STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395031	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven Place	24 Cree Drive Lock Haven, PA 17745

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38839 Based on clinical record review and staff interview, it was determined that the facility failed to establish clear and consistent resident wishes regarding advance directives for one of three residents reviewed (Resident 34). Findings include: Review of Resident 34's electronic clinical record revealed a physician's order dated [DATE], indicating the resident was a DNR, (do not resuscitate) in the event the resident's heart stops beating. A review of Resident 34's paper clinical record revealed a large sticker on the outside of the chart indicating DNR. At the front of Resident 24's paper clinical record a sheet entitled Physician Provider Orders - Indication of resuscitation level noted it was discussed with the POA (power of attorney) DNR/DNI (do not resuscitate/do not intubate), over the phone and this is also what the patient wants. The form was signed by the resident on [DATE]. Directly behind the form noted above in the paper record was a POLST (Physician Orders for Life-Sustaining Treatment, a document for specific medical orders to be honored by health care workers during a medical crisis) form dated [DATE], which indicated Resident 34 chose CPR (cardiopulmonary resuscitation, a lifesaving procedure performed when the heart stops beating). There was no evidence Resident 34's physician order for life sustaining treatment was ever changed to full resuscitation (CPR) as indicated in the resident's wishes on the POLST dated [DATE], as the active order had remained since [DATE], and the resident had conflicting information between a POLST and physician provider order's sheet at the front of the resident's paper clinical record located on the nursing unit. This was reviewed with the Director of Nursing and Employee 5, assistant nursing home administrator, on [DATE], at 2:20 PM. In an interview with the Director of Nursing on [DATE], at 11:00 AM they indicated staff would follow the form dated the most recent, which would be the physician order form dated [DATE], of DNR. The nurse practitioner met with Resident 34 on [DATE], and the resident indicated his wish was to have CPR and full treatment, another POLST was completed with the resident and nurse practitioner. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The above findings were reviewed with the Director of Nursing and Employee 5 on [DATE], at 11:45 AM. 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Discontinue Trmnt; Formulate Adv Dir Previously cited deficiency [DATE] 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 18229 Based on observation, clinical record review, and resident family and staff interview, it was determined that the facility failed to provide a dependent resident with activities of daily living assistance for one of one resident reviewed (Resident 35). Findings include: Observation of Resident 35 on October 1, 2024, at 10:52 AM revealed several days of beard growth on his face. Resident 35 stated that he had a shower that morning and prefers to be clean shaven. Further interview with Resident 35's family on October 1, 2024, at 12:38 PM revealed that the staff do not shave Resident 35 because the razors were too dull, and they cut his face. Resident 35's family stated that he only gets shaved when he goes to the beautician. Clinical record review for Resident 35 revealed a plan of care developed by the facility to address his activity of daily living deficit initiated on March 6, 2024, noting Resident 35 required extensive to total dependence on staff for personal hygiene. Clinical record review for Resident 35 revealed his most recent MDS (Minimum Data Set, an assessment completed at specific interval to determine care needs) dated August 18, 2024, noted staff assessed him as requiring substantial/maximum assistance for personal hygiene (including shaving). Interview with the Director of Nursing and Employee 5 (assistant nursing home administrator) on October 2, 2024, at 2:04 PM stated that electric razors are supposed to be in each resident room. Further observation of Resident 35's room on October 2, 2024, at 2:42 PM revealed there were no electric razors in Resident 35's room. The facility failed to provide assistance for personal hygiene for a resident dependent on staff assistance. 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 29512 Based on clinical record review and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician ordered pain medications for two of two residents reviewed (Residents 59 and 63) Findings include: Clinical record review for Resident 59 revealed physician orders for the following pain medications: Ordered on March 28, 2024, and discontinued on June 14, 2024, Acetaminophen (Tylenol, for mild pain) 325 milligrams (mg) 2 tablets by mouth (PO) every 6 hours as needed (PRN) for pain, not to exceed 3 grams per 24 hours. Ordered on May 25, 2024, and discontinued on May 28, 2024, Oxycodone (for moderate to severe pain) 5 mg one-half tablet PO every 4 hours PRN for moderate pain 4-6 on a scale of 1-10. Ordered on May 28, 2024, Oxycodone 10 mg PO every 4 hours PRN for pain 5-10. There was no documentation that the facility identified which pain medication staff were to administer for mild, moderate, and/or severe pain parameters or that the facility identified that multiple medications were available for the same pain parameter. Review of Resident 59's May 2024 MAR (medication administration record, a form to document medication administration) revealed the following: Staff administered the following PRN pain medicine: Oxycodone 5 mg one-half tablet PO every 4 hours PRN for moderate pain 4-6 on a scale of 1-10. May 25, 2024, at 9:46 AM staff did not document a level of pain May 26, 2024, at 10:43 AM staff did not document a level of pain May 26, 2024, at 8:11 PM for a pain level of 8 May 27, 2024, at 6:26 AM for a pain level of 8 May 28, 2024, at 5:25 AM for a pain level of 7 Clinical record review for Resident 63 revealed physician's orders for the following pain medications: Ordered on September 23, 2024, Acetaminophen 325 mg 2 tablets PO every 6 hours PRN for pain 1-7, not to exceed 3 grams per 24 hours. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ordered on September 23, 2024, Oxycodone 5 mg PO every 6 hours PRN for moderate to severe pain 7-10 related to restlessness and agitation. Review of Resident 63's September 2024 MAR revealed staff administered the following PRN pain medications: Oxycodone 5 mg PO every 6 hours PRN for moderate to severe pain 7-10 related to restlessness and agitation. September 30, 2024, at 10:28 PM for a pain level of 4. October 1, 2024, at 10:49 PM for a pain level of 4. Acetaminophen 325 mg 2 tablets PO every 6 hours PRN for pain 1-7, not to exceed 3 grams per 24 hours September 29, 2024, at 2:53 PM, for a pain level of N/A (not applicable). The surveyor reviewed Resident 53 and 63's pain medication information during an interview with the Director of Nursing on October 3, 2024, at 10:38 AM, and October 4, 2024, at 10:45 AM. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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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** 38839 Based on observation, clinical record review, and staff interview, it was determined that the facility failed to ensure an environment free from the potential spread of infection for one of one resident reviewed for COVID-19 transmission-based precaution concerns (Residents 218). Findings include: The Infection Control Guidance: SARS-CoV2 https://www.cdc.gov/covid/hcp/infection-control/index.html, last updated June 24, 2024, notes that health care personnel who enter the room of a patient with suspected or confirmed SARS=CoV-2 should adhere to standard precautions and use a NIOSH approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face. Clinical record review for Resident 218 revealed the resident was admitted to the facility on [DATE]. A nursing note dated September 27, 2024, noted the resident's COVID swab results positive. An observation of Resident 218's room on October 1, 2024, at 12:47 PM revealed a plastic bin outside the doorway of the resident's room with gloves and gowns in the drawers of the bin and two boxes of N95 masks sitting on top of the bin. Additional storage of gloves and gowns was also observed hanging over the resident's door to the room. A sign on the resident's door frame noted Airborne and contact precautions, visitors please go to the nurse's station for instructions for hand hygiene and mask use. The sign also indicated, All staff must follow these precautions with words and pictures: hand hygiene, gown, gloves, N95 or PAPR (powered air purifying respirator). An observation of Resident 218 on October 1, 2024, at 12:47 PM revealed Employee 3, nurse aide, approached the resident's room, donned an N95 mask only and proceeded to enter the resident's room. Employee 3 was observed from the resident's doorway to obtain the resident's meal tray, set it by a sink near the resident's door, go back to the resident to obtain an empty beverage container, and other tray items to add to the used meal tray. Employee 3 then picked up the tray, exited the resident's room, and walked down the hallway past several resident rooms to a meal delivery cart parked in the hallway. Employee 3 opened the door to the cart, placed the tray in the cart, sanitized her hands at a nearby sanitizing station, and then closed the door to the meal delivery cart. In a concurrent interview with Employee 3 after the above events, when Employee 3 was asked what was needed to enter Resident 218's room, Employee 3 looked at the sign referenced above and stated a mask, a gown, and gloves, and stated, I should have worn a gown and gloves. When asked about procedures to place used meal trays in delivery carts from the resident rooms for resident's on transmission based precautions, Employee 3 indicated she had only worked at the facility a short time, and had not been educated as to any specific procedure to do so, as the tray was carried down the hall, the door handle was touched by the employee to place the tray in the cart, the employee then sanitized and touched the contaminated door to the cart to close it. Employee 3 had not donned a gown or gloves to enter Resident 218's room and had contact with other items outside the resident's room immediately after leading to the potential spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident 218 and a family member on October 1, 2024, at 1:05 PM, Employee 4, licensed practical nurse, entered the resident's room, spoke with the resident and her family member, and administered medications to the resident. Employee 4 was not wearing a mask, gown, or gloves. In a concurrent interview with Employee 4, the employee stated she didn't see any regular masks in the storage holder on the door, and that she would have to refill it. Employee 4 was shown the above sign by the surveyor listing the precautions and required personal protective equipment, and the plastic bin of gowns, gloves, and boxes of N95 masks sitting on top of it, and Employee 5 stated she wasn't sure if she was coming off of precautions as she hadn't met her. Employee 4 was asked how she would know what personal protective equipment was required for a transmission-based precautions room, and she indicated the sign. During medication administration with Employee 1 (licensed practical nurse) on October 2, 2024, at 9:07 AM, Employee 1 (licensed practical nurse) donned a gown, gloves, and N95 mask prior to entering Resident 218's room. Upon exiting the room Employee 1 was unsure where to place her N95 mask for further use during her shift. Employee 1 questioned Employee 2 (nurse aide) where she placed her used N95 mask and Employee 2 stated that she placed her used N95 mask on top of the PPE (personal protective equipment) cart, uncovered next to the clean N95 masks. Facility staff did not follow airborne and contact precautions for a COVID-19 positive resident. The above information was reviewed with the Director of Nursing and Employee 5, assistant nursing home administrator, on October 2, 2024, at 2:30 PM. 28 Pa. Code 201.18(b)(3)(d)(e)(1) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services