STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395050	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garvey Manor	1037 South Logan Boulevard Hollidaysburg, PA 16648

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 48809 Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to provide a reasonable accommodation of needs by failing to ensure that the call bell was within reach for one of 39 residents reviewed (Resident 57). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 57, dated April 30, 2024, indicated that the resident was understood and could usually understand others, and she required minimal assistance of staff for care. The resident's care plan, dated January 9, 2024, included that staff were to encourage her to use her call bell for assistance, and the call bell would be placed within reach when the resident is in her room. A therapy note, dated July 28, 2024, revealed that Resident 57 was to have supervision with ambulation and transfers. Observations of Resident 57 on July 29, 2024, at 11:03 a.m. revealed that the resident was sitting on her bed attempting to ambulate, and her call bell was behind her nightstand on the floor and out of reach. Interview with Nurse Aide 1 at that time revealed that Resident 57 could use her call bell and that it should have been placed within her reach. Interview with Director of Nursing on July 30, 2024, at 2:16 p.m. confirmed that Resident 57 could use her call bell and that it should have been placed within her reach. 28 Pa. Code 211.12(d)(5) Nursing Services.

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

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 41233 Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for two of 39 residents reviewed (Residents 45, 89). Findings include: The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2019, revealed that Section O0100 was to be completed with the resident's special treatments, procedures, and programs, and Section O0100C was to be coded for the use of oxygen. Column (1) was to be checked if oxygen was used while not a resident of the facility within the last 14 days, and column (2) was to be checked if oxygen was used while a resident of the facility within the last 14 days. A care plan for Resident 45, revised on November 9, 2023, indicated that the resident had an altered respiratory status related to a history of aspiration (food or liquid entering the lungs) and sleep apnea (a sleep disorder in which breathing repeatedly stops). Physician's orders for Resident 45, dated August 8, 2023, included an order for the resident to use oxygen therapy. A quarterly MDS assessment for Resident 45, dated July 17, 2024, revealed that column (2) of Section 00100C (oxygen therapy) was not marked with a checkmark indicating that the resident used oxygen. A care plan for Resident 89, dated July 3, 2023, indicated that the resident had an altered respiratory status related to a history of congestive obstruction pulmonary disease (a long-term lung disease that makes it hard to breath). Physician's orders for Resident 89, dated July 3, 2023, included an order for the resident to use oxygen therapy. An quarterly MDS assessment for Resident 89, dated July 12, 2024, revealed that column (2) of Section 00100C (oxygen therapy) was not marked with a checkmark indicating that the resident used oxygen. Interview on August 1, 2024, at 10:27 a.m. with Licensed Practical Nurse 7, who was responsible for the completion of the MDS assessment, confirmed that Section O0100C of Resident 45 and 89's MDS assessment was inaccurate and should have indicated that the residents received oxygen therapy 28 Pa. Code 211.5(f) Clinical Records.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43856 Based on policy review, clinical record reviews, and staff interviews, it was determined that the facility failed to develop an individualized care plan for diabetes mellitus and/or comfort care for two of 39 residents reviewed (Residents 69, 88). Findings include: The facility's policy regarding care plans, dated July 2, 2024, revealed that care plans will be developed that include measurable goals and timeframes, and must describe the services that are to be provided to attain or maintain the resident's highest practicable physical, mental, and psychosocial needs identified in the comprehensive assessment. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 69, dated May 8, 2024, revealed that the resident was usually understood and could usually understand, was cognitively intact, dependent on staff for care, had diagnoses that included diabetes mellitus, and received insulin (a medication for the treatment of diabetes mellitus). A review of Resident 69's clinical record, including the medication administration records, revealed that the resident received daily insulin injections. There was no documented evidence in the clinical record for Resident 69 to indicate that a care plan regarding diabetes mellitus was developed for Resident 69. Interview with the Director of Nursing on August 1, 2024, at 9:08 a.m. confirmed that a care plan to address Resident 69's diabetes mellitus diagnosis was not developed and should have been. A quarterly MDS assessment for Resident 88, dated July 9, 2024, revealed that the resident was cognitively intact, required extensive assistance from staff for her daily care needs and had a diagnosis of cerebrovascular disease (group of conditions that affects the blood flow and the blood vessels in the brain). Physician's orders for Resident 88, dated April 11, 2024, included an order for the resident to receive comfort care (end-of-life care that focuses on comfort). A review of Resident 88's care plan, dated May 28, 2020, did not include comfort care as ordered by the physician. Interview with the Director of Nursing on August 1, 2024, at 11:10 a.m. confirmed that Resident 88's care plan dated May 28, 2020, should have been revised to reflect the physician order for comfort care and it was not. 28 Pa. Code 201.24(e)(4) Admission Policy. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 43856 Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for two of 39 residents reviewed (Residents 88, 103). Findings include: The facility policy for care plans, dated July 2, 2024, indicated that care plans are to evaluated and revised every 90 days, annually, and if there is a change in a resident's condition. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 88, dated July 9, 2024, revealed that the resident was cognitively intact and required extensive assistance from staff for her daily care needs and had a diagnosis of cerebrovascular disease. Physician's orders for Resident 88, dated April 12, 2024, included an order to discontinue the use of Keppra oral solution 100 mg/ml (a medication to control seizures dispensed in milligrams per milliliter). A review of care plans for Resident 88, dated May 28, 2020, included a care plan for the resident to receive Keppra oral solution to control seizures. There was no documented evidence to reflect that Keppra oral solution 100 mg/ml was discontinued. Interview with the Director of Nursing on August 1, 2024, at 11:10 a.m. confirmed that Resident 88's care plan, dated May 28, 2020, should have been revised to reflect the discontinuation of Keppra oral solution 100 mg/ml and it was not. An annual MDS assessment for Resident 103, dated July 1, 2024, revealed that the resident was cognitively intact and required assistance from staff for her daily care needs and had a diagnosis of cerebral infarction affecting right dominant side. A review of care plans for Resident 103, dated February 11, 2024, included a care plan for the resident to receive an anticoagulant (a medication that thins the blood) Physician's orders for Resident 103, dated March 27, 2024, included an order to discontinue the use of Eliquis 2.5 mg (an anticoagulant). Interview with the Director of Nursing on August 1, 2024, at 11:10 a.m. confirmed that Resident 103's care plan, dated February 11, 2024, should have been revised to reflect the discontinuation of Eliquis 2.5 mg and it was not. 28 Pa. Code 201.24(e)(4) Admission Policy. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 48809 Based on review of Pennsylvania's Nursing Practice Act, facility policies, and clinical records, as well as staff interviews, it was determined that the facility failed to obtain physician orders for pacemaker checks for two of 39 resident reviewed (Residents 36, 97) and failed to ensure that an assessment was completed by a professional (registered) nurse after an elopement occurred for one of 39 residents reviewed (Resident 99). Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals. The facility's policy regarding pacemaker rate checks, dated July 2, 2024, indicated that at the time of admission, the registered nurse supervisor would obtain an order for a pacemaker rate check. An Annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 36, dated June 25, 2024, revealed that the resident was cognitively intact, was clearly understood and able to clearly understand others, required assistance with care needs, and had diagnoses that included congestive heart failure (the heart cannot pump blood well enough to meet the body's needs) and atrial fibrillation (irregular heart rhythm). A care plan for Resident 36, dated March 4, 2020, indicated that the resident had a pacemaker (a surgically-implanted, small battery-powered device to manage irregular heartbeats or heart failure), and she was to have pacemaker checks (to check if pacemaker is functioning properly) done as per physician's order. There was no documented evidence in Resident 36's clinical record of a physician's order for pacemaker checks per facility policy and per care plan. Interview with the Director of Nursing on July 31, 2024, at 4:45 p.m. confirmed that Resident 36 did not have an order for pacemaker checks as per facility policy and she should have. An annual MDS assessment for Resident 97, dated June 25, 2024, revealed that the resident was cognitively intact, was usually understood and usually understood others, was independent with care needs, and had diagnoses that included coronary artery disease (a medical condition where there is blocking of coronary arteries) and stroke. A care plan for Resident 97, dated December 19, 2023, indicated that the resident had a pacemaker. The resident was to have pacemaker checks done as per physician's order and documented in the clinical record. There was no documented evidence in Resident 97's clinical record of a physician's order for pacemaker checks per facility policy and care plan. Interview with the Director of Nursing on August 1, 2024, at 8:57 a.m. confirmed that Resident 97 did not have an order for pacemaker checks per facility policy and he should have. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy regarding missing residents, dated July 2, 2024, revealed that once the missing resident is found or returns to the facility, the resident shall be assessed and examined for injuries by the registered nurse supervisor. A quarterly MDS assessment for Resident 99, dated May 8, 2024, indicated that the resident usually understood and was usually understood by others, was cognitively intact, and required maximum assistance from staff for daily care tasks. A care plan for Resident 99, dated May 17, 2023, revealed that the resident was at risk for falls and was to ambulate with an assist of one with her wheeled walker and gait belt. A nursing note for Resident 99, dated January 28, 2024, at 1:10 p.m., indicated that the resident was seen by the front desk staff returning to the facility from the front parking lot. The resident was not wearing a coat, only a sweater. The resident told the nurse that she came back inside because she was cold and realized her son was not coming to pick her up for an appointment. There was no documented evidence that Resident 99 was assessed by a registered nurse upon return to the facility after being outside for an unknown length of time. Interview with the Director of Nursing on July 31, 2024, at 12:27 p.m. confirmed that Resident 99 was not assessed by a registered nurse when she returned to facility after elopement per policy. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 48809 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure neurological checks were completed following an unwitnessed fall for one of 39 residents reviewed (Resident 99). Findings include: The facility's policy for unwitnessed falls, dated July 2, 2024, indicated that resident falls were to be reported, their causes identified when possible, timely interventions established to help reduce the probability of repeated incidents, and neurological checks (a neurological examination is the assessment of sensory neuron and motor responses, especially reflexes, to determine whether the nervous system is impaired) were to be completed. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) assessment for Resident 99, dated March 8, 2024, revealed that the resident was sometimes understood and sometimes could understand others, required substantial assistance with daily care needs, and had a diagnosis of Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors). A nurse's note for Resident 99, dated July 10, 2024, at 4:40 p.m., revealed that the resident had an unwitnessed fall at her recliner. The resident was assessed and neurological checks were to be completed. A review of Resident 99's clinical record revealed a neurological check flow sheet where neurological checks were to be completed after a fall. The checks were to be done every 15 minutes for two hours, then every 30 minutes for two hours, then every one hour for four hours, then every eight hours until 72 hours had passed. The neurological check flow sheet was initiated on July 10, 2024, at 3:10 p.m., and was completed per policy until July 11, 2024, on second shift. There was no further documentation that neuro checks were completed for the 8-hour checks. Interview with the Director of Nursing on July 31, 2024, at 12:27 p.m. confirmed that neurological checks should be completed after unwitnessed falls. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 41233 Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that devices for pressure relief were in place as ordered by the physician for one of 39 residents reviewed (Resident 89). Findings include: The facility's policy regarding pressure injuries care and treatment, dated July 2, 2024, indicated that residents who were identified as at risk for the development of pressure injuries (skin impairment caused by pressure) were to have interventions in place to promote skin integrity. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 89, dated July 12, 2024, revealed that the resident was cognitively impaired and required assistance for daily care tasks, and had medical diagnoses that included stroke, coronary artery disease, and high blood pressure. The resident's current care plan indicated that she had left-sided weakness and required pressure-reducing support surfaces to prevent skin breakdown. Care plan interventions included wearing an E-Z flex splint on the left hand and a left elbow comfy splint, each for four hours per shift. An interview with Resident 89 on July 30, 2024, at 8:25 a.m. confirmed that she was to wear her elbow splint four hours per shift. Physician's orders for Resident 89, dated November 13, 2023, included an order for the resident to wear an E-Z flex splint on the left hand in addition to a left elbow splint, each for four hours per shift. Observations on July 31, 2024, from 8:13 a.m. thru 5:00 p.m. revealed that Resident 89 was in bed wearing her E-Z flex left hand splint; however, she did not have her left elbow comfy splint in place as ordered by the physician. The elbow splint was noted to be in her room on a chair beside her bed. Interview with the Director of Therapy on August 1, 2024, at 8:11 a.m. confirmed that the left hand and elbow splints were utilized to promote skin integrity in the palm of her hand and the inside bend of her arm and should have been in place per physician order. She also indicated that at times the resident will refuse to wear them. Interview with the Director of Nursing on August 1, 2024, at 8:20 p.m. confirmed that the left elbow splint should have been in place as ordered, and that there was no documented evidence of refusal by the resident. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48809 Based on a review of clinical records, as well as staff interviews, it was determined that the facility failed to assess a resident for safety in a chair after a known history of falls from the chair, resulting in a fall with fracture for one of 39 residents reviewed (Resident 2), and failed to follow fall prevention interventions for one of 39 residents reviewed (Resident 5) who had a history of falls. Findings include: The facility's policy regarding accidents and incidents, dated July 2, 2024, revealed that if a fall is involved the resident must be assessed by the professional (registered) nurse supervisor and additional assessment as appropriate. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated November 13, 2023, indicated that the resident was sometimes understood and could sometimes understand others, required extensive assistance of one for ambulation and transfers, and extensive assistance of one for bathing and toileting. A nursing note for Resident 2, dated November 12, 2023. at 4:14 p.m., revealed that the resident was found face down on the floor by her recliner. An incident report for Resident 2, dated November 12, 2023, revealed that the resident stated she was in her recliner and reached for something when she fell out of the recliner. There was no documented evidence in Resident 2's clinical record to indicate that a safety assessment was conducted for her with the use of the recliner. A nursing note for Resident 2, dated January 5, 2024, at 4:10 p.m., revealed that the resident was found on the floor positioned with her back supported by the recliner and was seated on the floor, head erect, and legs flexed. The call bell was attached to her recliner, her walker was near the recliner in front of the resident. The resident stated she was trying to put a book back in a basket at time of her fall. There was no documented evidence in Resident 2's clinical record to indicate that a safety assessment was conducted for her with the use of the recliner. A nursing note for Resident 2, dated January 14, 2024, at 4:30 p.m., revealed that the resident was found lying face down on the floor with her right arm under her. When the resident was turned over there was a bruise to her forehead, and the resident had limited range of motion to her right arm due to pain. Physician's orders for Resident 2, dated January 14, 2024, at 4:34 p.m., included an order for an x-ray of her right shoulder. X-ray results, dated January 14, 2024, at 6:30 p.m., revealed a fracture of the resident's right shoulder. Physician's orders for Resident 2, dated January 22, 2024, at 1:11 p.m., included an order for occupational therapy to evaluate and treat as indicated. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with Activities Assistant 2 on July 31, 2024, at 1:30 p.m. revealed that she was the person who found Resident 2 on the floor on January 14, 2024 at 4:30 p.m., and she does not remember if her call bell and reacher were within her reach. Interview with Registered Nurse 3 on August 1, 2024, at 11:09 revealed that she was made aware of resident's fall by Activities Assistant 2, and she does not remember if she specifically had her call bell; however, the resident had a tendency to lead forward in her chair and has had several incidents as a result. Interview with Director of Nursing on August 1, 2024, at 1:23 p.m. revealed that residents are not assessed for personal chairs; however, they will be assessed if there is a concern. Interview with Occupational Therapist 4 on August 1, 2024, at 1:26 p.m. revealed that the resident was picked up by therapy on January 22, 2024; however, she was not assessed for safety in a recliner upon admission to the facility or at any other time. The resident was provided with a motion alarm for her recliner after the fall on January 14. Interview with the Director of Nursing on August 1, 2024, at 1:38 p.m. confirmed that there was no documented evidence of a safety assessment for Resident 2 to use her personal recliner. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated July 8, 2024, revealed that the resident was cognitively impaired, was usually understood and usually able to understand others, required assistance with daily care needs, had a history of falls since the prior assessment, and had a diagnosis that included dementia with behavioral disturbance. A fall care plan, dated July 6, 2023, revealed that the resident was to be on safety checks every hour effective August 17, 2023. A nursing note for Resident 5, dated May 13, 2024, at 11:56 a.m., revealed that the resident was sitting in her room on the floor near the door in front of her wheelchair with legs extended out in front of her. The resident stated she slipped while attempting to get up to go to the bathroom. No apparent injury was noted, and she denied hitting her head. An area of redness was noted to her left mid back. The resident reported generalized pain. Staff assisted the resident back into her wheelchair per facility protocol, and the resident was reminded to utilize her call bell for assistance. An intervention was added not to leave the resident in her room unattended in her wheelchair. There was no documented evidence in Resident 5's clinical record that safety checks were being done every hour for fall prevention per the resident's care plan. A nursing note for Resident 5, dated June 17, 2024, at 7:25 a.m., revealed that the resident was in her room on the floor. On arrival to the room the resident was on her buttocks, sitting upright just next to her recliner with her legs extended out towards the bed. The nurse aide witnessed the fall. Prior to the fall she was sitting on the recliner footrest. The nurse aide explained that the call light was ringing and when she went in to answer it, the resident was sitting on the recliner footrest with the chair control in her hand. When the chair moved, the trash can moved and caused the chair footrest to go down along with the resident. The resident bumped her head on the window seat. Neuro checks were initiated. The resident was assisted back to recliner. No obvious injuries were noted. An intervention was added to keep her recliner chair unplugged to prevent further falls from her chair. There was no documented evidence in Resident 5's clinical record that safety checks were being done every hour for fall prevention as per the resident's care plan. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with the Director of Nursing on August 1, 2024, at 11:33 a.m., confirmed that there was no documented evidence in Resident 5's clinical record that safety checks were being done every hour for fall prevention per the resident's care plan. 28 Pa. Code 211.10(a) Resident Care Policies. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395050	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garvey Manor	1037 South Logan Boulevard Hollidaysburg, PA 16648

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48941 Based on a review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders were followed to provide tracheostomy care (care of a surgical incision in the neck that creates an opening into the windpipe) for one of 39 residents reviewed (Resident 127). Findings include: The facility's policy for tracheostomy care, dated July 2, 2024, indicated that tracheostomy care should be provided as per physician's orders and documented as completed in the electronic Medication Administration Record (eTAR) Treatment Page. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 127, dated May 28, 2024, revealed that the resident was cognitively intact, required limited assistance with daily care needs, and had diagnoses that included tracheostomy (surgical incision in the neck that creates an opening into the windpipe) and chronic respiratory failure (blood does not have enough oxygen and causes difficulty breathing). A care plan for Resident 127, dated February 22, 2024, indicated that the resident had a tracheostomy related to diphtheria in 1940 (an infectious disease that can affect the throat and make breathing difficult) and chronic respiratory failure and included interventions for tracheostomy care per physician's orders. A physician's order for Resident 127, dated February 28, 2024, included an order for tracheostomy care daily every day shift and as needed. A physician's order for Resident 127, dated March 27, 2024, included an order for a tracheostomy sponge to be applied to the neck beneath the trach canula and tie with trach care. Change daily every day shift and as needed for soilage. A review of nurses' notes, Medication Administration Records (MAR), and Treatment Administration Records (TAR) for Resident 127 for March 2024 revealed that there was no documented evidence of tracheostomy care being provided on March 1 and March 11, 2024. A review of nurses' notes, Medication Administration Records (MAR), and Treatment Administration Records (TAR) for Resident 127 for April 2024 revealed that there was no documented evidence of tracheostomy care being provided and no documented evidence of the tracheostomy sponge being applied with trach care on April 5, 2024. Interview with Assistant Director of Nursing on July 31, 2024, at 4:11 p.m. confirmed that there was no documented evidence that tracheostomy care or tracheostomy sponge application was provided for Resident 127 on the dates listed above. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 41233 Based on review of personnel files, as well as staff interviews, it was determined that the facility failed to ensure that nurse aide performance evaluations were completed at least annually for two of five nurse aides reviewed (Nurse Aides 5, 6). Findings include: Review of nurse aide performance evaluation records revealed that Nurse Aide's 5 and 6 were each hired over one year ago, with a hire date of October 10, 2022. Neither of these nurse aides had performance evaluations completed in the past year. Interview with the Director of Nursing on August 1, 2024, at 1:55 p.m. confirmed that she was unable to find documentation to show that the above nurse aides had an annual performance evaluation completed in the past year. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 41233 Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plans of corrections for a State Survey and Certification (Department of Health) survey ending August 3, 2023, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending August 1, 2024, identified repeated deficiencies related to assessment coding, developing and revising residents' care plans, services provided meeting professional standards, and quality of care. The facility's plan of correction for a deficiency regarding assessment coding, cited during the survey ending August 3, 2023, revealed that audits of care plans would be completed, and the results would be reported to the QAPI committee for review. The results of the current survey, cited under F641, revealed that the QAPI committee was ineffective in maintaining compliance with the regulation regarding assessment coding. The facility's plan of correction for a deficiency regarding developing residents' care plans, cited during the survey ending August 3, 2023, revealed that audits of care plans would be completed, and the results would be reported to the QAPI committee for review. The results of the current survey, cited under F656, revealed that the QAPI committee was ineffective in maintaining compliance with the regulation regarding developing residents' care plans. The facility's plans of correction for deficiencies regarding revising resident's care plans, cited during the survey ending on August 3, 2023, revealed that audits of care plans would be conducted and the results of the audits would be brought before the QAPI committee for further monitoring. The results of the current survey, cited under F657, revealed that the QAPI committee was ineffective in maintaining compliance with the regulation regarding revising residents' care plans. The facility's plan of corrections for deficiencies regarding, professional standards, cited during the survey August 3, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F658, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding professional standards. The facility's plan of correction for a deficiency regarding quality of care, cited during the survey ending August 3, 2023, revealed that quality of care would be monitored by QAPI. The results of the current survey, cited under F684, revealed that the QAPI committee was ineffective in maintaining compliance with quality of care. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Refer to F641, F656, F657, F658, F684. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.