).  Findings include: A review of the facility policy for resident call system dated January 22, 2026, indicated that each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 32 dated February 6, 2026, indicated that the resident was sometimes understood and sometimes able to understand others, required assistance from staff for daily care needs and had diagnoses that included Parkinson's disease (brain condition that causes problems with movement, mental health, sleep, pain and other health issues) and dementia. Care plan for Resident 32 dated March 20, 2019, indicated that the resident had a self-care performance deficit and staff were to encourage the resident to use the call bell for assistance. An intervention dated February 10, 2021, indicated that staff where to assure the call pendant is in place and functioning properly. Observation of Resident 32 on April 20, 2026, at 9:00 a.m. revealed the resident lying in her bed with her call pendant	F 0558		

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F 0558  SS=D	Continued from page 5  on her nightstand on the left side of her bed, out of reach. An interview with the Director of Nursing at the time revealed that the resident was unable to use the call pendant and proceeded to place the call pendant in place around the resident's neck. During an interview with Resident 32 on April 20, 2026, at 9:05 a.m., when the resident was asked how she would call for a nurse, she replied "push this button", and pointed to her call pendant. Interview with Resident 32 on April 21, 2026, at 3:21 p.m., when the resident was asked how she would call for a nurse, she replied "they tell me there is a bell somewhere to use". Observations at that time revealed the resident was wearing a call pendant and had a tap bell on her overbed table that was not within reach. Interview with Licensed Practical Nurse 1 on April 22, 2026, at 1:04 p.m. revealed that the resident prefers to stay in bed and that she sometimes does use her call pendant to call for assistance if she wants something. An annual MDS assessment for Resident 78 dated March 20, 2026, indicated that the resident was usually understood and was usually able to understand others, required assistance from staff for daily care needs and had diagnosis that included dementia and stroke. Care plan for Resident 78 dated April 11, 2017, indicated that the resident had a self-care performance deficit and staff were to encourage the resident to use the call bell for assistance. Observation of Resident 78 on April 20, 2026, at 8:56 a.m.	F 0558		

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F 0558  SS=D	Continued from page 6  revealed the resident lying in his bed with his call pendant on his nightstand on the right side of his bed, out of reach. An interview with Nurse Aide 2 at the time of the observation revealed that the resident should have had his call pendant within reach. During an interview with Resident 78 on April 21, 2026, at 1:15 p.m., when the resident was asked how he would call for a nurse if needed, he showed me his call pendant hanging on his neck. Interview with the Director of Nursing on April 20, 2026, at 9:00 a.m. revealed that all residents that are able to use their call pendants should have them within reach.  28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.	F 0558		
F 0628  SS=E		F 0628		

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F 0628  SS=E	Continued from page 7  483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) Discharge Process  §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i) (A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.  §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-	F 0628	The facility is unable to retroactively correct that the resident and/or representative was notified in writing as follow up to the verbal notification regarding the reason for their transfer to the hospital for Residents 7, 8, 9, 43, 67 and 81.  The Administrator will re-educate the Business Office Manager, Social Service Director and Admissions Coordinator on the need to notify the resident and/or resident representative in writing as follow up to the verbal notification regarding the reason(s) for transfer to the hospital.  The Administrator will complete random audits to ensure written notification to the resident and/or resident representative as follow-up to the verbal notification of transfer, with reason(s), to hospital is completed for 4 weeks and then monthly for 2 weeks.  Audit results will be reviewed by the facility Quality Assurance	Completion Date: <b>05/29/2026</b> Status: <b>APPROVED</b> Date: <b>05/19/2026</b>

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F 0628  SS=E	Continued from page 8  (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c) (2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.  §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c) (1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i) (A) of this section; or (E) A resident has not resided in the facility for 30 days.	F 0628	Performance Improvement Committee to determine compliance or need for continuation of audits.	

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F 0628  SS=E	Continued from page 9  §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:  (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy	F 0628		

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F 0628  SS=E	Continued from page 10  for Mentally Ill Individuals Act.  §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.  §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).  §483.15(d) Notice of bed-hold policy and return-  §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F 0628		

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F 0628  SS=E	Continued from page 11  (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.  §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.  §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).	F 0628		

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F 0628  SS=E	Continued from page 12  This REQUIREMENT is not met as evidenced by:	F 0628		

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F 0628  SS=E	Continued from page 13  Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to notify the resident and/or the resident's representative in writing regarding the reason for transfer to the hospital for six of 40 residents reviewed (Residents 7, 8, 9, 43, 67, and 81).  Findings include:  A nursing note for Resident 7, dated February 11, 2026, revealed that at 12:00 p.m. the resident had an unwitnessed fall. Resident 7 was yelling for help which staff responded to and found her sitting on the floor near her dresser. Resident 7 did not appear to hit her head, but stated her right arm hurt. A new order was received to send to the emergency for evaluation and treatment.  A nursing note for Resident 7, dated April 2, 2026, revealed that at 12:55 p.m. the x-ray results showed the right elbow and shoulder showed a subacute displaced fracture in the right humerus (upper arm bone). A new order was received to send to the emergency for evaluation and treatment.  Review of Resident 7's clinical record revealed that there was no documented evidence that the resident's representative or emergency contact were notified in writing of the purpose for the resident's transfer regarding her hospitalization of February 11, 2026 and April 2, 2026.	F 0628		

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F 0628  SS=E	<p>Continued from page 14</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated March 8, 2026, indicated that the resident was cognitively impaired, required assistance from staff for her daily care needs and had diagnoses that included paralytic syndrome following cerebral infarction (persistent, bilateral muscle weakness or paralysis affecting both sides of the body as a long-term consequence of a stroke).</p> <p>A nursing note for Resident 8, dated March 12, 2026, revealed that at 12:10 a.m. the resident had increased shortness of breath and abdominal pain. The physician was notified and orders were obtained to transfer the resident to the hospital for evaluation. A nursing note dated March 12, 2026, at 5:10 a.m., revealed the resident was admitted to the hospital with a diagnosis of sepsis (a life-threatening reaction to an infection).</p> <p>Review of Resident 8's clinical record revealed that there was no documented evidence that the resident or the resident's responsible party were notified in writing of the reason for the resident's transfer to the hospital on March 12, 2026.</p> <p>A quarterly MDS assessment for Resident 9, dated February 12, 2026, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs and had diagnoses that included</p>	F 0628		

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F 0628  SS=E	Continued from page 15  dementia.  A nursing note for Resident 9, dated April 16, 2026, at 11:09 a.m. the resident had abnormal lung sounds irregular breathing. The physician was notified and orders were received to transfer her to the hospital for evaluation. A nursing note dated April 16, 2026, at 6:25 p.m. revealed that the resident was admitted to the hospital with diagnosis of atrial fibrillation (an irregular and often very rapid heart rhythm) and urinary tract infection.  Review of Resident 9's clinical record revealed that there was no documented evidence that the resident or the resident's responsible party were notified in writing of the reason for the resident's transfer to the hospital on April 16, 2026.  A quarterly MDS assessment for Resident 43, dated February 20, 2026, indicated that the resident was cognitively impaired, had limited range of motion to her upper and lower extremity on one side, required assistance from staff for daily care needs, had an indwelling urinary catheter (a thin, flexible tube inserted into the bladder to drain urine from the bladder), had a feeding tube (a mechanical device surgically implanted into the stomach to provide nutrition, fluids and medications), had a Stage 3 pressure ulcer (pressure wound involving the fat layers beneath the skin) present on admission, and had diagnoses including cerebral vascular accident (an event	F 0628		

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F 0628  SS=E	Continued from page 16  caused by poor blood flow or bleeding to in the areas of the brain) and hemiparesis and hemiplegia (paralysis or weakness to one side of the body due to brain injury) affecting right dominant side.  A nursing note for Resident 43, dated March 24, 2026, at 1:02 p.m. revealed that the facility received a call from a nurse in the hospital emergency room stating that per the attending hospitalist, the resident had results of positive blood cultures of Staphylococcus epidermidis. The resident's physician was contacted, and orders were received to send the resident to the hospital for treatment of positive blood cultures. A nursing note for the resident, dated March 24, 2026, at 3:51 p.m. revealed that the resident was admitted with a diagnosis of bacteremia (the presence of bacteria in the bloodstream).  Review of Resident 43's clinical record revealed that there was no documented evidence that the resident or the resident's responsible party were notified in writing of the reason for the resident's transfer to the hospital on March 24, 2026.  A nursing note for Resident 67, dated April 15, 2026, revealed that at 9:15 a.m. the resident had a witnessed fall in the Bayside lounge and had no injuries at that time. A nursing note dated April 15, 2026, revealed that at 4:26 p.m. the therapy department reported that the resident was complaining of pain in her left hip during therapy.	F 0628		

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F 0628  SS=E	Continued from page 17  Physician was notified and ordered for the resident to have an x-ray of the left hip. A nursing note on April 15, 2026, at 7:38 p.m. revealed that had a left femoral neck fracture (left hip fracture) and was to be sent to the local hospital.  Review of Resident 67's clinical record revealed that there was no documented evidence that the resident and legal guardian were notified in writing of the purpose for the resident's transfer regarding her hospitalization of April 15, 2026.  A quarterly MDS assessment for Resident 81, dated February 12, 2026, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs and had diagnoses that included hemiplegia (severe or complete paralysis affecting one side of the body) or hemiparesis (one-sided muscle weakness) after a stroke.  A nursing note for Resident 81, dated January 20, 2026, at 10:47 a.m. the resident was having stroke-like symptoms. She was evaluated by the physician, who provided orders to transfer the resident to the hospital for evaluation. A nursing note dated January 20, 2026, at 1:51 p.m. revealed that the resident was admitted to the hospital with diagnosis of stroke.  Review of Resident 81's clinical record revealed that there was no documented evidence that the resident or the	F 0628		

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F 0628  SS=E	Continued from page 18  resident's responsible party were notified in writing of the reason for the resident's transfer to the hospital on January 20, 2026.  Interview with the Nursing Home Administrator on April 22, 2026, at 11:02 a.m. confirmed that they were not completing written transfer letters to the families regarding the reason for transfer for the residents listed above.  28 Pa. Code 201.29(j) Resident Rights.	F 0628		
F 0641  SS=E		F 0641		

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F 0641  SS=E	Continued from page 19  483.20(g)(h)(i)(j) Accuracy of Assessments  §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.  §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement.	F 0641	Minimum Data Set (MDS) modifications were completed for Residents 2, 10, 12, 34, 43, and 57 to reflect correct coding.  The Clinical Reimbursement Consultant re-educated the MDS Coordinator related to MDS accuracy with specifics on sections M, N, O and P items.  An Initial audit review will be completed for section M, N, O and P items for residents with MDS Assessment Reference Dates of 4/23/26 through 5/8/26 for coding accuracy.  The Director of Nursing and/or designee will complete random audits for MDS accuracy for sections M, N, O and P items weekly for 4 weeks and then monthly for 2 weeks.  Audit results will be reviewed by the facility Quality Assurance Performance Improvement Committee to determine compliance	Completion Date: <b>05/29/2026</b> Status: <b>APPROVED</b> Date: <b>05/19/2026</b>

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F 0641  SS=E	Continued from page 20  This REQUIREMENT is not met as evidenced by:	F 0641	or need for continuation of audits.	

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F 0641  SS=E	Continued from page 21  Based on a 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 (MDS) assessments for six of 40 residents reviewed (Residents 2, 10, 12, 34, 43, 57).  Findings include:  The Long-Term Care Facility 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 N0415K1 Anticoagulant was to be checked if the resident took the medication during the seven-day look-back period.  Physician's orders for Resident 2, dated June 7, 2026, included an order for the resident to receive 500 milligrams (mg) of Divalproex Sodium (anticonvulsant) two times a day for seizure disorder.  Review of the Medication Administration Record (MAR) for Resident 2, dated March 2026, revealed that staff administered the 500 mg of Divalproex two times a day from March 1 through March 31, 2026. However, a quarterly MDS assessment for Resident 2, dated, March 16, 2026, revealed that Section NO415K1 was not checked, indicating that the resident did not receive an	F 0641		

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F 0641  SS=E	Continued from page 22  anticoagulant medication during the seven-day look-back assessment period.  Interview with Licensed Practical Nurse Assessment Coordinator on April 21, 2026, at 2:09 p.m. confirmed that Resident's 2 MDS was coded inaccurately.  The RAI User's Manual, dated October 2025, revealed that Section P0100A Restraints used in bed: bedrails, was to be coded (0) if not used, (1) if used less than daily, and (2) if used daily during the seven-day look-back period.  Review of Side Rail/Enabler Bar Assessments for Resident 10 dated January 30, 2026, and February 11, 2026, indicated that side rails/enabler bars were not indicated. There was no documented evidence that Resident 10 had side rails in place during the seven-day look-back period. However, a quarterly MDS assessment for Resident 10, dated February 12, 2026, revealed that Section P0100A was coded (2) to indicate that the resident used side rails daily.  The RAI User's Manual, dated October 2025, revealed that Section N0415A1 Antipsychotic; N0415B1 Antianxiety; N0415G1; and N0415K1 was to be checked if the resident took the medication during the seven-day look-back period.  Physician's orders for Resident 12 dated November 3, 2025 included orders for the resident to receive 250 mg of	F 0641		

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F 0641  SS=E	<p>Continued from page 23</p> <p>Seroquel (a antipsychotic) at bedtime for schizoaffective disorder; orders for the resident to receive 5 mg of buspirone (a antianxiety) two times a day for anxiety; orders for the resident to receive 40 mg of Furosemide (a diuretic) one time a day for edema, and orders for the resident to receive 0.5 mg Clonazepam (a antianxiety and anticonvulsant) two times a day for anxiety.</p> <p>Review of the Medication Administration Record (MAR) for Resident 12, dated February 2026, revealed that staff administered 250 mg of Seroquel at bedtime, 5 mg of Buspirone two times a day, 40 mg of Furosemide one time a day, and 0.5 mg of Clonazepam two times a day starting February 1, 2026, through February 28, 2026. A quarterly MDS assessment for Resident 12, dated, February17, 2026, revealed that Section NO415A1, N0415B1, N0415G1, and N0415K1 were not checked, indicating that the resident did not receive an antipsychotic, antianxiety, diuretic and anticonvulsant medication during the seven-day look-back assessment period.</p> <p>Interview with Licensed Practical Nurse Assessment Coordinator on April 21, 2026, at 2:09 p.m. confirmed that Resident 10 and 12's MDS was coded inaccurately.</p> <p>The Long-Term Care Facility 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</p>	F 0641		

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F 0641  SS=E	Continued from page 24  needs), dated October 2025, revealed that Section N0415F1 Antibiotics were to be checked if the resident took the medication during the seven-day look-back period.  Physician's orders for Resident 34, dated January 31, 2026, included an order for the resident to receive 100 mg of Doxycycline Hyclate (an antibiotic) two times a day for two days for urinary tract infection, and an order dated February 4, 2026 for the resident to receive 2% of Mupirocin (an antibiotic) one time a day to the right great toe ulcer.  Review of the MAR and Treatment Administration Record (TAR) for Resident 34, dated February 2026, revealed that staff administered 100 mg of Doxycycline Hyclate two times a day and 2% of Mupirocin one time a day starting February 1 through February 28, 2026. A quarterly MDS assessment for Resident 34, dated February 6, 2026, revealed that Section NO415F1 was not checked, indicating that the resident did not receive an antibiotic during the seven-day look-back assessment period.  Interview with Licensed Practical Nurse Assessment Coordinator on April 21, 2026, at 2:09 p.m. confirmed that Resident's 34 MDS was coded inaccurately.  The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments	F 0641		

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F 0641  SS=E	<p>Continued from page 25</p> <p>(required assessments of a resident's abilities and care needs), dated October 2025, revealed that Section O0110H1B intravenous medications was to be checked if the resident received intravenous medications while a resident during the 14 day look-back period.</p> <p>Review of the MAR for Resident 43, dated February 2026, revealed that staff administered 1 gram of Meropenem intravenously every eight hours from February 2, 2026, through February 6, 2026. However, a quarterly MDS assessment for Resident 43, dated February 20, 2026, revealed that Section O0110H1B was coded, indicating that the resident received intravenous medications during the 14 day look-back assessment period.</p> <p>Interview with Licensed Practical Nurse Assessment Coordinator on April 22, 2026, at 10:42 a.m. confirmed that Resident 43's MDS was coded in error.</p> <p>The Long-Term Care Facility 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 M0150 should be coded 0-'no' if the resident is not at risk for developing a pressure ulcer/injury, and coded 1- 'yes' if the resident is at risk for developing a pressure ulcer/injury. This answer is based on the items reviewed for determination of pressure ulcer risk in Section M0100 items</p>	F 0641		

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F 0641  SS=E	Continued from page 26  A through Z; check M0100A if the resident has a Stage 1 or greater pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device; check M0100B if a formal assessment has been completed; check M0100C if the resident's risk for pressure ulcer/injury development is based on clinical assessment; and check M0100Z if none of the above apply.  A quarterly MDS assessment for Resident 43, dated February 20, 2026, revealed that Section M0100A, M0100B, and M0100C were all checked indicating that the resident was at risk for developing a pressure ulcer/injury; however, Section M0150 was coded 0-'no', indicating that the resident was not at risk for developing a pressure ulcer/injury.  Interview with the Nursing Home Administrator on April 23, 2026, at 2:15 p.m. indicated that the Licensed Practical Nurse Assessment Coordinator confirmed that Resident 43's MDS was coded in error.  The RAI User's Manual, dated October 2025, revealed that Section N0415A1 Antipsychotic was to be checked (1) yes if the resident took the medication during the seven-day look-back period.  Physician's orders for Resident 57 dated August 27, 2025, included for the resident to receive 50 milligrams (mg) of Seroquel (an antipsychotic medication) daily at bedtime.	F 0641		

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F 0641  SS=E	Continued from page 27  Physician's orders dated March 6, 2026, included for the resident to receive 25 mg of Seroquel two times a day for bipolar disorder.  Review of the MAR for Resident 57 dated March 2026 revealed that 50 mg of Seroquel was administered daily at 9:00 p.m. and 25 mg of Seroquel was administered at 9:00 a.m. and 2:00 p.m. daily during the seven-day look-back period. However, a quarterly MDS assessment for Resident 57 dated March 29, 2026, indicated that Section N0415A1 Antipsychotic was checked (0) no, indicating that the Resident did not receive an antipsychotic medication during the seven-day look-back period.  Interview with Licensed Practical Nurse Assessment Coordinator on April 21, 2026, at 2:09 p.m. confirmed that Resident 57's MDS was coded inaccurately.  28 Pa. Code 211.5(f) Medical records	F 0641		
F 0656  SS=E		F 0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395702</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/23/2026</b>	
NAME OF PROVIDER OR SUPPLIER: <b>BEACON RIDGE</b>  STATE LICENSE NUMBER: <b>033102</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>1515 WAYNE AVENUE INDIANA, PA 15701</b>		
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F 0656  SS=E	Continued from page 28  483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	Individualized care plans will be reviewed, developed, and implemented as needed for Residents 1, 2, and 43 to accurately reflect care and services provided.  The Clinical and Clinical Reimbursement Consultants re-educated the Minimum Data Set (MDS) Coordinator, Interdisciplinary Team, and Administrative Nurses (Director of Nursing, Assistant Director of Nursing, Staff Development/Infection Control Nurse Coordinator, and Nursing Supervisor) regarding developing and implementing a comprehensive person-centered care plan on May 14 and May 15, 2026.  Director of Nursing and/or designee will educate all Licensed Nursing staff regarding development of care plans.  An initial audit review will be completed by the Director of Nursing and/or designee to assure the development and implementation	Completion Date: <b>05/29/2026</b> Status: <b>APPROVED</b> Date: <b>05/19/2026</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395702</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/23/2026</b>
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F 0656  SS=E	Continued from page 29  discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.  This REQUIREMENT is not met as evidenced by:	F 0656	of a comprehensive person-centered care plan to reflect current in-house residents with anticoagulants, cognitive impairments, diuretic(s), and prophylactic antibiotics.  The Director of Nursing and/or designee will complete random audits for a comprehensive person-centered care plan reflecting current in-house residents with anticoagulants, cognitive impairments, diuretic(s), and prophylactic antibiotics weekly for 4 weeks and then monthly for 2 weeks.  Audit results will be reviewed by the facility Quality Assurance Performance Improvement Committee to determine compliance or need for continuation of audits.	

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F 0656  SS=E	<p>Continued from page 30</p> <p>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 40 residents reviewed (Residents 1, 2, and 43).</p> <p>Findings include:</p> <p>A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated February 3, 2026, revealed that the resident was cognitively impaired, required assistance from staff with daily care needs, received antipsychotic medications (medications used to treat mental health disorders), had a diagnosis of dementia, depression with severe psychosis and obsessive-compulsive disorder (a chronic mental health condition characterized by uncontrollable repeated thoughts and/or behaviors).</p> <p>A physician's order for Resident 1, dated January 16, 2026, included orders for the resident to receive 0.25 milligrams (mg) of risperidone twice daily related to severe depression with psychotic features.</p> <p>There was no documented evidence that a care plan was developed to address Resident 1's use of antipsychotic medication. There was no documented evidence that a care</p>	F 0656		

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F 0656  SS=E	Continued from page 31  plan was developed to address that the resident had dementia and cognitive impairment.  Interview with the Assistant Director of Nursing on April 22, 2026, at 12:17 p.m. confirmed that Resident 1 did not have care plans developed to address her use of antipsychotic medication and to address her dementia with cognitive impairment.  A quarterly MDS assessment for Resident 2, dated January 2, 2026, revealed that the resident was cognitively impaired, required assistance with daily care needs, and had medical diagnosis that included dementia and high blood pressure.  Physician's orders for Resident 2 dated December 4, 2025, included an order for the resident to receive 40 milligrams of Furosemide, a diuretic medication used for edema.  There was no documented evidence that a care plan was developed to address Resident 2's diuretic medication.  Interview with Licensed Practical Nurse Assessment Coordinator dated April 23, 2026, at 11:22 a.m. confirmed that Resident 2 did not have a diuretic care plan and that he should have in place.  A quarterly MDS assessment for Resident 43, dated February 20, 2026, indicated that the resident was cognitively impaired, had limited range of motion to her	F 0656		

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F 0656  SS=E	<p>Continued from page 32</p> <p>upper and lower extremity on one side, required assistance from staff for daily care needs, had an indwelling urinary catheter (a thin, flexible tube inserted into the bladder to drain urine from the bladder), had a feeding tube (a mechanical device surgically implanted into the stomach to provide nutrition, fluids and medications), had a Stage 3 pressure ulcer (pressure wound involving the fat layers beneath the skin) present on admission, and had diagnoses including cerebral vascular accident (an event caused by poor blood flow or bleeding to in the areas of the brain) and hemiparesis and hemiplegia (paralysis or weakness to one side of the body due to brain injury) affecting right dominant side.</p> <p>A physician's order for Resident 43, dated March 27, 2026, included orders for the resident to receive a 50 mg capsule of Nitrofurantoin Macrocrystal (an antibiotic) daily every Monday, Wednesday and Friday via her feeding tube for prophylaxis for urinary tract infections.</p> <p>There was no documented evidence that a care plan was developed to address Resident 43's long term use of antibiotic therapy for prophylaxis for urinary tract infections.</p> <p>Interview with the Nursing Home Administrator on April 23, 2026, at 11:39 a.m. confirmed that there was no documented evidence that a care plan was developed to address Resident 43's long term use of antibiotic therapy</p>	F 0656		

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F 0656  SS=E	Continued from page 33  for prophylaxis for urinary tract infections.  28 Pa. Code 211.11(d) Resident care plan.  28 Pa. Code 211.12(d)(5) Nursing services.	F 0656		
F 0657  SS=D		F 0657		

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F 0657  SS=D	Continued from page 34  483.21(b)(2)(i)-(iii) Care Plan Timing and Revision  §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.  This REQUIREMENT is not met as evidenced by:	F 0657	F 0657  Comprehensive care plans will be revised for Residents 18 and 43 to reflect current status of diuretic and intravenous medications.  The Clinical and Clinical Reimbursement Consultants re-educated the Minimum Data Set (MDS) Coordinator, Interdisciplinary Team and Administrative Nurses (Director of Nursing, Assistant Director of Nursing, Staff Development/Infection Control Nurse Coordinator, and Nursing Supervisor) regarding care plan timing and revision to the comprehensive care plan, to reflect specific care, on May 14 and May 15, 2026.  Director of Nursing and/or designee will educate all Licensed Nursing staff regarding updating and maintaining comprehensive care plans.  An initial audit review will be completed for current in-house	Completion Date: <b>05/29/2026</b> Status: <b>APPROVED</b> Date: <b>05/19/2026</b>

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F 0657  SS=D	Continued from page 35	F 0657	<p>residents to assure revisions to the comprehensive care plans for diuretic and intravenous medication(s) were accurately reflected.</p> <p>The Director of Nursing and/or designee will complete random audits for revisions to the comprehensive person-centered care plan reflecting use of diuretic and intravenous medication(s) weekly for 4 weeks and then monthly for 2 weeks.</p> <p>Audit results will be reviewed by the facility Quality Assurance Performance Improvement Committee to determine compliance or need for continuation of audits.</p>	

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F 0657  SS=D	Continued from page 36  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 two of 40 residents reviewed (Residents 8 and 43).  Findings include:  A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated March 8, 2026, indicated that the resident was cognitively impaired, required assistance from staff for her daily care needs and had diagnoses that included paralytic syndrome following cerebral infarction (persistent, bilateral muscle weakness or paralysis affecting both sides of the body as a long-term consequence of a stroke).  Care plan for Resident 8 dated March 18, 2026, indicated that the Resident was receiving diuretic (medicines that help reduce fluid buildup in the body) therapy for edema (swelling caused by excess fluid trapped in the body's tissues) and staff were to administer diuretic medication as ordered by the physician.  Review of the Medication Administration Record (MAR) for Resident 8 dated April 2026, revealed that the resident was not receiving diuretic medication during the time of the survey.	F 0657		

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F 0657  SS=D	Continued from page 37  Interview with the Director of Nursing on April 4, 2026, at 3:21 p.m. confirmed the Resident's care plan should have been revised when the diuretic was discontinued.  A quarterly MDS assessment for Resident 43, dated February 20, 2026, indicated that the resident was cognitively impaired, had limited range of motion to her upper and lower extremity on one side, required assistance from staff for daily care needs, had an indwelling urinary catheter (a thin, flexible tube inserted into the bladder to drain urine from the bladder), had a feeding tube (a mechanical device surgically implanted into the stomach to provide nutrition, fluids and medications), had a Stage 3 pressure ulcer (pressure wound involving the fat layers beneath the skin) present on admission, and had diagnoses including cerebral vascular accident (an event caused by poor blood flow or bleeding to in the areas of the brain) and hemiparesis and hemiplegia (paralysis or weakness to one side of the body due to brain injury) affecting right dominant side.  A care plan for Resident 43, dated March 24, 2026, indicated that the resident was receiving intravenous (administration of fluids and/or medications directly into a person's vein) medications related to an Extended-Spectrum Beta-Lactamase (ESBL-multi-drug resistant bacterial infection) infection in the urine. There was no documented evidence in the resident's clinical	F 0657		

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F 0657  SS=D	Continued from page 38  record that she was receiving intravenous medications.  Interview with the Nursing Home administrator on April 23, 2026, at 11:39 a.m. confirmed that Resident 43's care plan should have been revised to reflect that she was no longer receiving intravenous medications.  28 Pa. Code 211.12(d)(5) Nursing services.	F 0657		
F 0658  SS=D		F 0658		

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F 0658  SS=D	Continued from page 39  483.21(b)(3)(i) Services Provided Meet Professional Standards  §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.  This REQUIREMENT is not met as evidenced by:	F 0658	Physician orders for R9 Tylenol was addressed on 4/20/2026 upon return from the hospital. R34 treatment orders for toe wound clarified on 4/12/2026. No ill effects noted to either resident.  The Clinical and Clinical Reimbursement Consultants re-educated the Minimum Data Set (MDS) Coordinator, Interdisciplinary Team and Administrative Nurses (Director of Nursing, Assistant Director of Nursing, Staff Development/Infection Control Nurse Coordinator, and Nursing Supervisor) regarding resident services provided meeting professional standards, to reflect resident orders for care and services being provided, on May 14 and May 15, 2026.  Initial review of physician/provider progress notes for current in-house residents will be completed to ensure resident orders are present per recommendations from 4/23/26 to 5/8/26.	Completion Date: <b>05/29/2026</b> Status: <b>APPROVED</b> Date: <b>05/19/2026</b>

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F 0658  SS=D	Continued from page 40	F 0658	<p>The Director of Nursing and/or designee will complete random audits of current in-house resident physician/provider progress notes to ensure orders are present per recommendations as needed weekly for 4 weeks and then monthly for 2 weeks.</p> <p>Audit results will be reviewed by the facility Quality Assurance Performance Improvement Committee to determine compliance or need for continuation of audits.</p>	

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F 0658  SS=D	Continued from page 41  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 order for two of 40 residents reviewed (Resident 9, 34).  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. A quarterly MDS assessment for Resident 9, dated February 12, 2026, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs and had diagnoses that included dementia. Physician's progress note for Resident 9 dated April 7, 2026, included that the resident was to have routine Tylenol for pain control. Physician's orders for Resident 9 dated November 12, 2024, indicated that the resident was to receive 500 milligrams (mg) of Acetaminophen (generic name for Tylenol), two tablets every eight hours as needed for pain. There was no documented evidence that physician's orders for Tylenol to be given routinely were implemented. Interview with the Assistant Director of Nursing on April	F 0658		

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F 0658  SS=D	Continued from page 42  22, 2026, at 1:15 p.m. revealed that the order for routine Tylenol in the physician's progress note was missed, therefore it was not added to the resident's medication orders, and it should have been. A quarterly MDS assessment for Resident 34 dated February 6, 2026, revealed that the resident is cognitively impaired, required assistance with daily care needs, and had medical diagnosis that included diabetes mellitus and cellulitis of the right lower limb. Physician's orders for Resident 34 dated February 4, 2026, included orders for 2% Mupirocin ointment apply to right great toe ulcer one time a day for wound care. Physician orders dated April 3, 2026, included orders to cleanse right great toe diabetic ulcer with wound cleanser, apply Iodosorb ointment to wound bed and surrounding callus area, and cover with dry dressing and secure with rolled gauze daily. A wound consultant note for Resident 34 dated April 1, 2026, indicated that the Certified Registered Nurse Practitioner recommended that staff cleanse the right great toe wound with wound cleaner, apply Iodosorb ointment to wound bed and surrounding callus area, then cover with a dry dressing and secure with rolled gauze change daily. Review of the Treatment Administration Record for Resident 34, dated April 2026, revealed that the resident was receiving two separate wound treatments to the same right great toe wound. Interview with the Director of Nursing on April 22, 2026, at 1:41 p.m. confirmed that Resident 34 was receiving two	F 0658		

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F 0658  SS=D	Continued from page 43  wound treatment orders and that the order for Mupirocin ointment should have been discontinued and the wound consultant recommendation should have been followed. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.	F 0658		
F 0686  SS=G		F 0686		

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F 0686  SS=G	Continued from page 44  483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer  §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.  This REQUIREMENT is not met as evidenced by:	F 0686	Resident 43 pressure injury resolved as of 4/29/2026.  Skin evaluations were completed 05/08/2026 for current in-house facility residents which resulted in no new findings and no declines in existing wounds.  An audit of the last 30 days of residents with pressure injuries was completed ensure treatment orders were signed for administration.  The Director of Nursing and/or designee re-educated current in-house and agency Nursing Staff on completing treatments and services with timely documentation of administration per physician order for pressure injuries.  Newly hired and agency Nursing staff will be educated upon on boarding on completing treatments and services with timely documentation of administration per physician order for pressure injuries.	Completion Date: <b>05/29/2026</b> Status: <b>APPROVED</b> Date: <b>05/19/2026</b>

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F 0686  SS=G	Continued from page 45	F 0686	<p>An approved directed inservice provider was secured to provide the directed in-service training to facility in-house and agency licensed nursing and nurse aide staff regarding the federal regulation and accompanying guidance for treatment and services to prevent and heal pressure injuries on May 27, 2026.</p> <p>The Director of Nursing and/or designee will complete random audits of the Treatment Administration Record (TAR) to ensure treatments are complete and administration documented timely by nursing staff weekly for 4 weeks and then monthly for 2 weeks.</p> <p>Audit results will be reviewed by the facility Quality Assurance Performance Improvement Committee to determine compliance or need for continuation of audits.</p>	

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F 0686  SS=G	Continued from page 46  Based on review of facility policies, and clinical records, as well as resident and staff interviews, it was determined that the facility failed to provide necessary treatment and services for a Stage 3 pressure ulcer (pressure wound involving the fat layers beneath the skin) for one of 40 residents reviewed (Resident 43), resulting in a deterioration of the wound and delayed healing.  Findings include:  The facility's pressure ulcer policy, dated January 22, 2026, indicated that the facility will ensure that a resident with pressure ulcers receives necessary treatment and services to promote healing, prevent infection, and prevent new sore from developing. Document in the resident's record and the Treatment Administration Record (TAR) that wound care was administered as prescribed.  An admission Minimum Data Set (MDS)	F 0686		

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F 0686  SS=G	Continued from page 47  assessment (a mandated assessment of a resident's abilities and care needs) for Resident 43, dated August 25, 2025, indicated that the resident was cognitively impaired, was dependent on staff for bed mobility, transfers, dressing/grooming and hygiene, was incontinent of bowel and bladder, had a Stage 3 pressure ulcer present on admission, had diagnoses including cerebral vascular accident (an event caused by poor blood flow or bleeding to in the areas of the brain), hemiparesis and hemiplegia (paralysis or weakness to one side of the body due to brain injury) affecting right dominant side, and wound infection. A care plan for the resident, dated August 19, 2025, revealed that the resident had a Stage 3 pressure ulcer to her right hip on admission and staff were to administer medications as ordered.  Review of hospital documentation for Resident 43, dated August 17, 2025, revealed that the resident had a wound to her right hip with purulent discharge (a thick, opaque, and often foul-smelling fluid, ranging in color from yellow and green to brown or white, that indicates a likely bacterial infection) along	F 0686		

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F 0686  SS=G	Continued from page 48  with surrounding erythema (abnormal skin redness or rash caused by dilated blood vessels near the skin's surface, typically resulting from inflammation, infection, or injury) and warmth. A Computed Tomography (CT) scan of the right hip, completed on August 17, 2025, for suspected abscess (a localized collection of a mixture of white blood cells, bacteria, and dead tissue that forms in the body, often due to bacterial infections, viruses, or foreign objects) and infection showed subcutaneous fat stranding in the anterior pelvic wall, and lateral to the right hip, consistent with cellulitis (a common, potentially serious bacterial skin infection affecting deep dermis layers, often caused by Streptococcus or Staphylococcus bacteria entering through skin breaks). She was treated with vancomycin at the hospital to cover Methicillin-resistant Staphylococcus aureus (MRSA) (type of staph bacteria resistant to many antibiotics making treatment difficult).  An admission screen for Resident 43, dated August 19, 2025, revealed that the resident had a Stage 3	F 0686		

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F 0686  SS=G	Continued from page 49  pressure ulcer to her right lateral hip measuring 2.5 centimeters (cm) length x 1.5 cm width x 0.1 cm depth, and it was noted that a treatment was ordered.  A physician's order for Resident 43, dated August 19, 2025, included orders to cleanse the right hip with normal saline (a sterile solution used for the moistening of wound dressings and wound debridement), apply adaptic (non-adhering wound dressing made of knitted cellulose acetate fabric impregnated with a petrolatum emulsion used to protect regenerating tissue in draining, partial- and full-thickness wounds) and cover with bordered dressing daily and as needed for soilage/dislodgement until resolved. Review of the resident's TAR for August 2025, revealed that the treatment order was not transcribed to appear on the TAR for the treatment to be completed as ordered. There was no documented evidence that the treatment was completed as ordered from August 19, 2025, through August 26, 2025, delaying treatment to the wound.	F 0686		

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F 0686  SS=G	Continued from page 50  A physician's note for Resident 43, dated August 21, 2025, revealed that the resident had a Stage 3 pressure ulcer over her right hip. A weekly skin assessment, completed August 23, 2025, indicated that the resident had no open areas or skin issues.  A wound consultation note for Resident 43, dated August 26, 2025, revealed the resident was seen for a pre-existing ulcer of the right hip. The wound was classified as a Stage 3 pressure ulcer present on admission. The wound base contained 40 percent slough (dead tissue within a wound, often appearing as a yellow, tan, or white fibrous material) and a surgical wound debridement was completed and indicated removal of necrotic tissue (dead, non-viable tissue that impedes healing and increases the risk of infection, requiring prompt identification and removal). The wound prior to and after surgical debridement measured 7.5 cm x 6 cm x 0.3 cm, revealing that the wound worsened since admission to the facility on August 19, 2025.	F 0686		

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F 0686  SS=G	Continued from page 51  Interview with the Assistant Director of Nursing on April 22, 2026, at 10:42 a.m. confirmed that the treatment order, dated August 19, 2025, to Resident 43's right hip was not transcribed to appear on the TAR for the treatment to be completed as ordered, and that there was no documented evidence that the treatment was completed as ordered from August 19, 2025, through August 26, 2025.  Interview with the Director of Nursing on April 23, 2026, at 2:31 p.m. revealed that Resident 43's wound to her right hip was not very big when she was admitted, about 0.1 cm deep and had no drainage or necrotic tissue.  A physician's order for Resident 43, dated October 14, 2025, included orders to cleanse the right hip with 0.125 percent Dakins solution (a solution used to treat and prevent tissue infections) and pack with Dakins soaked rolled gauze and cover with silicone bordered super absorb dressing (designed for moderate to heavily exuding wounds, such as ulcers	F 0686		

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F 0686  SS=G	Continued from page 52  and surgical wounds) twice daily and as needed for soilage/dislodgement. There was no documented evidence that the treatment was completed as ordered on November 17, 2025.  A physician's order for Resident 43, dated November 24, 2025, included orders to irrigate the right hip with normal saline solution, apply Plurogel (designed to create a moist wound healing environment that promotes debridement, softens necrotic tissue/debris) to wound base, pack with normal saline moistened gauze and cover with silicone bordered super absorb dressing daily and as needed for soilage/dislodgement. There was no documented evidence that the treatment was completed as ordered on December 8, 2025.  A physician's order for Resident 43, dated December 9, 2025, included orders to irrigate the right hip with normal saline solution, apply Plurogel to wound base, pack with normal saline moistened gauze, apply calmoseptine (moisture barrier) to periwound and cover with silicone bordered super	F 0686		

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F 0686  SS=G	Continued from page 53  absorb dressing daily and as needed for soilage/dislodgement. There was no documented evidence that the treatment was completed as ordered on December 14, 2025.  A physician's order for Resident 43, dated December 14, 2025, included orders to irrigate the right hip with normal saline solution, apply calmoseptine to periwound, pack wound with Dakins 0.125% moistened rolled gauze, and cover with silicone bordered super absorb dressing daily and as needed for soilage/dislodgement. There was no documented evidence that the treatment was completed as ordered on December 15, 2025.  A physician's order for Resident 43, dated December 19, 2025, included orders to irrigate the right hip with acetic acid solution (topical antimicrobial agent used to treat infected wounds) 0.25 percent, sprinkle flagyl powder (antifungal used to treat wounds with infection, necrotic (dead) tissue, or bacterial growth) 500 milligram (mg) crushed tablet into wound bed, then pack wound	F 0686		

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F 0686  SS=G	Continued from page 54  with acetic acid 0.25% moistened rolled gauze, and cover with silicone bordered super absorb dressing twice daily and as needed for soilage/dislodgement. There was no documented evidence that the treatment was completed as ordered on December 23 and December 27, 2025, on the night shift.  A physician's order for Resident 43, dated January 27, 2026, included orders to irrigate the right hip with normal saline solution, then pack wound with calcium alginate rope (may cut in half to fit into wound bed) and cover with super absorb bordered dressing once daily and as needed for soilage/dislodgement. There was no documented evidence that the treatment was completed as ordered on March 13, 2026, and April 12, 2026.  Interview with the Assistant Director of Nursing on April 22, 2026, at 10:42 a.m. confirmed that there was no documented evidence that the treatments to Resident 43's right hip were completed as ordered on the above-mentioned dates.	F 0686		

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F 0686  SS=G	Continued from page 55  28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.	F 0686			
F 0691  SS=D		F 0691			

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F 0691  SS=D	Continued from page 56  483.25(f) Colostomy, Urostomy, or Ileostomy Care  §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.  This REQUIREMENT is not met as evidenced by:	F 0691	The physician orders for Resident 16 were updated to include colostomy size with orders to change the appliance on 4/21/2026 with no ill effects noted.  An audit of current in-house resident colostomy orders will be completed to ensure specification of size with orders to change appliance present.  The Director of Nursing and/or designee will re-educate the Nursing Staff on verifying that resident colostomy orders specify size with orders to change the appliance.  Newly hired and agency Nursing staff will be educated upon on boarding on verifying that resident colostomy orders specify size with orders to change the appliance.  The Director of Nursing and/or designee will complete random audits weekly for 4 weeks and then monthly for 2 weeks to assure resident colostomy orders are	Completion Date: <b>05/29/2026</b> Status: <b>APPROVED</b> Date: <b>05/19/2026</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395702</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/23/2026</b>
NAME OF PROVIDER OR SUPPLIER: <b>BEACON RIDGE</b>  STATE LICENSE NUMBER: <b>033102</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>1515 WAYNE AVENUE INDIANA, PA 15701</b>		
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F 0691  SS=D	Continued from page 57	F 0691	<p>present and specify size with orders to change appliance. with colostomy's have corresponding orders on the Treatment Administration Record (TAR).</p> <p>Audit results will be reviewed by the facility Quality Assurance Performance Improvement Committee to determine compliance or need for continuation of audits.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395702</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/23/2026</b>
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F 0691  SS=D	Continued from page 58  Based on review clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that residents were provided with proper colostomy care for one of 40 residents reviewed (Resident 16).  Findings include: The facility's policy regarding colostomy care (care for an artificial opening in the bowel), dated January 22, 2026, colostomy care will be provided per physician orders to provide the stoma with good skin care and check the condition of the stoma and surrounding skin. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 16 dated March 17, 2025, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs, had medical diagnosis that included intellectual disabilities and had an ostomy (a surgically created opening in the abdomen for bowel elimination). A review of Resident 16's clinical record revealed that there was no physician order for the resident colostomy size or orders to change the colostomy appliance. Interview with the Nursing Home Administrator on April 22, 2026, at 9:35 a.m. confirmed that there was no physician order for the ostomy size and that there was no documented evidence that colostomy appliance was being changed for Resident 16. 28 Pa. Code 211.12(d)(5) Nursing Services.	F 0691		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395702</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/23/2026</b>
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F 0691  SS=D	Continued from page 59	F 0691		
F 0693  SS=D		F 0693		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395702</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/23/2026</b>
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F 0693  SS=D	Continued from page 60  483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills  §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-  §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and  §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.  This REQUIREMENT is not met as evidenced by:	F 0693	The facility is unable to retroactively correct the lack of documentation for enteral feeding site care administration to Resident 43 as verified during survey on the Treatment Administrative Record (TAR). There were no ill effects noted to the resident.  An audit of the last 30 days of current in-house residents with enteral feeding sites will be completed to ensure order for site care are present with documentation of administration.  The Director of Nursing and/or designee will re-educate current in-house and agency Nursing Staff on the importance of documenting administration of enteral feeding site care as ordered.  Newly hired and agency Nursing staff will be educated upon on boarding on providing and completing the documentation on the necessary treatment and services per physician order for enteral	Completion Date: <b>05/29/2026</b> Status: <b>APPROVED</b> Date: <b>05/19/2026</b>

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F 0693  SS=D	Continued from page 61	F 0693	feeding care.  The Director of Nursing and/or designee will complete random audits of enteral feeding care to verify that the treatment is completed and documented on the TAR weekly for 4 weeks and then monthly for 2 weeks.  Audit results will be reviewed by the facility Quality Assurance Performance Improvement Committee to determine compliance or need for continuation of audits.	

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F 0693  SS=D	Continued from page 62  Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents who were receiving enteral feedings (delivers liquid nutrients directly into the stomach) received appropriate treatment and services to prevent complications for one of 40 residents reviewed (Resident 43).  Findings include:  A facility policy for feeding tubes, dated January 22, 2026, indicated that the licensed practical nurse will change feeding tube dressings at least every 24 hours unless the physician's orders say otherwise and they are to document the dressing change in the resident's chart.  A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 43, dated February 20, 2026, indicated that the resident was cognitively impaired, had limited range of motion to her upper and lower extremity on one side, required assistance from staff for daily care needs, had an indwelling urinary catheter (a thin, flexible tube inserted into the bladder to drain urine from the bladder), had a feeding tube (a mechanical device surgically implanted into the stomach to provide nutrition, fluids and medications), had a Stage 3 pressure ulcer (pressure	F 0693		

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F 0693  SS=D	Continued from page 63  wound involving the fat layers beneath the skin) present on admission, and had diagnoses including cerebral vascular accident (an event caused by poor blood flow or bleeding to in the areas of the brain) and hemiparesis and hemiplegia (paralysis or weakness to one side of the body due to brain injury) affecting right dominant side.  Physician's orders for Resident 43, dated August 19, 2025, included orders to cleanse the feeding tube site with normal saline (a sterile solution used for the moistening of wound dressings and wound debridement), pat dry and apply drain sponge (specialized wound gauze used around tubes, drains and catheters) daily and as needed for soilage or dislodgement.  Review of Resident 43's Treatment Administration Record (TAR) for August 2025 through December 2025, and for March and April 2026, revealed that there was no documented evidence that the resident's feeding tube site care was completed as ordered on August 19, 20, 22, and 24; September 15, 16, 19, and 29; October 4, 5, 8, 9, and 13; November 30; December 27; March 21, 29, 31; April 9, 13, 17, and 19.  Interview with the Assistant Director of Nursing on April 22, 2026, at 10:42 a.m. confirmed that there was no documented evidence that Resident 43's feeding tube site care was completed as ordered on the above-mentioned dates.	F 0693		

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F 0693  SS=D	Continued from page 64  28 Pa. Code 211.12(d)(3)(5) Nursing services.	F 0693			
F 0760  SS=E		F 0760			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395702</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/23/2026</b>
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F 0760  SS=E	Continued from page 65  483.45(f)(2) Residents are Free of Significant Med Errors  The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by:	F 0760	The facility is unable to retroactively correct the observation for Resident 44 and 73. There were no ill effects noted. The Director of Nursing and/or designee will complete medication pass competency for Licensed Practical Nurse 3 to ensure competence with medication administration.  The Director of Nursing and/or designee will re-educate in-house and agency Nursing Staff on safe medication administration and clarifying and following physician orders. Newly hired and agency Nursing staff will be educated on safe medication administration and clarifying and following physician orders. Random audits will be completed by the Director of Nursing or designee weekly for 4 weeks and monthly for 2 months to assure that anticoagulants were clarified and administered per physician order. Audit results will be reviewed by the	Completion Date: <b>05/29/2026</b> Status: <b>APPROVED</b> Date: <b>05/19/2026</b>

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F 0760  SS=E	Continued from page 66	F 0760	facility Quality Assurance Performance Improvement Committee to determine compliance or need for continuation of audits.	

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F 0760  SS=E	Continued from page 67  Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to provide medication as ordered by the physician, resulting in a significant medication error for two of 40 residents reviewed (Residents 44 and 73).  Findings include:  A facility policy for medication and treatment administration dated January 22, 2026, indicated that medications are administered in accordance with prescriber orders.  A admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 44 dated January 12, 2026, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs and had diagnoses that included atrial fibrillation (a heart rhythm disorder characterized by a rapid and irregular heartbeat).  A nursing note dated January 6, 2026, revealed that the resident was admitted to the facility as a hospice respite stay.	F 0760		

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F 0760  SS=E	<p>Continued from page 68</p> <p>Hospice medication orders for Resident 44 dated November 12, 2025, included physician's orders to administer 5mg of Jantoven (a blood thinner medication) once daily three times a week and administer 7.5 mg of Jantoven four times a week. A review of his Medication Administration Record (MAR) revealed that the facility did not clarify physician orders for Jantoven dose to be administered. The MAR revealed that the resident did not receive Jantoven on January 6, 2026, January 7, 2026, and January 8, 2026.</p> <p>Interview with the Director of Nursing on April 22, 2026, at 1:41 p.m. confirmed that Resident 44's Jantoven was not clarified by the physician and that the resident had missed three doses of Jantoven.</p> <p>A admission MDS assessment for Resident 73 dated April 14, 2026, revealed that the resident is cognitively intact, required assistance with daily care needs, and had medical diagnosis that included a nondisplaced fracture of right tibia (bone in lower leg).</p> <p>Physician orders for resident 73 dated April 9, 2026, included orders for the resident to receive 70 milligrams of Enoxaparin Sodium injection (an anticoagulant) to prevent deep vein thrombosis (a blood clot) one time a day.</p>	F 0760		

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F 0760  SS=E	Continued from page 69  Observation on April 21, 2026, at 8:00 a.m. revealed that Licensed Practical Nurse 3 administered a prefilled 80 mg dose of Enoxaparin into Resident 73's abdomen.  Interview with Licensed Practical Nurse 3 on April 21, 2026, at 8:05 a.m. confirmed that the Enoxaparin Sodium is an 80 mg prefilled syringe from pharmacy and that she administered the incorrect dose to Resident 73.  Interview with the Director of Nursing on April 21, 2026, at 8:41 a.m. confirmed that the Licensed Practical Nurse 3 administered the Enoxaparin Sodium 80 mg prefilled syringe and did not follow physician's orders resulting in a medication error.  28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0760		
F 0761  SS=D		F 0761		

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F 0761  SS=D	Continued from page 70  483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals  §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  §483.45(h) Storage of Drugs and Biologicals  §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.  This REQUIREMENT is not met as evidenced by:	F 0761	Upon identification, the controlled drugs were relocated to another nursing unit secured medication refrigerator and housed in a separately locked, permanently affixed compartment in the refrigerator. Medication room refrigerator controlled drug box was secured and medications returned to the refrigerator on the assigned unit. The Director of Nursing and/or designee will re-educate current in-house and agency Nursing Staff on the requirement for storage of controlled drugs in a separately locked, permanently affixed compartment in the refrigerator separate from other non-narcotic medications. Newly hired and agency Nursing staff will be educated on the storage of controlled drugs in a separately locked, permanently affixed compartment in the refrigerator separate from other no- narcotic medications. Random audits will be completed by the Director of Nursing or designee weekly for 4 weeks and monthly for 2	Completion Date: <b>05/29/2026</b> Status: <b>APPROVED</b> Date: <b>05/19/2026</b>

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F 0761  SS=D	Continued from page 71	F 0761	months to assure that controlled drugs are stored in a separately locked, permanently affixed compartment in the refrigerator separate from other non-narcotic medications. Audit results will be reviewed by the facility Quality Assurance Performance Improvement Committee to determine compliance or need for continuation of audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395702</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/23/2026</b>
NAME OF PROVIDER OR SUPPLIER: <b>BEACON RIDGE</b>  STATE LICENSE NUMBER: <b>033102</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>1515 WAYNE AVENUE INDIANA, PA 15701</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0761  SS=D	Continued from page 72  Based on observations, and staff interviews, it was determined that the facility failed to provide a separately locked, permanently affixed compartment in the refrigerator for the storage of controlled drugs (medications with the potential to be abused) in one of two medication rooms reviewed.  Findings include: Observations in the facility's medication room on the Landings unit on April 22, 2026, at 1:11 p.m. revealed one small, locked refrigerator containing five bottles of liquid Ativan (a controlled medication used to treat anxiety). The liquid Ativan was not in a secured, locked compartment separate from other non-narcotic medications. Interview with Licensed Practical Nurse 1 at the time of the observation confirmed that the five bottles of liquid Ativan were not in a secured, locked compartment separate from other non-narcotic medications. Interview with the Nursing Home Administrator on April 22, 2026, at 1:40 p.m. confirmed the five bottles of liquid Ativan were not in a secured, locked compartment separate from other non-narcotic medications. 28 Pa. Code 211.9(a)(1) Pharmacy Services.	F 0761		

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F 0770  SS=D		F 0770		

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F 0770  SS=D	Continued from page 74  483.50(a)(1)(i) Laboratory Services  §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.  This REQUIREMENT is not met as evidenced by:	F 0770	The facility is unable to retroactively correct the observation of a Urinalysis (UA) being completed when a Urinalysis with Culture and Sensitivity (UA C&S) was ordered. There were no ill effects noted. The Director of Nursing and/or designee will re-educate the current in-house and agency Nursing Staff regarding obtaining laboratory services per physician order and assuring that the laboratory requisition is completed correctly and per physician order. Newly hired and agency Nursing staff will be educated regarding obtaining laboratory services per physician order and assuring that the laboratory requisition is completed correctly and per physician order. Random audits will be completed by the Director of Nursing or designee weekly for 4 weeks and monthly for 2 months to assure that UA and UA C&S specimen laboratory requisitions are accurate per physician order. Audit results will be reviewed by the	Completion Date: <b>05/29/2026</b> Status: <b>APPROVED</b> Date: <b>05/19/2026</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395702</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/23/2026</b>
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F 0770  SS=D	Continued from page 75	F 0770	facility Quality Assurance Performance Improvement Committee to determine compliance or need for continuation of audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395702</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/23/2026</b>	
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F 0770  SS=D	Continued from page 76  Based on a review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that laboratory services were obtained as ordered by the physician for one of 40 residents reviewed (Resident 57).  Findings include: Facility policy for Laboratory Services dated January 22, 2026, indicated that the facility will provide or obtain laboratory services to meet the needs of the residents, and will promote practices to ensure the quality and timeliness of laboratory services. The day shift unit nurse will fill out and send laboratory requests for newly ordered laboratory tests. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 57, dated March 29, 2026, indicated that the resident was cognitively intact, was independent with daily care needs, and had a history of urinary tract infection. Nurse's note for Resident 57 dated February 24, 2026, at 1:31 p.m. revealed that the resident complained of burning and pain on urination, that the physician was notified, and orders were received to obtain a UA flex to culture (diagnostic test that performs a standard urine analysis first, and automatically orders a urine culture if specific indicators of infection are present) to rule out a urinary tract infection. Nurse's note for Resident 57 dated February 24, 2026, at	F 0770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395702</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/23/2026</b>
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F 0770  SS=D	Continued from page 77  5:58 p.m. revealed that the physician was notified of the urinalysis results and ordered 100 milligrams (mg) of Macrobid (an antibiotic) to be given twice a day for seven days pending the culture and sensitivity (C&S- laboratory procedure that identifies infectious germs (culture) and determines the most effective antibiotic (sensitivity) to treat the infection) results. Review of Resident 57's lab results for February 2026 revealed no documented evidence that a C&S was obtained from the resident's urine sample on February 24, 2026, as ordered by the physician. Interview with the Nursing Home Administrator on April 23, 2026, at 10:25 a.m. revealed that a urine C&S was not obtained for Resident 57 as ordered and it should have been. Interview with the Nursing Home Administrator on April 23, 2026, at 11:30 a.m. revealed that the order for laboratory services that were to be obtained on Resident 57's urine sample on February 24, 2026, was transcribed wrong and therefore a urine C&S was never completed by the lab. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.	F 0770		
F 0804  SS=F		F 0804		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395702</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/23/2026</b>
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F 0804  SS=F	Continued from page 78  483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp  §483.60(d) Food and drink Each resident receives and the facility provides-  §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;  §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.  This REQUIREMENT is not met as evidenced by:	F 0804	Eggs were immediately discarded upon discovery of temperatures less than 135-degrees with fresh breakfast items offered to the residents.  The Dietary Manager and/or designee will re-educate current in-house dietary department staff as well as newly hired and agency dietary staff regarding proper placement of dome covers for maintenance of food temperatures.  The Director of Nursing and/or designee will re-educate current in-house nursing staff as well as newly hired and agency staff to monitor dome cover placement upon meal delivery with need to take temperatures for palatability and/or have the food items replaced.  Random audits will be completed by the Dietary Manager and/or designee weekly for 4 weeks then every other week for 4 weeks to assure palatability.  Audit results will be reviewed by the facility Quality Assurance Performance Improvement Committee to determine compliance	Completion Date: <b>05/29/2026</b> Status: <b>APPROVED</b> Date: <b>05/19/2026</b>

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F 0804  SS=F	Continued from page 79	F 0804	or need for continuation of audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395702</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/23/2026</b>	
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F 0804  SS=F	Continued from page 80  Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to serve food that was palatable and at safe and appetizing temperatures.  Findings include:  The facility's policy regarding food preparation, dated January 22, 2026, indicated that all foods will be held at appropriate temperatures, greater than 135 degrees Fahrenheit (or as state regulations requires) for hot holding, and less than 41 degrees Fahrenheit for cold food holding.  A dietary tracking form of tray delivery times revealed that on April 20, 2026, breakfast trays were delivered to Bayside at 7:40 a.m.  Observations on Bayside on April 20, 2026, at 8:09 a.m. revealed a breakfast cart containing nine undelivered breakfast trays. Two trays had protective lids only covering half of the dish and the eggs were exposed. At 8:18 a.m. the Regional Dietary Manager arrived on unit, and the trays were still on the cart. The Regional Dietary Manager took temperatures of the uncovered eggs which were 103 degrees Farenheit. Eggs with the protective coverings temped at 112.8 degrees Farenheit.  Interview with the Regional Dietary Manager on April 20,	F 0804		

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F 0804  SS=F	Continued from page 81  2026, at 8:20 a.m. confirmed that the breakfast tray should have been covered and that the eggs were cold and not palatable and should not be served to the residents.  28 Pa. Code 201.18(b)(1)(2)(e) Management.  28 Pa. Code 211.6(c) Dietary Services.	F 0804		
F 0812  SS=F		F 0812		

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F 0812  SS=F	Continued from page 82  483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary  §483.60(i) Food safety requirements. The facility must -  §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.  §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.  This REQUIREMENT is not met as evidenced by:	F 0812	The facility is unable to retroactively correct the observations in the kitchen. Upon discovery of the temperature of the main cooler, a sample of refrigerated foods were tested for appropriate temperature with no issues noted. No expired milk was distributed to residents as they were discarded upon discovery. The pie and apple crisp deserts observed were immediately discarded and not served to residents. The fan was removed from the food prep area.  The Regional Dietary Manager reviewed the policy for discarding expired foods and revised the policy to discard food items the day before the expiration date.  The Dietary Manager and/or designee will re-educate current in-house and agency the dietary department staff as well as newly hired and agency dietary department staff on the revised policy for discarding expired foods and proper storage and preparation for food	Completion Date: <b>05/29/2026</b> Status: <b>APPROVED</b> Date: <b>05/19/2026</b>

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F 0812  SS=F	Continued from page 83	F 0812	<p>services safety.</p> <p>Random audits will be completed by the Dietary Manager and/or designee five times a week for 4 weeks then weekly for four weeks to ensure proper storage and preparation of food.</p> <p>Audit results will be reviewed by the facility Quality Assurance Performance Improvement Committee to determine compliance or need for continuation of audits.</p>	

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F 0812  SS=F	Continued from page 84  Based on review of policies, observations and staff interviews, it was determined that the facility failed to ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety in the kitchen.  Findings include: The facility's policy for food temperatures, dated January 22, 2026, revealed the temperature of potentially hazardous cold foods must be served at a temperature of 41 degrees Fahrenheit or below. The facility policy regarding food storage, dated January 22, 2026, revealed that food should be stored in such a manner as to prevent contamination and to maintain the safety and wholesomeness of the food for human consumption. Observations on April 20, 2026, at 6:07 a.m. in the main kitchen walk in cooler revealed that the temperature inside the walk-in cooler was in the danger zone of 42 degrees Fahrenheit. Observations on April 20, 2026, at 6:07 a.m. in the main kitchen walk in cooler revealed that there were 56 cartoons of milk that expired on April 19, 2026, and were not discarded. Observations on April 20, 2026, at 6:10 a.m. in the main kitchen prep cooler revealed that there were six pies that were on Styrofoam plates that were open to the air. Interview with the Regional Dietary Manager on April 20, 2026, at 11:37 a.m. confirmed that the main cooler should	F 0812		

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F 0812  SS=F	Continued from page 85  have been below 41 degrees Fahrenheit, that the pies should have been sealed in such a way to prevent air from entering the food, and that expired food should have been removed from the main cooler. Observations on April 22, 2026, at 11:27 a.m. revealed a fan was blowing on three pans of apple crisp desert that were not covered. Interview with the Dietary Manager on April 22, 2026, at 11:27 a.m. confirmed that there should not be a fan blowing on food prep area. 28 Pa. Code 211.6(f) Dietary services.	F 0812		
F 0849  SS=E		F 0849		

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F 0849  SS=E	Continued from page 86  483.70(n)(1)-(4) Hospice Services  §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.  §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.	F 0849	Resident 38 ABHR gel order was clarified and updated per physician on 4/24/26. Initial audit of current in-house resident Hospice recommendations will be reviewed to ensure orders are in place. Director of Nursing and/or designee will re-educate current in-house facility and agency nursing staff as well as newly hired or agency staff regarding the requirement to review hospice recommendations with visits and transcribing orders appropriately to the Medication Administration Record. Director of Nursing/designee will complete random audits of Hospice recommendations to ensure orders are generated and transcribed correctly weekly for 4 weeks and monthly for 2 months. Audit results will be reviewed by the facility Quality Assurance Performance Improvement Committee to determine compliance or need for continuation of audits.	Completion Date: <b>05/29/2026</b> Status: <b>APPROVED</b> Date: <b>05/19/2026</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395702</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>04/23/2026</b>	
NAME OF PROVIDER OR SUPPLIER: <b>BEACON RIDGE</b>  STATE LICENSE NUMBER: <b>033102</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>1515 WAYNE AVENUE INDIANA, PA 15701</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0849  SS=E	Continued from page 87  (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and	F 0849		

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F 0849  SS=E	Continued from page 88  drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.  §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and	F 0849		

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F 0849  SS=E	Continued from page 89  capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any)	F 0849		

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F 0849  SS=E	Continued from page 90  orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.  §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.  This REQUIREMENT is not met as evidenced by:	F 0849		

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F 0849  SS=E	Continued from page 91  Based on review of hospice contracts and clinical records, as well as staff interviews, it was determined that the facility failed to coordinate care with the hospice provider by failing to follow recommendations for changes in medications for one of 40 residents reviewed (Resident 38).  Findings include:  The Hospice contact, effective June 3, 2022, indicated that hospice and the facility shall communicate with one another regularly and as needed for each particular hospice patient. Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of the hospice patients are met 24 hours per day. If there are physician orders that are inconsistent with the hospice plan of care or hospice protocols, a nurse with facility shall notify hospice. An authorized representative of hospice shall resolve differences directly with the physician and secure the necessary orders.  A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 38, dated March 20, 2026, revealed that the resident was cognitively impaired, required assistance from staff with daily care needs, received antipsychotic and antianxiety medications, received hospice services, and had diagnoses including dementia, psychotic disorder,	F 0849		

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F 0849  SS=E	Continued from page 92  anxiety and depression. A care plan for the resident, dated January 8, 2025, indicated that the facility would coordinate care with the resident's hospice provider.  Physician's orders for Resident 38, dated June 18, 2024, revealed that the resident was receiving hospice services effective June 19, 2024.  A current physician's order for Resident 38, dated March 14, 2025, included orders for the resident to receive ABHR cream (a compounded topical medication often used in hospice for terminal agitation, anxiety, or nausea) containing 1 milligram (mg) of Ativan (an antianxiety medication used to treat anxiety/agitation) per 12.5 mg of Benadryl (an antihistamine used to treat nausea) per 2 mg of Haldol (an antipsychotic medication used to treat nausea/agitation) per 10 mg of Reglan (used to treat nausea). Apply to inner wrist topically twice daily for anxiety and psychosis.  A hospice order for Resident 38, dated February 16, 2026, included orders for the resident to receive ABHR cream containing 1 mg of Ativan per 25 mg of Benadryl per 2 mg of Haldol per 10 mg of Reglan. Apply one syringe to wrist or neck every a.m. and p.m. for anxiety and agitation with care.  A hospice order for Resident 38, dated April 13, 2026, included orders for the resident to receive ABHR cream	F 0849		

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F 0849  SS=E	Continued from page 93  containing 1 mg of Ativan per 25 mg of Benadryl per 2 mg of Haldol per 10 mg of Reglan. Apply one syringe to wrist or neck every a.m. and p.m. for anxiety and agitation with care.  There was no documented evidence in Resident 38's clinical record that the hospice orders, dated February 16, 2026, and April 13, 2026, were transcribed into the resident's orders.  Interview with the Nursing Home Administrator, dated April 23, 2026, at 1:01 p.m. confirmed that there was no documented evidence in Resident 38's clinical record that the hospice orders, dated February 16, 2026, and April 13, 2026, were transcribed into the resident's orders and they should have been.  28 Pa. Code 211.12(d)(3)(5) Nursing services.	F 0849		



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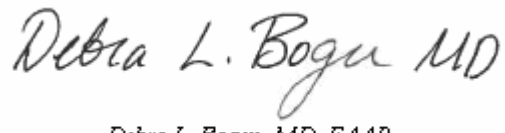
**BEACON RIDGE**

**STATE LICENSE NUMBER: 033102**

**SURVEY EXIT DATE: 04/23/2026**

**I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey**

  
Jeanne Parisi  
Deputy Secretary for Quality Assurance

  
Debra L. Bogen, MD, FAAP  
Secretary of Health



**Pennsylvania  
Department of Health**

THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY