STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395015	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Rehabilitation and Wellness Center	246 Friendship Circle Beaver, PA 15009

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to ensure that care was provided in a manner which maintained resident dignity for two of six residents (Residents R149 and R169) and the facility failed to provide the right to a dignified dining experience for two of two lunches observed. Findings include: Review of facility policy Resident Rights dated 10/1/24, indicated the resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Review of the clinical record indicated Resident R149 was admitted to the facility on [DATE]. Review of Resident R149's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/2/25, indicated diagnoses of high blood pressure, heart failure (a progressive heart disease that affects pumping action of the heart muscles), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). During an observation on 2/11/25, at 10:45 a.m. Resident R149 was sitting in his wheelchair, self-propelling in the hallway with other residents wearing a sweatshirt, socks, and a brief (adult protective underwear). Resident R149 failed to have clothing on to cover up his lower body. During an interview on 2/11/25, at 10:49 a.m. Licensed Practical Nurse (LPN) Employee E18 stated, He does this all the time, I'll try to cover him up. During an interview on 2/11/25, at 10:51 a.m. LPN Employee E18 confirmed that Resident R149 should have been dressed appropriately and failed to maintain Resident R149's dignity by allowing him to self- propel around nursing unit in his brief. Review of the clinical record indicated Resident R169 was admitted to the facility on [DATE]. Review of Resident R169's MDS dated [DATE], indicated diagnoses of high blood pressure, anemia (too little iron in the blood), and hip fracture. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility provided pressure ulcer list indicated Resident R169 developed a pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) to her right buttock on 1/9/25. During an observation of wound care on 2/13/25, from 11:04 a.m. through 11:42 a.m. Wound Care Registered Nurse Employee E3 wrote on the dressing after it was placed on Resident R169's right buttock. During an interview on 2/13/25, at 11:44 a.m. Wound Care Registered Nurse Employee E3 confirmed the facility failed to maintain Resident R169's dignity when writing on the dressings after placement on the resident. During a lunch time observation on 2 Main Dining Room on 2/10/25 all residents were observed with plastic utensils. 3 Main Dining Room on 2/10/25 all residents were observed to have plastic utensils. During a lunch time observation on 2 Main Dining Room on 2/11/25 all residents were observed with plastic utensils. 3 Main Dining Room on 2/11/25 all residents were observed to have plastic utensils. During the tray line observation on 2/12/25 at 11:30 a.m. all resident trays were observed with plastic utensils. During an interview on 2/12/25, at 11:45 a.m. Dietary Manager Employee E23 confirmed the facility failed to provide metal silverware to residents, therefore failing to provide a dignified dining experience. 28 Pa. Code: 201.29(j) Resident rights.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of facility policy, observations and staff interview, it was determined that that the facility failed to determine it was safe to self-administer medications for two of six residents (Resident R811 and R812). Findings include: Review of the facility policy Self-Administration of Medications dated 10/1/24, indicated residents have the right to self-administer medications if ordered by the physician, and the resident is competent to safely self-administer the medications as determined by the interdisciplinary team. Review of the clinical record revealed that Resident R811 was admitted to the facility on [DATE]. Review of Resident 811's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 2/5/25, indicated diagnoses of alcoholic cardiomyopathy (the heart is unable to pump blood efficiently, leading to heart failure from prolonged alcohol consumption), sarcoidosis of lung (autoimmune disease where the immune system starts attacking the body, forming small inflammatory lumps called granulomas), and depression. Review of Resident R811's physician orders dated 1/29/25, indicated to administer Breo Ellipta (medication used to long term to prevent and control wheezing) one puff inhaled daily for chronic obstructive pulmonary disease (COPD- a group of diseases that block airflow and make it hard to breathe). Observation on 2/10/25, at 9:24 a.m. a Breo Ellipta inhaler was noted to be on the overbed table of Resident R811. Review of Resident R811's clinical record on 2/10/25, at 9:30 a.m., failed to include a care plan, order for self-administration of medications, or an interdisciplinary assessment. During an interview on 2/10/25, at 9:45 a.m. Unit Director Registered Nurse (RN) Employee E6 confirmed Resident R811 did not have a current order, care plan to self-administer medications, or an interdisciplinary assessment. Review of the admission record indicated Resident R812 was readmitted to the facility on [DATE], with diagnosis that included angina pectoris (chests pain caused by reduced blood flow to the heart), cardiomyopathy (disease of the heart that makes it hard for the heart to deliver blood to the body), intracardiac thrombosis (blood clot in the heart's chambers). Observation on 2/10/25, at 9:30 a.m. Resident R812 was sitting on bed, Desenex powder (treats fungal infections), and triamcinolone cream (a steroid cream to treat inflammatory conditions) were on the bedside table, along with two bottles of betadine on the windowsill. Review of Resident R812's clinical record on 2/10/25, at 9:35 a.m., failed to include a care plan, order for self-administration of medications, or an interdisciplinary assessment. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/10/25, at 9:45 a.m. Unit Director RN Employee E6 confirmed Resident R812 did not have a current order, care plan to self-administer medications, or an interdisciplinary assessment. During an interview on 2/14/25, at 12:30 p.m. the Director of Nursing confirmed the facility failed to determine it was safe to self-administer medications for two of six residents (Resident R811 and R812). 28 Pa. Code 201. 18(b)(1) Management 28 Pa Code:201.29(a)(d) Resident rights 28 Pa code:211.10(c)(d) Resident care policies 28 Pa Code:211.12(a)(c)(d)(1)(2)(5) Nursing services

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 48546 Based on review of facility policy, observation, and staff interview it was determined that the facility failed to maintain the confidentiality of residents' medical information on one of 12 medication carts (Grove One- Back Medication Cart). Findings include: Review of facility policy Health Insurance Portability and Accounting Act (HIPAA) of 1996 dated 10/1/24, indicated the facility will keep information regarding a resident's health private and confidential. Do not allow any papers, documents, or any other format with resident information unattended. During an observation on 2/12/25, at 9:17 a.m. the Grove One Back Medication Cart at the nurses station was left unattended with the computer screen open with identifiable information any passerby could see resident personal and confidential information. During an interview on 2/12/25, at 9:20 a.m. Registered Nurse Employee E10 confirmed the above observation. During an interview on 2/12/25, at 11:56 a.m. the Director of Nursing confirmed that the facility failed to maintain the confidentiality of residents' medical information as required. 28 Pa. code: 211.5(b) Clinical records. 28 Pa. Code: 201.29(i) Resident Rights. 28 Pa. Code: 211.12(d)(3) Nursing Services.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075 Based on review of facility policy, resident council group interview, observations and staff interviews it was determined that the facility failed to provide a clean, safe, comfortable, and homelike environment for two of 12 nursing units (Four and Five Main Nursing Units.) Findings include: Review of the facility policy Resident Environment dated 10/1/24, indicated the facility will provide an environment that is safe, clean, comfortable, and homelike, allowing the resident to use his or her personal belongings to the extent possible. Review of Title 42 Code of Federal Regulations S483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely. S483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. During a resident council group interview on 2/12/25, at 11:01 a.m. two out of 11 residents voiced concerns with facility cleanliness. On 2/12/25, at 1:00 p.m. observation of four main nursing unit included: - room [ROOM NUMBER] floor was dirty with garbage laying all over the floor. - room [ROOM NUMBER] floor was brown, sticky and black marks noted. - room [ROOM NUMBER] bedside commode was used and not clean. - room [ROOM NUMBER] overbed table observed with dirt and stains on the frame During an interview on 2/12/15, at 1:05 Licensed Practical Nurse (LPN) Employee E14 confirmed the above findings. On 2/13/25, at 1:15 p.m. observation of five main nursing unit included: - Multiple brown stained ceiling tile throughout the five main nursing unit - Dust noted around ceiling vents - Residents' common bathroom privacy curtains were dirty and stained - room [ROOM NUMBER]-2 window curtain stained - room [ROOM NUMBER]-3 window curtain stained (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Common room ceiling fan dusty and dust on ceiling tiles - room [ROOM NUMBER]-2 privacy curtain stained - Patches on the walls in the hallway throughout the unit not painted. During an interview on 2/13/25, at 1:45 LPN Employee E13 confirmed the above findings. On 2/13/25, at 2:00 p.m. observation of four main nursing unit included: - Multiple brown stained ceiling tile throughout the four main nursing unit - Resident common bathroom was missing a piece of metal from a vent - room [ROOM NUMBER]-1 privacy curtain was marked with a brown stain - room [ROOM NUMBER] ceiling in multiple areas had visible splatter marks - room [ROOM NUMBER]-2 privacy curtain was marked with brown stains On 2/13/25, at 2:05 p.m. LPN Employee E14 confirmed the above findings. During an interview on 2/13/25, at 3:00 p.m. Director of Nursing confirmed that the facility failed to provide a clean, safe, comfortable, and homelike environment for two of 12 nursing units (Four and Five Main Nursing Units). 28 Pa. Code 201.18(b)(3)(e)(2) Management. 28 Pa code 211.12(d)(1) Nursing services.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 35785 Based on review of facility policy, resident interview, observations of resident areas and nursing units, and staff interviews it was determined that the facility failed to make certain anonymous grievance forms are readily accessible for resident use and the facility failed to post the grievance procedure in prominent areas for two of 12 nursing units (Two East nursing unit and Three East nursing unit). Findings include: The facility Grievances/Concerns policy dated 10/1/24, indicated that the grievance/Complaint form will be submitted to the Grievance Official, who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusion, leading any necessary investigations by the facility, maintaining confidentiality of all information associated with the grievance, issuing written grievance decisions to the resident, and coordinating with state and federal agencies as necessary. A copy of the grievance/complaint procedure is posted in prominent locations throughout the facility. During an interview on 2/11/25, at 9:46 a.m. Resident R7 stated the following: I've been here two and a half years. There are no grievance forms. The employees that do dirt and know we cannot complaint, they know they will not get reported. During a tour on 2/11/25, at 12:02 p.m. the Two East nursing unit and resident solarium/common area was observed without grievance forms for resident use and without a grievance policy posted. During a tour on 2/12/25, at 9:34 a.m. the Two East nursing unit and resident solarium/common area was observed without grievance forms for resident use and without a grievance policy posted. During an interview on 2/12/25, at 9:37 a.m. interview with Licensed Practical Nurse (LPN) Supervisor Employee E7 confirmed that the facility failed to make certain anonymous grievance forms are readily accessible for resident use as required. During a tour on 2/12/25, 12:26 p.m. Three East nursing unit and resident solarium/common area was observed Three East found the grievance procedure posted in the hallway without a name of compliance officer and without a mailing address. During an interview on 2/12/25, at 12:28 p.m. Registered Nurse (RN) Supervisor Employee E8 confirmed that the facility failed to make certain anonymous grievance forms are readily accessible for resident use and the facility failed to post the grievance procedure in prominent areas as required. 28 Pa Code: 201.29(l) Resident rights 28 Pa Code: 201.18 (e)(4) Management

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on a review of facility policy and the RAI (Resident Assessment Instrument), clinical records, and staff interviews it was determined that the facility failed to make certain that resident assessments were accurate for six of 28 residents (Residents R296, R352, R381, R413, R458, and Closed Resident Record CR611). Findings include: Review of the facility policy Resident Assessment/Minimum Data Set, dated dated dated [DATE], indicated the facility will conduct initially and periodically a comprehensive, accurate, and standardized reproducible assessment of each resident's functional capacity under the direction of a designated registered nurse. The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (periodic assessments of resident care needs), dated October 2024, indicated the following: - Section A2105: Discharge Status: This item documents the location to which the resident is being discharged at the time of discharge. Select the two-digit code that corresponds to the resident's discharge status. Code 01, Home/Community: if the resident was discharged to a private home, apartment, board and care, assisted living facility, group home, transitional living, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community, whether owned by the resident or another person. - Section H0100 Appliances check all that apply in the past seven days A. Indwelling catheter. - Section J1300 Current Tobacco Use: code 1, yes if the resident or any other source indicates that the resident used tobacco in some form during the look-back period. - Section K0300 Weight Loss: code 2, yes if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was not planned and prescribed by a physician. Review of the clinical record indicated Resident R296 was admitted to the facility on [DATE]. Review of Resident R296's clinical record revealed diagnoses of high blood pressure, malnutrition (lack of sufficient nutrients in the body), and Post Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and may have triggers that can bring back memories of trauma accompanied by intense emotional and physical reactions). Review of a physician order dated 10/14/24, indicated Resident R296 was OK for supervised smoking - does not need smoking apron. Review of Resident R296's care plan dated 2/29/24, indicated the resident does not need smoking apron when smoking and the resident will smoke in designated are with staff supervision. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R296's annual MDS dated [DATE], Section J - Health Conditions, Question J1300 indicated the resident was coded 0 No for Current Tobacco Use. During an interview on 2/14/25, at 11:49 a.m. Licensed Practical Nurse Assessment Coordinator (LPNAC) Employee E12 stated, Residents will have a smoking order and we check the order and the care plan. It should be checked yes on the MDS if they are a current smoker. During an interview on 2/14/25, at 11:49 a.m. LPNAC Employee E12 confirmed that the facility failed to make certain that resident assessments were accurate for Resident R296. Review of Resident R352's admission record indicated he was originally admitted on [DATE]. Review of Resident R352's MDS assessment dated [DATE], indicated he had diagnoses that included bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), dementia (a condition characterized by memory loss and progressive or persistent loss of intellectual functioning), history of alcohol abuse and anxiety disorder (a medical condition creating a sense of acute fear, restlessness, and worry). Review of Resident R352's MDS assessment dated [DATE], Section I6000-Active diagnoses/psychiatric disorders indicated an x next to Schizophrenia. Review of Resident R352's Certified Registered Nurse Practitioner (CRNP) note dated 5/14/24, did not include a diagnosis of schizophrenia on the evaluation. Review of Resident R352's Certified Registered Nurse Practitioner (CRNP) note dated 9/30/24, did not include a diagnosis of schizophrenia on the evaluation. Review of Resident R352's care plans dated 1/10/25, did not include a diagnosis of schizophrenia. During an interview on 2/12/25, at 10:39 a.m. LPNAC Employee E12 confirmed that the facility failed to make certain that Resident R352 MDS assessment and diagnoses were accurate as required. Review of the clinical record indicated Resident R381 was admitted to the facility on [DATE]. Review of Resident R381's MDS dated [DATE], indicated diagnoses of high blood pressure, anxiety (a feeling of worry, nervousness, or unease), and overactive bladder. Review of a physician order dated 2/28/24, indicated Resident R381 was OK for supervised smoking - must wear apron when smoking. Review of Resident R381's care plan dated 2/27/24, indicated resident will smoke in designated are under staff supervision and resident will use smoking apron when actively smoking. Review of Resident R381's annual MDS dated [DATE], Section J - Health Conditions, Question J1300 indicated the resident was coded 0 No for Current Tobacco Use. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/14/25, at 11:49 a.m. LPNAC Employee E12 stated, Residents will have a smoking order and we check the order and the care plan. It should be checked yes on the MDS if they are a current smoker. During an interview on 2/14/25, at 11:49 a.m. LPNAC Employee E12 confirmed that the facility failed to make certain that resident assessments were accurate for Resident R381. Review of the admission record indicated Resident R413 admitted to the facility on [DATE]. Review of Resident R413's MDS dated [DATE], indicated the diagnoses of schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), hypotension (low blood pressure), and septicemia (a life-threatening condition where bacteria enter the bloodstream and spread throughout the body). Section H indicated yes to indwelling catheter. Review of Resident R413's current physician orders failed to include an order for indwelling catheter. Review of Resident R413's care plan dated 1/23/25, failed to include indwelling catheter or management of. Observation on 2/14/25, at 10:00 a.m. Resident R413 was in bed and an indwelling catheter was not observed. Interview on 2/14/25, at 10:00 a.m. Resident R413 indicated I've never had an indwelling catheter for my urine, it was collecting fluid from stomach, so I didn't vomit. Interview on 2/14/25, at 2:30 p.m. LPNAC Employee E12 confirmed the indwelling catheter was coded incorrectly and that Resident R413 did not have an indwelling catheter. Review of the admission record indicated Resident R458 was admitted to the facility on [DATE]. Review of Resident R458's MDS dated [DATE], indicated the diagnoses of multiple sclerosis (a disease that affects central nervous system), repeated falls, and nicotine dependence. Section A2105 was entered as 04, which indicated that resident R91 was discharged to a Short-Term General Hospital. Review of a physician's order dated 11/15/24, indicated that Resident R458 was to be discharged to home on 11/18/24. During an interview on 2/13/25, at 12:42 p.m. RNAC Employee E28 confirmed the facility failed to make certain that resident assessments were accurate for Resident R458. Review of Closed Resident Record CR611's clinical record indicated the resident was admitted to the facility on [DATE]. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Closed Resident Record CR611's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and dysphagia (difficulty swallowing). Section K - Swallowing/Nutritional Status, Question K0300: Weight Loss was coded 0 no or unknown for a loss of 5% or more in the last month or a loss of 10% or more in the last 6 months. Review of Closed Resident Record CR611's Weights and Vitals Summary revealed the following documented weights: - 11/4/24: 137.2 pounds, a loss of 5.95% in one month and a loss of 21.13% in six months - 10/1/24: 146.1 pounds - 9/4/24: 151.7 pounds - 8/1/24: 157.4 pounds - 7/2/24: 166.1 pounds - 6/2/24: 172.5 pounds - 5/1/24: 174.2 pounds During an interview on 2/14/25, at 10:54 a.m. Registered Dietitian Employee E11 stated that Closed Resident Record CR611's MDS should have been coded as yes for weight loss, stating, It was probably a typo. During this interview, Registered Dietitian Employee E11 confirmed that the facility failed to make certain that resident assessments were accurate for Closed Resident Record CR611. Interview with the Director of Nursing on 2/14/25, at 3:00 p.m. confirmed the facility failed to make certain that resident assessments were accurate for six of 28 residents (Residents R296, R352, R381, R413, R458, and Closed Resident Record CR611). 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.5(f) Clinical Records 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of facility policy, clinical records, resident and staff interview it was determined that the facility failed to follow physician orders for wound care for two of four residents (Resident R436, and R812), failed to monitor a CGM (continuous glucose monitoring device), obtain physician orders for continuous monitoring of results, and failed to have a care plan for care and management of the device for one of three residents with special devices (Resident R213). Findings include: Review of the facility policy Wound Care dated 10/1/24, indicated the facility follows physician's orders to maintain the highest level of comfort and promote healing of wounds. Interview with the Director of Nursing on 2/13/25, at 2:00 p.m. indicated the facility did not have a policy for CGM. Review of the admission record indicated Resident R436 was admitted on [DATE]. Review of Resident R436's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/2/25, indicated the diagnoses of cellulitis (a bacterial infection of the skin and underlying tissues), anxiety (intense, excessive, and persistent worry and fear about everyday situations), and paranoid personality disorder (PPD - a mental health condition characterized by a long-term pattern of extreme distrust and suspicion of others). Review of Resident R436's physician order dated 1/29/25, indicated wound care to bilateral (both sides) lower extremities, cleanse with soap and water, apply triple antibiotic ointment wrap in gauze and secure with tape. Review of Resident R436's care plan dated 1/23/25, failed to include a plan for management and care of cellulitis. Observation on 2/10/25, at 10:00 a.m. Resident R436 was sitting on the side of the bed with feet dangling. The dressings on the left leg indicated 2/8/25, and the right leg dressing had no date. Interview on 2/10/25, at 10:00 a.m. Resident R436 indicated My legs are sore and draining. I changed my right leg myself this morning because it was so wet. They changed the other leg the other day. Nobody did my legs yesterday. Review of Resident R436's Treatment Administration Record (TAR) indicated the treatments were administered on 2/9/25. Review of Resident R436's Nurse Practitioner note dated 2/10/25, indicated bilateral lower extremity stasis color changes equal in appearance, with dry cracked skin to the right lower extremity, with increased erythema (redness) and seeping yellow/green drainage, warm to touch. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/10/25, at 10:05 a.m. Unit Director Registered Nurse (RN) Employee E6 confirmed the dressing on the left leg was dated 2/8/25, and should have been changed on 2/9/25, and the TAR indicated it was completed when it was not. Review of the admission record indicated Resident R812 was readmitted to the facility on [DATE], with diagnosis that included angina pectoris (chests pain caused by reduced blood flow to the heart), cardiomyopathy (disease of the heart that makes it hard for the heart to deliver blood to the body), intracardiac thrombosis (blood clot in the heart's chambers). Observation on 2/10/25, at 9:30 a.m. Resident R812 was sitting on bed, with dressing to right foot dated 2/8/25, and dressing to right arm dated 2/8/25. Review of Resident R812's physician order dated 2/8/25, indicated right wrist, cleanse with normal saline, apply betadine (antiseptic) soaked gauze & cover with dry dressing one time a day for wound care. Right toes, cleanse with normal saline, apply betadine-soaked gauze & cover with dry dressing one time a day for wound care. Review of Resident R812's care plan dated 2/9/25, indicated to administer treatments as ordered. Interview with resident R812 on 2/10/25, at 9:30 a.m. indicated nobody changed his dressings yesterday, 2/9/25. Interview on 2/10/25, at 10:05 a.m. Unit Director RN Employee E6 confirmed the dressing on the right leg and right arm were dated 2/8/25, and should have been changed on 2/9/25. Review of the admission record indicated Resident R 213 admitted to the facility on [DATE]. Review of the Resident R213's MDS dated [DATE], indicated the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), heart failure (heart doesn't pump blood as well as it should), and diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). Review of Resident R213's physician order dated 11/14/24, indicated change Dexcom device (CGM) every 15 days, family provides supplies for monitoring. Review of Resident R213's care plan failed to include a plan of care for the Dexcom monitoring and management. Observation of Resident R213 on 2/10/15, at 12:40 p.m. indicated resident in her wheelchair with her cell phone on the overbed table. Interview with Resident R213 on 2/10/25, at 12:40 p.m. indicated I have a Dexcom in my left arm. It monitors my glucose and goes straight to my cell phone. When asked how the nurses would know if her phone alarmed high or low readings, she indicated the nurses wouldn't know because it rings on my phone. Some of the nurses know I have it and will ask to see my phone. Other nurses don't know I have it and they poke my finger for my sugar. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/10/25, at 12:45 p.m. Unit Director RN Employee E19 verified the nurses don't monitor the Dexcom. It goes to Resident R213's phone, and if the device alarmed nursing staff would not be aware unless they were near resident's personal cell phone at the time of alarm. Interview on 2/14/25, at 3:00 p.m. the Director of Nursing confirmed the facility failed to follow physician orders for wound care for two of four residents (Resident R436, and R812), failed to monitor a CGM, obtain physician orders for continuous monitoring of results, and failed to have a care plan for care and management of the device for one of three residents with special devices (Resident R213). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code: 201.29(a)(d) Resident rights 28 Pa. Code: 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on facility policy, observation, clinical record review, and staff interview, it was determined that the facility failed to provide treatment and services to prevent further decrease in range of motion for one of three residents (Resident R113). Findings include: Review of the facility policy Assistive Devices and Equipment dated 10/1/24, indicated the facility maintains and supervises the use of assistive devices and equipment for residents. Staff are trained and demonstrate competency on the use of devices and equipment prior to assisting or supervising residents. Review of the facility policy Pressure Ulcer Prevention dated 10/1/24, indicated residents will receive skin care, repositioning and nutritional support to assist in preventing the development of avoidable pressure ulcers. Pressure can come from shearing, friction, splints, casts, bandages, and wrinkles in the bed linen. Review of the admission record indicated R113 was admitted to the facility on [DATE]. Review of Resident R113's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/22/25, indicated the diagnoses of stroke (damage to the brain from an interruption of blood supply), anemia (the blood doesn't have enough healthy red blood cells), End Stage Renal Disease (ESRD - kidneys cease to function on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), and hip fracture (broken bone in hip). Review of Resident R113's physician order dated 1/27/25, indicated weight bearing as tolerated to left lower extremity, non-weight bearing to left upper extremity. Continue left arm sling when not exercising. Review of Resident R113's care plan dated 1/17/25, failed to include a plan for the sling, removal of, and/or skin assessments relating to the sling's use. Observation on 2/10/25, at 12:45 p.m. Resident R113 was observed in the dining room with a sling on the left arm. Interview on 2/10/25, at 12:50 p.m. Unit Director RN Employee E19 confirmed the orders did not define the removal of the sling, and/or skin assessments relating to the sling's use. Interview on 2/13/25, at 1:43 p.m. Assistant Director of Nursing (ADON) Employee E20 confirmed the facility the facility failed to provide treatment and services to prevent further decrease in range of motion for one of three residents (Resident R113). 28 Pa. Code: 201.29(j) Resident rights. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on facility policy, clinical record review, and interview, the facility failed to ensure that appropriate physician orders were obtained for residents with a supra-pubic catheter (a medical device that drains urine from the bladder directly through the abdominal wall), and failed to maintain catheter irrigation equipment for one of three residents (Resident R367). Findings include: Review of the facility policy Catheter Irrigation (flushing of the catheter and bladder with a sterile solution) dated 10/1/24, indicated the purpose is to cleanse and maintain a patent (open) catheter. Irrigate according to physician's order. Review of the clinical record indicated Resident R367 was admitted to the facility on [DATE]. Review of Resident R367's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/2/25, indicated diagnoses of neurogenic bladder (lack of bladder control due to a brain, spinal cord or nerve problem), paraplegia (paralysis of legs and lower body), and depression. Review of Resident R367's current physician orders failed to include orders for care and management of the suprapubic catheter and irrigation of. Review of Resident R367's current care plan indicated resident has suprapubic catheter related to neurogenic bladder. Monitor and report to physician signs and symptoms of infection, and to change the catheter as needed for blockage. Observation on 2/10/25, at 1:30 p.m. Resident R367 was positioned in bed with supra-pubic catheter and drainage bag on bed frame. The urine was thick with sediment (a solid material) visualized in tubing. The bedside table had an irrigation syringe kit labeled catheter which was dated 2/8/25. Interview and tour on 2/10/25, at 1:35 p.m. with Unit Manager Registered Nurse (RN) Employee E6 confirmed Resident R367 was positioned in bed with supra-pubic catheter and drainage bag on bed frame. The urine was thick with sediment (a solid material) visualized in tubing. The bedside table had an irrigation syringe kit labeled catheter which was dated 2/8/25. Also indicated the physician orders must have fallen off, when he was out to the hospital and he currently did not have any orders relating to the supra-pubic catheter and irrigation of. Interview on 2/14/25, at 3:00 p.m. the Director of Nursing confirmed the facility failed to ensure that appropriate physician orders were obtained for residents with a supra-pubic catheter, and failed to maintain catheter irrigation equipment for one of three residents (Resident R367). 28 Pa. Code 201. 18(b)(1) Management. 28 Pa code:211.10(c)(d) Resident care policies. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code:211.12(a)(c)(d)(1)(2)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on facility policy review, clinical record review, resident, and staff interviews, it was determined that the facility failed to obtain colostomy (a surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall so as to bypass a damaged part of the colon) care and management physician orders consistent with professional standards of practice for one of five residents reviewed (Resident R367). Findings include: Review of the Code of Federal Regulations (CFR) S483.25(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. Review of the facility policy Colostomy Care dated 10/1/24, indicated the purpose is to provide guidelines that will aid in preventing exposure of the resident's skin to fecal matter (stool). Review of the clinical record indicated Resident R367 was admitted to the facility on [DATE]. Review of Resident R367's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/2/25, indicated diagnoses of neurogenic bladder (lack of bladder control due to a brain, spinal cord or nerve problem), paraplegia (paralysis of legs and lower body), and depression. Review of Resident R367's current physician orders failed to include orders for care and management of the colostomy. Review of Resident R367's current care plan indicated resident has a colostomy for bowel diversion. Resident will have functioning colostomy and maintain skin integrity through next review date. Observation on 2/10/25, at 1:30 p.m. Resident R367 was positioned in bed covered in a blanket. Interview on 2/10/25, at 1:30 p.m. Resident 367 indicated he has a colostomy on his abdomen. Interview and tour on 2/10/25, at 1:35 p.m. with Unit Manager Registered Nurse (RN) Employee E6 confirmed Resident R367 has a colostomy and that the physician orders failed to include care and management of it. Interview on 2/14/25, at 10:39 a.m. the Director of Nursing confirmed the facility failed to obtain colostomy care and management physician orders consistent with professional standards of practice for one of five residents reviewed (Resident R367). 28 Pa. Code: 201.18 (b) (1) (e) (1) Management. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075 Based on review of facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that residents with an enteral feeding tube (a tube inserted in the stomach through the abdomen) received appropriate treatment and services to prevent potential complications for one of three residents (Residents R379). Findings include: Review of Resident R379's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R379's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/4/24, indicated diagnoses of high blood pressure, cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain), and dysphagia (difficult swallowing). MDS section K-Swallowing/Nutritional Status K0520 indicated a feeding tube. Review of current physician order indicated Osmolite 1.2 (a type of feeding that will supply a person with nutrients and minerals) to be administered continual over 24 hours. Flush tube with 30 ml of warm water every hour. During a tour of unit on 2/10/25, at 12:00 p.m. Resident R379's enteral feeding and water flush bag was observed hanging at bedside and failed to have a date written on the enteral feeding bottle or the water flush bag. During an interview on 2/10/25, at 12:37 p.m. Licensed Practical Nurse (LPN) Employee E13 confirmed she did not see a date on the enteral feeding bottle and the water flush bag. During an interview on 2/10/25, at 3:00 p.m. the Director of Nursing confirmed that the facility failed to ensure that residents with an enteral feeding tube received appropriate treatment and services to prevent potential complications for one of three residents (Residents R379). 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.12(d)(1) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of policy and clinical records, staff and resident interview, it was determined that the facility failed to ensure that physician's orders were followed for the care of an IV Midline Catheter (a type of long-term intravenous catheter) for one of three residents reviewed (Resident R229). Findings include: Review of facility policy Intravenous access: Dressing Change dated 10/1/24, indicated the purpose is to prevent complications associated with intravenous therapy, including catheter-related infections associated with contaminated, loosened or soiled catheter site dressings. Perform site care and dressing change at established intervals or immediately if the integrity of the dressing is compromised (e.g., damp, loosened or visibly soiled). Review of the admission record indicated Resident R229 was admitted to the facility on [DATE]. Review of Resident R229's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/5/25, indicated the diagnoses of seizure disorder (a person experiences abnormal behaviors, symptoms and sensations, sometimes including loss of consciousness), osteomyelitis (inflammation of bone caused by infection) right ankle and foot, and spina bifida (a birth defect where the spinal cord fails to develop or close properly while in the womb). Review of Resident R229's physician order dated 1/31/25, indicated IV Midline - monitor site every shift for signs and symptoms of infection. Transparent dressing changes on admission, weekly, and as needed thereafter. Review of the Resident R229's current care plan failed to include a plan for care and management of the IV midline catheter. Review of Resident R229's Medication Administration Record, and Treatment Administration Record failed to include the physician order for transparent dressing changes. Observation on 2/10/25, at 12:15 p.m. Resident R229 was in the dining room working a puzzle. The left arm IV catheter site appeared soiled with dried blood underneath the dressing. The dressing failed to include a date it was last changed. Interview on 2/10/25, at 12:20 p.m. Unit Director RN Employee E19 confirmed the dressing appeared soiled with dried blood underneath, and that the dressing failed to include a date it was last changed, and a care plan was not present. Interview with the Director of Nursing on 2/14/25, at 12:30 p.m. confirmed that the facility failed to ensure that physician's orders were followed for the care of an IV Midline Catheter (a type of long-term intravenous catheter) for one of three residents reviewed (Resident R229). 28 Pa. Code 211.11(a) Resident care plan. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on observation, clinical record review and interview, the facility failed to provide specialized care needs for the provision of respiratory care in accordance with professional standards of practice for three of six residents (Residents R42, R235 and R811). Findings include: Review of facility policy Oxygen Administration dated 10/1/24, indicated to change pre-filled humidification systems and tubing at least weekly. Review of the admission record indicated Resident R42 was admitted to the facility on [DATE]. Review of Resident R42's Minimum Data Set (MDS - a periodic review of care needs) dated 11/16/24, indicated the diagnoses of high blood pressure, chronic obstructive pulmonary disease (COPD- a group of diseases that block airflow and make it hard to breathe), and diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). Review of Resident R42's physician orders dated 11/11/24, indicated change oxygen tubing, humidification bottle, and cleanse oxygen filter (replace if soiled or missing) weekly. Review of Resident R42's care plan dated 12/5/24, indicated provide oxygen therapy. Observation on 2/12/25, at 10:45 a.m. Resident R42 was in the dining room connected to an oxygen concentrator (medical device that provides 95 percent pure oxygen) running at 3 lpm (liters per minute). The tubing or humidifier contained a date last changed. The filter sponge on the back of the concentrator was missing and there was visible thick fuzz like gray debris in the filter's chamber dividers. Interview and tour on 2/12/25, at 10:45 a.m. with Unit Manager Registered Nurse (RN) Employee E6 confirmed Resident R42's tubing or humidifier contained a date last changed. The filter sponge on the back of the concentrator was missing and there was visible thick fuzz like gray debris in the filter's chamber dividers. Review of the admission record indicated Resident R235 was admitted to the facility on [DATE]. Review of Resident R235's MDS dated [DATE], indicated the diagnoses of chronic obstructive pulmonary disease (COPD- a group of diseases that block airflow and make it hard to breathe), diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy) and toxic liver disease. Review of Resident R235's physician orders dated 3/5/24, indicated change oxygen tubing, humidification bottle, and cleanse oxygen filter (replace if soiled or missing) every Tuesday. Interview and tour on 2/10/25, at 10:45 a.m. with Unit Manager Registered Nurse (RN) Employee E29 confirmed Resident R235's humidification bottle was empty. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record revealed that Resident R811 was admitted to the facility on [DATE]. Review of Resident 811's MDS dated [DATE], indicated diagnoses of alcoholic cardiomyopathy (the heart is unable to pump blood efficiently, leading to heart failure from prolonged alcohol consumption), sarcoidosis of lung (autoimmune disease where the immune system starts attacking the body, forming small inflammatory lumps called granulomas), and depression. Review of Resident R811's physician orders failed to include oxygen administration or maintenance of equipment. Review of Resident R811's baseline care plan dated 1/30/25, indicated oxygen as ordered. Observation on 2/10/25, at 9:24 a.m. Resident R811 was in bed with a nasal cannula (thin tubes that deliver oxygen through the nostrils) in his nose. Tubing was not dated. The tubing was connected to an empty humidification bottle, that was not dated on the wall. Interview and tour on 2/10/25, at 9:30 a.m. with Unit Manager Registered Nurse (RN) Employee E6 confirmed Resident R811's oxygen equipment was not dated, and the humidification bottle was empty. Interview on 2/14/25, at 3:00 p.m. the Director of Nursing confirmed the facility failed to provide specialized care needs for the provision of respiratory care in accordance with professional standards of practice for three of six residents (Residents R42, R235, and R811). 28 Pa. Code: 201.29(j) Resident rights. 28 Pa. Code 211.5(f) Clinical Records 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of facility policy and clinical record and staff interview it was determined that the facility failed to make certain consistent dialysis communication was maintained for two of five dialysis residents (Residents R113, and R213). Findings include: Review of the facility policy Dialysis Care dated 10/1/24, indicated all residents receiving dialysis (a treatment for advanced kidney failure that filters wastes, salts, and fluid from your blood) therapy will be monitored and documentation will be maintained in the medical record. They will be assessed before and after dialysis treatment for compliance with their individualized plan of care. Review of the admission record indicated R113 was admitted to the facility on [DATE]. Review of Resident R113's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/22/25, indicated the diagnoses of stroke (damage to the brain from an interruption of blood supply), anemia (the blood doesn't have enough healthy red blood cells), End Stage Renal Disease (ESRD - kidneys cease to function on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), and hip fracture (broken bone in hip). Review of Resident R113's physician order dated 1/17/25, indicated leave for dialysis at 8:00 a.m. every Tuesday, Thursday, and Saturday. Review of Resident R113's care plan dated 1/17/25, indicated to monitor dialysis catheter for bleeding. If bleeding apply direct pressure, notify physician for further orders. Review of Resident R113's dialysis communication sheets dated 1/18/25, through 2/8/25, indicated failure to complete the communication forms upon return to facility following dialysis on ten occasions (2/8/25, 2/6/25, 2/4/25, 2/1/25, 1/30/25, 1/28/25, 1/25/25, 1/23/25, 1/21/25, and 1/18/25). Interview on 2/10/25, at 12:50 p.m. Unit Director RN Employee E19 confirmed Resident R113's dialysis communication forms were not completed upon return to facility following dialysis on ten occasions (2/8/25, 2/6/25, 2/4/25, 2/1/25, 1/30/25, 1/28/25, 1/25/25, 1/23/25, 1/21/25, and 1/18/25). Review of the admission record indicated Resident R 213 admitted to the facility on [DATE]. Review of the Resident R213's MDS dated [DATE], indicated the diagnoses of anemia, heart failure (heart doesn't pump blood as well as it should), and diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). Review of Resident R213's physician order dated 1/23/25, indicated leave for dialysis at 5:30 a.m. every Monday, Wednesday, and Friday. Review of Resident R213's care plan dated 12/30/24, indicated to monitor dialysis catheter for bleeding. If bleeding apply direct pressure, notify physician for further orders. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R213's dialysis communication sheets dated 1/3/25, through 2/10/25, indicated failure to complete the communication forms upon return to facility following dialysis on 17 occasions (2/10/25, 2/7/25, 2/5/25, 2/3/25, 1/31/25, 1/29/25, 1/27/25, 1/24/25, 1/22/25, 1/20/25, 1/17/25, 1/15/25, 1/13/25, 1/10/25, 1/8/25, 1/6/25, and 1/3/25). Interview on 2/10/25, at 12:50 p.m. Unit Director RN Employee E19 confirmed Resident R213's dialysis communication forms were not completed upon return to facility following dialysis on 17 occasions (2/10/25, 2/7/25, 2/5/25, 2/3/25, 1/31/25, 1/29/25, 1/27/25, 1/24/25, 1/22/25, 1/20/25, 1/17/25, 1/15/25, 1/13/25, 1/10/25, 1/8/25, 1/6/25, and 1/3/25). Interview on 2/13/25, at 2:00 p.m. the Director of Nursing confirmed the facility failed to make certain consistent dialysis communication was maintained for two of five dialysis residents (Residents R113, and R213). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 201.18 (b) (1) (e) (1) Management. 28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, resident record review, and staff interviews, it was determined that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for five of six residents (Residents R33, R51, R141, R168, and R296). Findings include: Review of facility policy Trauma Informed Care dated 10/1/24, indicated the facility will develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate and identify and decrease exposure to triggers that may re-traumatize the resident. Review of Resident R33's record indicated the resident was admitted on [DATE]. Diagnoses included major depressive disorder, opioid dependance and Post Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and may have triggers that can bring back memories of trauma accompanied by intense emotional and physical reactions). Review of Resident R33's assessments did not include a Trauma Informed Care Evaluation (a data collection tool that gathers information on traumatic events and aids in identifying and addressing the resident's needs). Review of Resident R33's care plan initiated 8/14/24, did not include a plan of care developed with goals or interventions for post-traumatic stress disorder. Review of Resident R51's record indicated the resident was admitted on [DATE]. Diagnoses included congestive heart failure, chronic kidney disease and post-traumatic stress disorder. Review of Resident R51's assessments did not include a Trauma Informed Care Evaluation. Review of Resident R51's care plan initiated 9/5/23, did not include a plan of care developed with goals or interventions for post-traumatic stress disorder. Review of Resident R141's admission record indicated he was admitted [DATE]. Review of Resident R141's MDS assessment (MDS: Minimum Data Set assessment-a periodic assessment of resident care needs) dated 11/18/24, indicated he had diagnoses that include Bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), PTSD, diabetes (metabolic disorder impacting organ function related to glucose levels in the human body) and dementia (a condition characterized by memory loss and progressive or persistent loss of intellectual functioning). Review of Resident R141's Certified Registered Nurse Practitioner note dated 12/23/24, indicated that he PTSD and dementia since admission. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R141's care plans dated 12/3/24, did not include PTSD psychological triggers for trauma informed care. Review of Resident R168's admission record indicated he was originally admitted on [DATE]. Review of Resident R168's MDS assessment dated [DATE], indicated he had diagnoses that included paraplegia (a form of paralysis impacting the lower extremities of the body)., chronic pain disorder, and PTSD. Review of Resident R168's psychiatric evaluation note dated 1/21/25, indicated he experienced no PTSD symptoms as per staff. Review of Resident R168's care plans dated 11/8/24, did not include PTSD psychological triggers for trauma informed care. During an interview on 2/12/25, at 12:35 p.m. Registered Nurse (RN) Supervisor Employee E8 confirmed that the facility failed to develop and implement individualized person-centered plans to render trauma informed care to residents with a diagnosis of PTSD for Residents R141 and R168 as required. Review of the clinical record indicated Resident R296 was admitted to the facility on [DATE]. Review of Resident R296's clinical record revealed diagnoses of high blood pressure, malnutrition (lack of sufficient nutrients in the body), and PTSD. Review of Resident R296's care plan on 2/10/25, did not include a plan of care developed with goals and interventions related to post-traumatic stress disorder. During an interview on 2/13/25, at 1:13 p.m. Director of Social Services Employee E9 confirmed that the facility failed to assess Residents R33 and R51, failed to develop a care plan related to post-traumatic stress disorder for Resident R33, R51 and R296. and failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for five of six residents as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1) Management.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure a physician completed the initial visit for three of three residents (Resident R116, R229, and R422). Findings include: Review of Resident R116's clinical record indicated admission to the facility on [DATE]. Review of Resident R116's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/13/24, indicated diagnoses of dementia (occurs when the supply of blood to the brain is reduced or blocked completely, which prevents brain tissue from getting oxygen and nutrients.) hypertension (high blood pressure) and depression. Review of Resident R116's clinical record revealed a new patient visit was completed by Certified Registered Nurse Practitioner, Employee E35 on 6/7/24. The facility failed to ensure the resident's initial visit was conducted by a physician. Review of Resident R229's clinical record indicated admission to the facility on [DATE]. Review of Resident R229's MDS dated [DATE], indicated diagnoses of osteomyelitis (infection in the bone caused by bacteria or fungi), spina bifida occulta (a condition where a gap forms between the small bones (vertebrae) of your backbone (spine), and lymphedema (a chronic condition characterized by abnormal and persistent swelling). Review of Resident R229's clinical record revealed a new patient visit was completed by Certified Registered Nurse Practitioner, Employee E36 on 12/6/24. The facility failed to ensure the resident's initial visit was conducted by a physician. Review of Resident R422's clinical record indicated admission to the facility on [DATE]. Review of Resident R422's MDS dated [DATE], indicated diagnoses of traumatic brain injury, anxiety, and hypertension. Review of Resident R422's clinical record revealed a new patient visit was completed by Certified Registered Nurse Practitioner, Employee E37 on 12/11/24. The facility failed to ensure the resident's initial visit was conducted by a physician. During an interview on 2/14/25, at 10:16 a.m. the Director of Nursing confirmed the facility failed to ensure a physician completed the initial visit for three of three residents (Resident R116, R229, and R422). 28 Pa. Code 211.2(a) Physician Services.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on manufacturer's guidelines, facility policy, clinical record review, and staff interview it was determined that the facility failed to ensure that nursing staff have the specific competencies and skill sets necessary to provide care for a resident with a Life Vest (a wearable defibrillator designed to protect residents from sudden cardiac death), and placed one resident (Resident R811) in immediate jeopardy in which health and safety were impacted. Findings include: Review of the manufacturer's guidelines Life Vest Pocket Card indicated the following: -The Life Vest is a wearable cardiac defibrillator (a device that applies an electric charge to the heart to restore a normal heart beat). -The Respond message means: before delivering a treatment shock, Life Vest test to see if a patient is conscious (aware of their environment) by providing the patient an opportunity to press the response button to prevent a treatment shock. It is important that only the patient press the response button. -Life Vest therapy pads release a blue gel prior to a treatment shock to both improve shock conduction (the process by which heat or electricity is directly transmitted through a substance) and mitigate burning. The gel should remain on the patient as long as the patient is wearing the Life Vest in case additional treatment shocks are required. -Life Vest treats a ventricular (ventricles - the two lower chambers of the heart) arrhythmia (improper beating of the heart, irregular, too fast, or too slow). The time to treatment will be between 25 and 60 seconds depending on the type and rate of the arrhythmia and whether the patient presses the response buttons. -Nobody should touch the patient while a treatment shock is delivered. The device will warn bystanders with both a siren alert and a voice command stating Bystanders, do not interfere. before a shock is delivered. -Vibrations, along with the siren alerts and voice prompts are part of the device's consciousness test, which requires the patient to press the response button to avoid a shock. It is important that only the patient press the response button. -When possible the patient should bring the Life Vest charger, hotspot and extra battery to the hospital which allows the patient to download any stored data from the monitor and change the battery as required. Review of the facility policy Life Vest dated 10/1/24, indicated the facility is to establish procedures for the safe use of wearable defibrillators. The residents' wearable defibrillator will be in accordance with physician orders, and the medical record will include the following: (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Name and contact information of the manufacturer. -Name and contact information of the ordering cardiologist or specialist. -Product pamphlet or web address to access product pamphlet for operating instructions and/or trouble shooting information. Staff responsible for the care of the resident with orders for a wearable defibrillator shall receive education on the use of the device, which is includes but is not limited to: -Purpose of the device and how it works. -Application and care of the garment. -Application of and operating instructions of the monitor. -How to respond to alarms. -When to notify attending or ordering physician. -When to notify manufacturer for replacement. Review of the clinical record revealed that Resident R811 was admitted to the facility on [DATE]. Review of Resident R811's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 2/5/25, indicated diagnoses of alcoholic cardiomyopathy (the heart is unable to pump blood efficiently, leading to heart failure from prolonged alcohol consumption), sarcoidosis of lung (autoimmune disease where the immune system starts attacking the body, forming small inflammatory lumps called granulomas), and depression. Review of Resident R811's Nursing admission evaluation dated 1/29/25, indicated Section H Cardiac/circulation - irregular rate. Section L Skin indicated chest - Life Vest. Review of Resident R811's physician order dated 1/30/25, indicated check Life Vest placement and battery daily. Change Battery daily for Life Vest one time a day. Review of Resident R811's care plan on 2/10/25, failed to include a problem, goal, or interventions for care and management of Life Vest. Observation of Resident R811 on 2/10/25, at 9:29 a.m. in bed under blanket with a device stored inside a black bag attached to his person on top of the blanket. Interview with Resident R811 on 2/10/25, at 9:30 a.m. indicated Yes, I have a Life Vest, and no, the staff don't know how to use it. I change my own battery every night around 10:00 p.m. The hospital only sent me with one garment. Interview on 2/11/25, at 9:01 a.m. Nurse Aide (NA) Employee E1 indicated I don't know what a Life Vest is. I've never been trained at this facility. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 2/11/25, at 9:08 a.m. NA Employee E2 indicated A Life Vest is something they get at the hospital, it monitors their heart. I've never been trained by this facility, but we have a resident with Life Vest in room [ROOM NUMBER]-1 Resident R811. Survey Agency (SA) asked Is he allowed to take that off for showers? NA Employee E2 indicated I don't think so, because I don't think he's allowed to ever take it off. Interview on 2/11/25, at 9:20 a.m. Registered Nurse (RN) Wound Care Employee E3 indicated I've never had Life Vest training at this facility. Interview on 2/11/25, at 9:25 a.m. RN Employee E4 indicated A Life Vest is like a defibrillator, you can take off in the shower, I'm not sure for how long. I have not been trained at this facility on Life Vest. Interview on 2/11/25, at 9:30 a.m. Unit Director RN Employee E5 indicated she was in training and that they had Resident 811 with a Life Vest at the current time. I have not received training at this facility on Life Vest. Interview on 2/11/25, at 9:31 a.m. Unit Director RN Employee E6 indicated I've never been trained on Life Vest at this facility. On 2/11/25, at 10:35 a.m., the Nursing Home Administrator (NHA) and Director of Nursing (DON) were made aware that Immediate Jeopardy (IJ) existed, NHA was provided the IJ Template, that placed one resident (Resident R811) in immediate jeopardy in which health and safety were impacted, and a corrective action plan was requested. On 2/11/25, at 3:07 p.m., an acceptable Corrective Action Plan was received which included the following interventions: Immediate Action: -Facility will implement immediate education for nursing staff for care and operation of the Life Vest, on 2/11/25, to include what alerts mean, first responder instructions, emergency patient management, showering and laundering of vest. All additional staff will be in-serviced on care and operation of the Life Vest prior to the next shift worked. Any staff not scheduled prior to 2/12/25 will be contacted via telephone and educated prior to the next scheduled shift. Residents: -Resident R811's care plan will be revised to include use of the Life Vest on 2/11/25. Physician orders for R811 will be reviewed to ensure orders for care and operation of the Life Vest are present and being followed on 2/11/25. System Correction: (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The NHA and DON will review the policy and procedure for use of the Life Vest to be revised as necessary on 2/11/25. Policy for ensuring equipment needs on new admissions will be reviewed and revised to include communication of equipment needs by admissions staff to nursing staff prior to admission. Admissions director will be re-inserviced on communicating equipment needs to nursing department. Education needs regarding use of equipment will be assessed and provided prior to use. Monitoring: -The NHA will audit all new admissions for 30 days to ensure all equipment needs for new admissions are being met and staff are educated on equipment prior to use. Education, policy revision, and ongoing audits will be shared with Quality Assurance and Performance Improvement (QAPI) committee. During an interview on 2/12/25, at 11:00 a.m. NA Employee E2 indicated, Yes, I was trained on the Life Vest. They said he could take a shower, and I went in with him when he removed the vest. I'm glad I know now. During an interview on 2/12/25, at 11:05 a.m. NA Employee E1 indicated I was trained on the Life Vest. It's pretty amazing what that thing can do. I feel better about it now. During an interview on 2/12/25, at 11:15 a.m. RN Employee E4 indicated I was trained on the Life Vest. Now I know how long it can be off for. During interviews on 2/12/25 - 2/13/25, a total of 64 in person interviews of clinical staff was conducted and verified Life Vest training had occurred, and they had understanding of the education. -Verified the DON trained 91.1% of nursing staff. -Verified Resident R811's care plan was revised to include use of the Life Vest. Physician orders were reviewed and include the operation of the Life Vest on 2/12/25, at 9:10 a.m. -Verified the NHA and DON reviewed and revised the policy for Life Vest and policy for ensuring equipment needs by admissions staff to nursing staff prior to admission. Admission Director was re-educated on 2/12/25. -Verified the NHA will audit all new admissions for 30 days to ensure all equipment needs for new admissions are being met and staff are educated on equipment prior to use. Education, policy revision, and ongoing audits will be shared with Quality Assurance and Performance Improvement (QAPI) committee. -Verified the DON completed an audit on 2/12/25, at 11:08 am of all new admissions as of 2/11/25. Next meeting is 2/27/25. The Immediate Jeopardy was lifted on 2/13/25, at 11:51 a.m. when the action plan was verified. During an interview on 2/11/25, at 10:35 a.m. the NHA and DON confirmed that the facility failed to ensure that nursing staff have the specific competencies, and skill sets necessary to provide care for a resident with a Life Vest which created a situation that placed one resident (Resident R811) in immediate jeopardy in which health and safety were impacted. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	28 Pa Code 201.14(a) Responsibility of licensee. 28 Pa Code 201.18(a)(b)(1)(e)(1) Management. 28 Pa Code 201.29(a)Resident rights. 28 Pa Code 211.5(f) Clinical records 28 Pa. Code: 211.10 (c)(d) Resident care policies 28 Pa Code 211.12(c)(d)(1)(2)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of facility policy, observations and staff interview it was determined that the facility failed to store medications and biologicals as required for two of 12 medication carts (1 Grove Back Medication Cart and 3 Main Medication Cart) and three of six medication rooms (2 Grove Medication Room, 2 Main Medication Room, and 5 Main Medication Room). Findings include: Review of facility policy Storage of Medications dated [DATE], indicated drug containers having soiled, illegible, worn, makeshift, incomplete, damaged, or missing labels are relabeled before storing. Compartments containing medications are locked when not in use. Trays or carts used to transport such items are not left unattended. During an observation on [DATE], at 12:40 p.m. of the Third Main North Medication cart, three treatments were observed inside the medication cart that included: - One tube of Bengay (cream used for pain) - Tender Calm skin protectant (skin cream) - Zinc Oxide Ointment (used to protect skin) During an interview on [DATE], at 12:45 p.m. Licensed Practical Nurse (LPN) Employee E16 confirmed that treatments were in the medication cart and should be kept in the treatment cart. During an observation on [DATE], at 9:11 a.m. of the 1 Grove Back Medication Cart a medication cup with one white pill was observed sitting on top of the medication cart and left unattended. During an interview on [DATE], at 9:20 a.m. Registered Nurse (RN) Employee E10 confirmed that the medication was left unattended on top of the 1 Grove Back Medication Cart and that the facility failed to store medications and biologicals as required. During an observation on [DATE], 10:50 a.m. of Fifth Main Medication Room revealed expired supplies included: - one nasogastric feeding tube (tube inserted through your nose to your stomach) dated [DATE]. - one foley catheter (tube that drains urine from your bladder) dated [DATE]. During an observation on [DATE], at 11:00 a.m. of Fifth Main Medication Room revealed items being stored underneath the sink that included: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- filled sharps (needles, glass) container -bleach wipes -drug buster (used to dispose medication) -gallon of bleach -gallon of vinegar During an interview on [DATE], at 11:06 a.m. LPN Employee confirmed the above findings in Fifth Main Medication Room being stored underneath the sink. During an observation on [DATE], at 1:00 p.m. of Second Main Medication Room refrigerator revealed an outdated vial of Tuberculin (TB-a medication used to test for respiratory disease), dated [DATE]. During an interview on [DATE], at 1:07 p.m. RN Employee E17 confirmed the outdated vial of TB stored in the refrigerator. Observation on [DATE], at 9:22 a.m. of 2 Grove's medication room refrigerator indicated an insulin glargine pen (prefilled pen to inject long-acting insulin under the skin), that failed to have a label with resident's name and was not contained in a bag. Interview on [DATE], at 9:24 a.m. Unit Director RN Employee E6 confirmed the insulin glargine pen failed to have a label with resident's name and was not contained in a bag as required. Interview on [DATE], at 3:00 p.m. the Director of Nursing confirmed that the facility failed to store medications and biologicals as required for two of 12 medication carts (1 Grove Back Medication Cart and 3 Main Medication Cart) and three of six medication rooms (2 Grove Medication Room, 2 Main Medication Room, and 5 Main Medication Room). 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on clinical record review, facility documents and staff interviews, it was determined that the facility failed to provide dental services to meet the needs of residents for one of three residents reviewed (Residents R250). Findings include: Review of the facility Dental Services policy dated 10/1/24, indicated the facility will assist residents in obtaining routine dental care. This requirement makes the facility directly responsible for the dental care needs of the residents. Review of the clinical record revealed that Resident R250 was admitted to the facility on [DATE], and readmitted [DATE]. Review of Resident R250's care plan dated 4/11/24, indicated the resident is at risk for altered dentition and/or mucus membrane related to obvious or likely cavity or broken natural teeth. It was indicated to obtain a dental consult as necessary. Review of Resident R250's physician order dated 10/7/24, indicated to consult the dentist for routine evaluation. Review of Resident R250's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 1/31/25, indicated diagnoses of high blood pressure, depression, and dementia (loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities). During an interview on 2/12/25, at 11:36 a.m. Transportation Aide, Employee E34 confirmed Resident R250 was not seen by the dentist as ordered. During an interview on 2/12/25, at 11:51 a.m. the Director of Nursing confirmed the facility failed to provide dental services to meet the needs of residents for one of three residents (Residents R250). 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 211.15. Dental services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41984 Based on observations and staff interview, it was determined that the facility failed to properly maintain sanitary conditions in the main kitchen which created the potential for cross contamination. Findings include: During an observation of the main designated kitchen on 2/10/25, at 9:05 a.m. the following was observed: -brown debris in ice machine (two) -brown, fuzzy debris on wall fans (three) During an interview on 2/10/25, at 9:30 a.m. Dietary Manager Employee E24 confirmed the debris in ice machines. Employee E24 could not confirm the last time they were cleaned. During an interview on 2/10/25, at 9:45 a.m., Dietary Manager Employee E24 confirmed that the facility failed to maintain sanitary conditions in the main kitchen which created the potential for food borne illness. 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.6(c) Dietary services. 28 Pa. Code: 201.14(a) Responsibility of licensee.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 46337 Based on review of job descriptions, clinical records and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to effectively manage the facility to prevent the elopement of a resident (Resident R456), which created an immediate jeopardy situation for all 461 of 461 residents. Findings include: The job description for the Nursing Home Administrator dated 10/10/23, specified the primary purpose of the job is to manage the facility in accordance with current applicable, federal, state, and local standards, guidelines, and regulations the govern long-term care facilities. It is the NHA job to follow all facility policies and to ensure the highest degree of quality care is provided to the residents at all times. The job description for the Director of Nursing dated 3/22/21, specified it is the responsibility of the DON to organize, develop, and direct the overall operations of the Nursing Service Department in accordance with current federal, state and local standards, guidelines and regulations that govern the facility. Based on findings identified in this report, the facility failed to prevent the elopement of a resident who resided on a locked unit (Resident 456), which placed the residents in Immediate Jeopardy. The NHA and the DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed. During an interview on 2/11/25, at 10:13 a.m. the NHA and DON were notified that they failed to effectively manage the facility to prevent the elopement of a resident, which created an immediate jeopardy situation for all residents. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 207.2 (a) Administrator's responsibility. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on clinical record review, staff interviews and review of the facility's assessment it was determined that the facility failed to implement and document a complete facility wide assessment, which identified the specific resources necessary to care for its specific resident population. Findings include: Review of the clinical record revealed that Resident R811 was admitted to the facility on [DATE]. Review of Resident 811's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 2/5/25, indicated diagnoses of alcoholic cardiomyopathy (the heart is unable to pump blood efficiently, leading to heart failure from prolonged alcohol consumption), sarcoidosis of lung (autoimmune disease where the immune system starts attacking the body, forming small inflammatory lumps called granulomas), and depression. Review of Resident R811's Nursing admission evaluation dated 1/29/25, indicated Section H Cardiac/circulation - irregular rate. Section L Skin indicated chest - Life Vest. Review of Resident R811's physician order dated 1/30/25, indicated check Life Vest placement and battery daily. Change battery daily for Life Vest one time a day. Review of the Facility assessment dated [DATE], failed to include the use of a Life Vest as a condition that requires complex medical care and management routinely cared for in the facility. Interview on 2/13/25, at 2:43 p.m. the Nursing Home Administrator confirmed the facility failed to implement and document a complete facility wide assessment, which identified the specific resources necessary to care for its specific resident population. 28 Pa. Code: 207.2(a) Administrator's responsibility.

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. 46337 Based on review of facility documents, and staff interviews it was determined the facility failed to designate a physician to serve as medical director. Findings Include: Review of the facility's medical director contract dated 1/1/21, indicated Doctor of Osteopathic Medicine (DO), Employee E40 is the President and CEO of a group that is responsible for medical directorship services of the facility. Review of information submitted to the Department of Health, on 2/13/25, at 1:30 p.m. revealed Medical Director, Employee E38 was the designated Medical Director of the facility since 9/1/16. Review of the facility's emergency preparedness plan on 2/13/25, at 1:32 p.m. revealed DO, Employee E40 was the Medical Director. During an interview on 2/13/25, at 1:41 p.m. the Nursing Home Administrator (NHA) indicated Medical Director, Employee E38 has not been the Medical Director since he's been here. It was indicated Medical Director, Employee E38 was the medical director before 2023, and Medical Director, Employee E39 took over the beginning of 2024. NHA stated when Medicare/Medicaid recertifications were submitted, Medical Director, Employee E39 was listed. During an interview on 2/13/25, at 1:47 p.m. the NHA stated multiple people are the Medical Director and the facility uses a group. The NHA confirmed the facility failed to designate a physician to serve as medical director. During an interview on 2/13/25, at 2:09 p.m. the Director of Nursing stated DO, Employee E40 is not in the building much, and he delegated the Medical Director role to Medical Director, Employee E39. The DON indicated Medical Director, Employee E39 is the acting Medical Director, and he is the one who attends Quality Assurance and Performance Improvement (QAPI) meetings. During an interview on 2/14/25, at 9:55 am. Medical Director, Employee E39 stated he works for a medical group under DO, Employee E40 and functions as the facility's medical director. It was indicated he started coming to the facility in October 2023. 28 Pa. Code 211.2.(d) Medical director.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of facility documents, resident clinical records and staff interviews it was determined that the facility failed to ensure residents had the capacity to understand the terms of a binding arbitration agreement (A binding agreement by the parties to submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship, whether contractual or not.) for two of five residents (Residents R300, and R428). Findings include: Review of the admission record indicated Resident R300 was admitted to the facility on [DATE]. Review of Resident R300's Binding Arbitration Agreement indicated that the resident signed the document on 6/28/24. Review of Resident R300's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/4/24, indicated the diagnoses of Non-Alzheimer ' s Dementia (dementia caused by other diseases with symptoms forgetfulness, limited social skills, and impaired thinking abilities that interfere with daily functioning), weight loss, and depression. Section C0500 BIMS (Brief Interview for Mental Status - a screening test that aides in detecting cognitive impairment) indicated a score of 3 (score of 0 -7 indicates severe cognitive impairment. Review of the admission record indicated Resident R428 was admitted to the facility on [DATE]. Review of Resident R428's Binding Arbitration Agreement indicated that the resident signed the document on 11/6/24. Review of Resident R428's MDS dated [DATE], indicated the diagnoses of Non-Alzheimer ' s Dementia, diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and high blood pressure. Section C0500 BIMS (Brief Interview for Mental Status - a screening test that aides in detecting cognitive impairment) indicated a score of 0 (score of 0 -7 indicates severe cognitive impairment. Interview on 2/14/25, at 10:17 a.m. Admission Director, Employee E21 confirmed the facility failed to ensure a resident had the capacity to understand the terms of a binding arbitration agreement for two of five residents (Residents R300, and R428). 28 Pa. Code: 201.14(a)(c)(d)(e) Responsibility of licensee. 28 Pa. Code: 201.18(e)(1) Management

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 46167 Based on review of facility policy, Quality Assurance attendance records, and staff interview, it was determined that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all of the required committee members for two of four quarters (January 2024 through March 2024, and July 2024 through September 2024). Findings include: Review of facility policy Quality Assurance Performance Improvement (QAPI) dated 10/1/24, indicated that the facility will conduct quality assurance/improvement and assessment committee meeting at least quarterly to identify areas of service that are non-compliant, or with potential for improvement. Members include Administrator, Director Nursing, Physician, Pharmacy Consultant, three additional members that may include Nutrition. Environmental Services, Social Services, Activities, medical Records, Plant Operations, Human Resources, Rehabilitation. A review of the QAPI Committee meeting sign-in sheets from the period of January 2024 through March 2024, did not reveal that the Medical Director was in attendance. A review of the QAPI Committee meeting sign-in sheets from the period of July 2024 through September 2024, did not reveal that the Infection Preventionist was in attendance. During an interview on 2/14/25, at 10:44 a.m. the Director of Nursing confirmed that the facility failed to conduct QAA meetings at least quarterly with all of the required committee members as required. 28 Pa Code: 201.18(e)(1)(2)(3)(4) Management.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to follow enhanced barrier precautions for one of five residents (Residents R367). Findings include: Review of the facility policy Enhanced Barrier Precautions dated 10/1/24, indicated enhanced barrier precautions (EBP) are in place for residents with an infection or colonization of a multi-drug-resistant organism (MDRO), wounds and/or indwelling medical devices. Gowns and gloves are to be on and used when providing high contact care with a resident who is in EBP. Review of the clinical record indicated Resident R367 was admitted to the facility on [DATE]. Review of Resident R367's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/2/25, indicated diagnoses of neurogenic bladder (lack of bladder control due to a brain, spinal cord or nerve problem), paraplegia (paralysis of legs and lower body), and depression. Review of Resident R367's physician order dated 1/29/25, indicated EBP. Resident with presence of suprapubic catheter, colostomy, and wound. Staff to wear gloves and gown for high contact resident care: dressing, bathing, transferring, changing linen, toileting/hygiene care device/line care, and wound care. Review of Resident R367's care plan dated 1/3/25, indicated resident with presence of colostomy, suprapubic catheter, and wound requiring EBP. Observation on 2/10/25, at 1:29 p.m. Resident R367's door was adorned with EBP signage. Observation on 2/10/25, at 1:30 p.m. Resident R367 was receiving direct personal hygiene care from Nurse Aide (NA) Employee E25. NA Employee E25 failed to have a gown on as required for EBP. Interview on 2/10/25, at 1:30 p.m. NA Employee E25, confirmed she did not have a gown on as required for EBP. Observation on 2/11/25, at 9:09 a.m. Wound Care Registered Nurse (RN) Employee E3 was observed providing direct wound care with another staff member. Neither staff member had a gown on as required for EBP. Interview on 2/11/25, at 9:10 a.m. Wound Care RN Employee E3 confirmed that neither staff had a gown on as required for EBP. Interview on 2/14/25, at 3:00 p.m. the Director of Nursing confirmed the facility failed to follow enhanced barrier precautions as required for one of five residents (Residents R367). 28 Pa. Code 201. 18(b)(1) Management. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa code:211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(c)(d)(1)(3)(5) Nursing services

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075 Based on facility policy, clinical record review and staff interview, it was determined that the facility failed to provide accurate and timely documentation related to the Influenza and Pneumonia vaccine for two of six residents (Resident R101, and R133). Findings include: Review of facility policy Resident Immunizations dated 10/1/24, indicated that Pneumovax and influenza immunizations will be offered to residents. Purpose is to prevent transmission of pneumococcal pneumonia, influenza, and other agents as indicated. Pneumovax should be offered to all residents who have never received the vaccine, who have unknown status of vaccine, and those over age 65. Influenza vaccine is offered September through April of each year. Review of the clinical record indicated Resident R101 was admitted to the facility on [DATE]. Review of Resident R101's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/9/24, indicated diagnoses of high blood pressure, anemia (too little iron in the body causing fatigue), and arthritis. MDS Section O0250 Influenza marked 4 - offered but declined. MDS Section O0300 Pneumococcal Vaccine marked 2 - offered but declined. During a review of Resident R101's clinical record on 2/13/25, at 1:00 p.m. indicated that the Pneumonia and Influenza vaccination was refused. During a review of Resident R101's clinical record on 2/13/25, at 1:05 p.m. failed to include documentation of Pneumonia and Influenza vaccination refusal consent form, and that education was provided to Resident R101. Review of the clinical record indicated that Resident R133 was admitted to the facility on [DATE]. Review of Resident R133's MDS dated [DATE], included diagnoses of high blood pressure, chronic pain, and visual loss. MDS Section O0250 Influenza marked 4 - offered but declined. MDS Section O0300 Pneumococcal Vaccine marked 3 - not offered. During a review of Resident R133's clinical record on 2/13/25, at 1:10 p.m. indicated that the Influenza vaccination was refused, and the pneumonia vaccination was blank. During a review of Resident R133's clinical record on 2/13/25, at 1:12 p.m. failed to include documentation of pneumonia vaccination consent form, influenza declined consent form, and that education was provided to Resident R133. During an interview on 2/13/25, at 1:15 p.m. Infection Preventionist Employee E15 confirmed that the facility failed to provide accurate and timely documentation related to the Influenza and Pneumonia vaccine for two of six residents (Resident R101, and R133). 28 Pa. Code 211.5(f) Clinical records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395015	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Rehabilitation and Wellness Center	246 Friendship Circle Beaver, PA 15009

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075 Based on facility policy, clinical record review and staff interview, it was determined that the facility failed to provide accurate and timely documentation related to the COVID-19 (a respiratory infection) vaccine for two of six residents (Resident R101, and R133). Findings include: Review of facility policy Covid Management Plan dated 10/1/24, indicated that residents and staff members will be offered the vaccine unless the immunization is medically contraindicated, or the resident or staff member has already been immunized. The resident or resident representative may refuse the vaccine, and may change their decision. Review of the clinical record indicated Resident R101 was admitted to the facility on [DATE]. Review of Resident R101's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/9/24, indicated diagnoses of high blood pressure, anemia (too little iron in the body causing fatigue), and arthritis. MDS section O0350-Covid 19 vaccination, is up to date was marked 0 indicating - no, resident is not up to date. During a review of Resident R101's clinical record on 2/13/25, at 1:00 p.m. indicated that the Covid-19 vaccination was refused. During a review of Resident R101's clinical record on 2/13/25, at 1:05 p.m. failed to include documentation of Covid-19 vaccination refusal consent form, and that education was provided to Resident R101. Review of the clinical record indicated that Resident R133 was admitted to the facility on [DATE]. Review of Resident R133's MDS dated [DATE], included diagnoses of high blood pressure, chronic pain, and visual loss. MDS section O0350-Covid 19 vaccination, is up to date was marked 0 indicating - no, resident is not up to date. During a review of Resident R133's clinical record on 2/13/25, at 1:10 p.m. indicated that the Covid-19 vaccination was refused. During a review of Resident R133's clinical record on 2/13/25, at 1:12 p.m. failed to include documentation of Covid-19 vaccination refusal consent form, and that education was provided to Resident R133. During an interview on 2/13/25, at 2:15 p.m. Infection Preventionist Employee E15 confirmed that the facility failed to provide accurate and timely documentation related to the COVID-19 vaccine for two of six residents (Resident R101, and R133). (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.5(f) Clinical records

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075 Based on observations and staff interviews it was determined that the facility failed to make certain that equipment was in safe operating condition for one of six residents (Resident R761). Findings include: Review of facility Resident Right policy dated 10/1/24, indicated that the facility will promote the exercise of rights for each resident. The nursing home shall establish and implement written policies and procedures setting forth the right of residents for the protection and preservation of dignity, individuality and, to the extent medically feasible, independence. Review of the clinical record indicated Resident R761 was admitted to the facility on [DATE]. Review of Resident R761's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/6/25, indicated diagnoses of high blood pressure, absence of right and left lower legs, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). MDS Section GG Functional Abilities Admission RR1: Type of wheelchair used was marked 1, indicating a manual wheelchair. During a review of current physician orders on 2/10/25, at 12:05 p.m. indicated resident to be out of bed to manual wheelchair with pressure reduction cushion, bilateral leg rests and anti-rollback safety device in place to reduce fall risk. During Resident R761 interview on 2/10/25, at 1:40 p.m. resident stated, Look at this wheelchair, the brakes don't even work. I'm afraid if I transfer out of the wheelchair, it will move, and I will fall. During an observation on 2/10/25, at 1:55 p.m. bilateral braking mechanisms were loose, had yellow tape around the handles, and was not in working order. Resident R761 was able to wheel his wheelchair forward while the brakes were engaged. During an interview on 2/10/25, at 2:00 p.m. the Licensed Practical Nurse Employee E13 stated I thought they fixed the brakes. I will call our therapy department to come and see him. During an interview on 2/10/25, at 2:15 the LPN Employee E13 confirmed that the facility failed to make certain that equipment was in safe operating condition for one of six residents (Resident R761). 28 Pa Code: 201.14(a) Responsibility of licensee.

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F 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure each resident has 1) at least one window to the outside in a room; 2) a room at or above ground level; 3) adequate bedding; 4) furniture that meets the resident's needs; or 5) adequate closet space. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45577 Based on observation and staff interview, it was determined the facility failed to provide a bed, a mattress and functional furniture in resident rooms on the [NAME] Wing for 17 out of 17 rooms (Third Floor). Findings include: Review of the facility policy Resident Environment dated 10/1/24, indicated the facility will provide an environment that is safe, clean, comfortable, and homelike, allowing the resident to use his or her personal belongings to the extent possible. S483.90(e)(2) -The facility must provide each resident with-- (i) A separate bed of proper size and height for the safety and convenience of the resident; (ii) A clean, comfortable mattress; (iii) Bedding, appropriate to the weather and climate; and (iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident. During an observation on 4/10/25, at 1:00 p.m., of the [NAME] Wing 3rd floor revealed: - room [ROOM NUMBER] (dual occupancy room) was missing one bed frame, 2 mattresses, and furniture. - room [ROOM NUMBER] (quad occupancy room) was missing mattresses, and furniture. - room [ROOM NUMBER] (quad occupancy room) was missing mattresses, and furniture. - room [ROOM NUMBER] (quad occupancy room) was missing 1 bed frame, mattresses, and furniture. - room [ROOM NUMBER] (quad occupancy room) was missing bed frames, mattresses, and furniture. - room [ROOM NUMBER] (quad occupancy room) was missing bed frames, mattresses, and furniture. - room [ROOM NUMBER] (quad occupancy room) was missing bed frames, mattresses, and furniture. - room [ROOM NUMBER] (single occupancy room) was missing bed frame, mattress, and furniture. - room [ROOM NUMBER] (single occupancy room) was missing bed frame, mattress, and furniture. - room [ROOM NUMBER] (dual occupancy room) was missing one bed frame, mattresses, and furniture. (continued on next page)

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F 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- room [ROOM NUMBER] (quad occupancy room) was missing 2 bed frames and mattresses. - room [ROOM NUMBER] (quad occupancy room) was missing 2 operational bed frames, mattresses, and furniture. - room [ROOM NUMBER] (quad occupancy room) was missing 1 operational bed frame, mattresses, and furniture. - room [ROOM NUMBER] (quad occupancy room) was missing 3 bed frames, mattresses, and furniture. - room [ROOM NUMBER] (quad occupancy room) was missing 1 operational bed frame, mattresses, and furniture. - room [ROOM NUMBER] (quad occupancy room) was missing 2 bed frames, mattresses, and furniture. - room [ROOM NUMBER] (single occupancy room) was missing mattress and furniture. During an interview conducted on 4/10/25, at 12:45 p.m., Nursing Home Administrator (NHA) stated that [NAME] Wing 3rd floor could be ready for resident occupancy at a moment's notice; would only require area to be cleaned and put beds and furniture into rooms. During an interview on 4/10/25, at 3:00 p.m., Maintenance Director (MD) Employee E2 stated that [NAME] Wing 3rd floor has been used for backup of beds and other items, and that about 20 bed frames are usable at this time. MD Employee E2 stated that equipment to furnish [NAME] Wing 3rd floor has been ordered, and first order was received today, however at this time, only about three quarters of this unit could be brought to regulation and resident ready within 24 hours. MD Employee E2 confirmed that the facility failed to provide a bed, a mattress and functional furniture in resident rooms on the [NAME] Wing for 17 out of 17 rooms (Third Floor). 8 Pa. Code 201.18 (e) (2.1) Management

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 35785 Based on review of facility policy, observations and staff interview, it was determined that the facility failed to maintain an effective call system for one out of three resident restrooms in the East building (Two East Solarium/ common area restroom). Findings include: The facility Call lights policy dated 10/1/24, indicated that a call light system is used by this facility to respond to the resident's requests and needs. Be sure that the call light is plugged in at all times. During an observation on 2/10/25, at 9:38 a.m. of the Two East Solarium/ common area restroom door was observed open with no emergency call light or call cord attached for emergency use. During an observation on 2/12/25, at 9:33 a.m. of the Two East Solarium/ common area restroom door was observed open with no emergency call light or call cord attached for emergency use. During an interview on 2/12/25, at 9:35 a.m. the Licensed Practical Nurse (LPN) Supervisor Employee E7 indicated that failed to maintain an effective call system for one out of three resident restrooms in the East building as required. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (b) (1) Management