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	07/24/2025

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 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. Based on observations and staff interviews it was determined that the facility failed to keep a clean, homelike environment on the D1 wing. Observations on July 21, 2025 at 11:15 a.m., July 22, 2025 at 9:32 a.m., and July 23, 2025 at 10:18 a.m. revealed that the D1 hallway carpeting and the D1 lounge carpeting had large brown and black stains. Interview on July 23, 2025 at 11:10 a.m. with the Director of Maintenance revealed that the carpeting on D1 and in the D1 lounge needs replaced and that despite the effort of the housekeepers to keep the area clean, the carpet is stained in multiple places.

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on review of policies, investigation reports, clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from abuse for one of 41 residents reviewed (Resident 122). This deficiency is being cited as past non-compliance.The facility's policy dated June 20, 2025, regarding prevention of abuse, neglect, misappropriation of resident property and exploitation states that systems are in place to prevent resident abuse, including neglect, exploitation, and misappropriation of property.An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 122 dated June 4 2025, revealed that the resident was alert with confusion, required total assistance from staff for her daily care needs, and had diagnoses that included dementia, encephalopathy (condition where the brain does not function properly), and sepsis (serious infection in the blood).Resident 122's care plan, dated May 29, 2025, indicates that the resident exhibited physical/verbal aggression to staff and resistive to care. Staff were to explain all procedures to the resident prior to care, continue to provide simple explanations of care while completing the task, use diversional conversation to distract during care and decrease any potential anxiety/stress. If the resident became combative, staff were to stop care and allow the resident to cool down and then re-approach after at least 15 minutes to half hour later. Staff were to consider change in caregiver if needed.Facility investigation for Resident 122, dated June 11, 2025, indicated that during her therapy session, Resident 122 was reported to have been yelled at by Physical Therapist 1. Rehabilitation Manager 2 and Occupational Therapist 3, reported that Physical Therapist 1 was verbally abusive to Resident 122 during the therapy session that day before lunch. Occupational Therapist 3, reported that Physical Therapist 1 was working with Resident 122 in the therapy gym and was trying to get her to stand, working on her functional transfers. Occupational Therapist 3 stated Resident 122 was fearful and resisted completing the tasks and that Physical Therapist 1 was trying to explain to her that she had to participate as her insurance required the assessment. Occupational Therapist 3 reported that Resident 122 did not want to participate despite encouragement and that Physical Therapist 3 was becoming more impatient with her, began to increase her volume and insist that the resident stand. Occupational Therapist 3 then stated that Physical Therapist 1 looked and whispered to her I f*cking hate her, I can't do this speaking about Resident 122. Occupational Therapist 3 stated that she reminded Physical Therapist 1 that residents have the right to refuse treatment, and, at that time, Physical Therapist 1 then said she was done with this bullshit so take her back.A witness statement from Rehabilitation Manager 2, dated June 11, 2025, revealed that she overheard Physical Therapist 1 working with Resident 122 and that Physical Therapist 1 was frustrated and had an escalating tone. A witness statement from Speech Therapist 4 dated June 11, 2025, revealed that she also overheard Physical Therapist 1 working with Resident 122 and that Physical Therapist 1 was frustrated and had an escalating tone. Interview with Director of Nursing on July 22, 2025, at 01:58 p.m. revealed that the Physical Therapist 1 was terminated from employment for her aggressive and abusive treatment of Resident 122.Following the incident on June 11, 2025, the facility's corrective actions included:1. Resident 122 was assessed by a registered nurse for any signs of injury.2. The nursing facility immediately removed Physical Therapist 1 from employment and notified the contracting agency that she would not be permitted to return to the facility. 3. Education records dated June 27, 2025, revealed that all facility staff, including contracted therapy staff, received education regarding the abuse prevention, recognition, and notification policy as of June 27, 2025. 4. The Director of Nursing or designee initiated audits of residents receiving therapy/care three times a week for two weeks then weekly for four weeks, beginning on June 27, 2025. Further audits will be completed as determined by the Quality Assurance Performance Improvement (QAPI) committee.Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F600 on June 27, 2025. 28 Pa. Code 211.10(c)(d) Resident care policies.28 Pa. Code 211. 11(d) Resident care plan.28 Pa. Code 211.12(d)(1) Nursing services.28 Pa. Code 211.12(d)(5) Nursing services.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on review of policies and employee files, as well as staff interviews, it was determined that the facility failed to ensure that license checks were obtained prior to hire for two of two Registered Nurses (Registered Nurses 5 and 6).The facility's policy regarding protection from abuse, dated June 20, 2025, indicated that policies and procedures were developed to aid in preventing abuse, neglect, or mistreatment of residents, and protocols for conducting employment background checks and screening of employees.The personnel file for Registered Nurse 5 revealed a start date of June 9, 2025, with a license check done on July 23, 2025. There was no documented evidence that a license check was obtained prior to the staff's start date of June 9, 2025. The personnel file for Registered Nurse 6 revealed a start date of May 27, 2025, with a license check done on June 6, 2025. There was no documented evidence that a license check was obtained prior to the staff's start date of May 27, 2025.Interview on July 23, 2025, at 2:32 p.m. with the Director of Nursing revealed that Registered Nurses 5 and 6's license checks should have been completed prior to their start date and they were not. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(e)(1) Management.

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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. Based on facility policy, clinical record reviews, as well as resident and staff interviews, it was determined that the facility failed to implement an individualized care plan for fall prevention for one of 41 residents reviewed (Resident 12). Findings include:Facility policy for safety alarms dated June 20, 2025, revealed that alarms will be used to alert staff to assist residents who have a history of transferring unassisted and when it has been determined that staff assistance is necessary for resident safety.An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 12, dated July 2, 2025, indicated that the resident was alert and oriented, required maximum assistance for daily care, had a diagnosis of a hip fracture, and utilized a motion sensor alarm less than daily.Resident 12's care plan for fall safety, dated July 8, 2025, revealed that the resident required a motion sensor alarm at the foot of the bed at all times when the resident is in bed.A nursing note for Resident 12 dated July 9, 2025, revealed that the resident was found on the floor leaning against a wall.A witness statement from Nurse Aide 7 dated July 9, 2025, revealed that the alarm was not present at time of Resident 12's incident.An interview with the Director of Nursing on July 23, 2025, at 11:21 a.m. confirmed that the alarm was not at the foot of the bed and turned on when Resident 12 was in bed and should have been. 28 Pa. Code 211.10 (a)(c)(d) Resident care policies28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. Based on review of policies and employee files, as well as staff interviews, it was determined that the facility failed to ensure that Pennsylvania Nurse Aide Registry checks were obtained prior to hire for two of two Nurse Aides reviewed (Nurse Aides 8 and 9).The facility's policy regarding protection from abuse, dated June 20, 2025, indicated that policies and procedures were developed to aid in preventing abuse, neglect, or mistreatment of residents, and protocols for conducting employment background checks and screening of employees.The personnel file for Nurse Aide 8 revealed a start date of May 27, 2025, with a Pennsylvania Nurse Aide registry check done on June 10, 2025. There was no documented evidence that the registry check was obtained prior to the staff's start date of May 27, 2025. The personnel file for Nurse Aide 9 revealed a start date of April 7, 2025, with a Pennsylvania Nurse Aide registry check done on July 23, 2025. There was no documented evidence that the registry check was obtained prior to the staff's start date of April 7, 2025. Interview on July 23, 2025 at 2:32 p.m. with the Director of Nursing revealed that registry checks for Nurse Aides 8 and 9 should have been completed prior to their start date and they were not. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(e)(1) Management.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on review of facility policies and information provided by the facility, as well as observations and staff interviews, it was determined that the facility failed to serve food items at appetizing temperatures.Findings include:The facility's policy regarding food temperature records, dated June 20, 2025, revealed that the temperatures of foods shall be taken prior to service. Breakfast temperatures were checked by the cook in the kitchen to assure the food is at proper temperature. Any hot foods falling below established standards of 165 degrees Fahrenheit (F) would be reheated to the proper temperature.An annual minimum data set (MDS) assessment (mandated to assess the resident abilities and care needs) for Resident 6, dated July 8, 2025, indicated that the resident was able to understand others, was understood by others, had clear speech, and was cognitively intact.Interview and observations with Resident 6 on July 21, 2025, at 12:20 p.m. , revealed that she eats in her room and the eggs taste like plastic.The posted breakfast menu on July 23, 2025, was juice of choice, hot and cold cereal, egg of choice, French toast with syrup, coffee, tea, and milk. Observations of the breakfast meal service in the D2 Dining room on July 23, 2025, revealed that the D2 hallway cart containing a test tray left the main kitchen at 8:11 a.m. and arrived on D2 hallway at 8:11 a.m. Trays were passed to the residents that were in their rooms starting at 8:12 a.m. and the last resident was served at 8:33 a.m. The test tray was removed from the cart at 8:34 a.m. The temperature of the coffee was 139.6 was degrees F, the cream of wheat was 139.6 degrees F, the scrambled eggs were 121.7 degrees F, and the French toast was 112.6 degrees F. The white milk was 56.1 degrees, the fried eggs were 108 degrees F, the slice of thin bacon was warm and crispy. The French toast and fried eggs were cool and not at a palatable or appetizing temperature. The white milk was not cold and was chalky tasting and not palatable. Interview with the Dietary Supervisor 11 and the Dietary Director at that time revealed that eggs are difficult to keep at temperature for room delivery. Dietary plates the food, but dietary staff do not deliver the trays. The milk, french toast, and the fried egg should be served at palatable temperatures.Interview with the Dietary Director on July 23, 2025, at 11:29 a.m. confirmed that the breakfast tray items should have been served at palatable temperature. 28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 211.6(f) Dietary Services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to store and prepare food in accordance with professional standards for food service safety by failing to ensure hair was properly covered with a hair restraint.Findings include:The facility's policy regarding dietary operations, dated June 20, 2025, revealed that hair and beard restraints would be worn while working in the kitchen.Observations in the facility's kitchen on July 21, 2025, at 9:24 a.m. revealed that Dietary Aide 10 was in the kitchen working and had uncovered facial hair. Interview with Dietary Director at that time confirmed that Dietary Aide 10 should be wearing a beard restraint. 28 Pa. Code 211.6(f) Dietary services