STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395090	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windber Woods Senior Living & Rehabilitation Ctr	277 Hoffman Avenue Windber, PA 15963

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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 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. 42079 Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to develop a comprehensive care plan that included specific and individualized interventions to address care needs for one of 44 residents reviewed (Resident 60). Findings include: A facility policy for care plans, dated December 20, 2024, indicated that resident care plans will have multiple focuses, goals, and interventions according to their needs, level of care, and capabilities. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 60, dated February 7, 2025, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs, and diagnoses that included high blood pressure and diabetes. Observations of Resident 60 on March 26, 2025, at 8:35 a.m. revealed that he had two containers of smokeless tobacco and an empty milk carton that he was using as a spittoon. There was no documented evidence that a care plan was developed to address the resident's use of smokeless tobacco. An interview with the Nursing Home Administrator on March 26, 2025, at 9:30 a.m. confirmed that there was no documented evidence that a care plan was developed for Resident 60 to address his use of smokeless tobacco/chew. 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 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. 19102 Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that care plans were updated/revised to reflect specific care needs for three of 44 residents reviewed (Residents 48, 90, 94). Findings include: A facility policy for care plans, dated December 20, 2024, indicated that resident care plans will have multiple focuses, goals, and interventions according to their needs level of care and capabilities. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 48, dated March 5, 2025, revealed that the resident had moderate cognitive impairment and was occasionally incontinent of urine. Physician's orders for Resident 48, dated January 16, 2025, included orders for the resident to receive 70 milligrams (mg) of Gentamicin Sulfate intramuscularly one time a day for three days for a urinary tract infection and contact isolation precautions (used to prevent the spread of infections that can be transmitted through direct or indirect contact with a patient or their environment, requiring healthcare workers and visitors to wear gloves and gowns) due to ESBL (Extended-Spectrum Beta-Lactamase, an enzyme produced by some bacteria that makes them resistant to certain antibiotics) in the urine. Observations of Resident 48 on March 24, 2025, at 10:28 a.m. revealed that signage was posted outside of the resident's room indicating that contact isolation precautions were in place. A care plan, dated February 22, 2025, indicated that the resident had ESBL of the urine; however, there was no documented evidence that the care plan included contact isolation precautions. Interview with the Director of Nursing on March 26, 2025, at 9:44 a.m. confirmed that Resident 48's care plan did not include contact isolation precautions for ESBL. A quarterly MDS assessment for Resident 90, dated February 3, 2025, revealed that the resident was cognitively impaired, had adequate vision, and did not use corrective lenses. The current care plan for Resident 90 indicated that the she required glasses; however, they were lost on January 18, 2025, and were not in her possession. Observations of Resident 90 on March 26, 2025, at 9:30 a.m. revealed that the resident had glasses in her possession. Interview with the Nursing Home Administrator on March 26, 2025, at 9:44 a.m. confirmed that Resident 90's glasses were not lost and that her care plan should have been updated to reflect that the resident was in possession of her glasses. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An admission MDS assessment for Resident 94, dated February 3, 2025, revealed that the resident was rarely understood, rarely understood others, and was dependent on staff for care. A care plan for Resident 94, dated December 15, 2025, indicated that the resident was on Bumex (a medication that increases urination). A review of Resident 94's clinical record revealed no documented evidence that the resident was currently receiving Bumex. Interview with the Nursing Home Administrator on March 26, 2025, at 2:36 p.m. confirmed that Resident 94's care plan should have been updated to reflect that the resident was no longer receiving Bumex. 28 Pa. Code 211.12(d)(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 - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 19102 Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents received care and treatment in accordance with professional standards of practice, by failing to ensure that physician's orders were followed for four of 44 residents reviewed (Residents 19, 41, 60, 102), and failed to ensure that bowel protocols were followed as ordered by the physician for two of 44 residents reviewed (Residents 52, 82). Findings include: The facility's policy regarding medication administration, dated December 20, 2024, indicated that medications are to be administered in a safe and legal manner. Medications given need to follow the 5 Rights, right resident, right time, right drug, right frequency, and right route. Recently a sixth right was implemented. The right documentation. Pour the medication reading each order on the computer screen and comparing the directions on each medication box. After the resident takes the medication, electronically record your signature. Any narcotic medication given must be signed off in the narcotic book at the time the medication is given. Physician's orders for Resident 19, dated February 11, 2025, included an order for the resident to receive one 25 milligram (mg) tablet of Metoprolol (used alone or in combination with other medications to treat high blood pressure) two times a day. Staff was to hold the medication if the resident's systolic blood pressure (the top number) was less than 100 millimeters of mercury (mmHg) or for a heart rate less than 60 beats per minute (BPM). A care plan for Resident 19, dated May 16, 2024, revealed that the resident had an altered cardiovascular status related to hypertension (high blood pressure) and staff was to administer the resident's medications as per the physician's order. Staff was also to monitor the resident's vital signs as per the physician's orders, and as needed. Review of the Medication Administration Records (MARs) for Resident 19, dated February and March 2025, revealed that staff administered a 25 mg dose of Metoprolol at 8:00 a.m. on March 12 and 19, 2025, and at 8:00 p.m. on February 12, 15, 16, 20, 24, and 25, 2025, and March 6, 16, and 19, 2025; however, there was no documented evidence that staff obtained the resident's blood pressure and heart rate as ordered prior to the medication administration on the dates and times listed. Interview with the Nursing Home Administrator on March 25, 2025, at 11:57 a.m. confirmed that there was no documented evidence that staff obtained Resident 19's blood pressure and heart rate prior to the 25 mg tablet of Metoprolol being administered to determine if the medication should have been held on the above dates. Physician's orders for Resident 41, dated September 22, 2024, included an order for the resident to receive one 240 mg tablet of Verapamil (used to treat high blood pressure) at bedtime for hypertension. Staff was to hold the medication if the resident's systolic blood pressure was less than 100 mmHg. A care plan for Resident 41, dated October 9, 2024, revealed that the resident had hypertension, and staff was to administer the resident's anti-hypertensive medications as per the physician's order. Staff was also to obtain the resident's blood pressure as per the physician's orders, as well as needed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MARs for Resident 41, dated February and March 2025, revealed that staff administered the 240 mg tablet of Verapamil at 9:00 p.m. on February 12, 15, 16, and 20, 2025, and on March 6, 16, 19, and 20, 2025; however, there was no documented evidence that staff obtained the resident's blood pressure prior to the medication being administered to determine if the medication should have been held. Interview with the Nursing Home Administrator on March 26, 2025, at 9:15 a.m. confirmed that there was no documented evidence that staff obtained Resident 41's blood pressure prior to the medication being administered to determine if the medication should have been held on the above dates. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 60, dated February 7, 2025, indicated that the resident was cognitively impaired, required assistance from staff for daily care needs, and had diabetes (body does not use insulin effectively or does not produce enough insulin). A care plan for Resident 60, dated September 23, 2023, revealed that the resident had diabetes and staff were to obtain labs and accu checks (a blood glucose monitor that tests the level of sugar in the bloodstream) as physician ordered. Physician's orders for Resident 60, dated December 9, 2024, included an order for the resident to receive accu checks before breakfast and in the evening two times a day; call the physician if the reading is less than 70 milligrams per deciliter (mg/dL) or above 450 mg/dL. Review of the MAR for Resident 60, dated March 2025, revealed that staff did not obtain an accu check on March 13 and 19, 2025, per physician's orders. Interview with the Director of Nursing on March 26, 2025, at 2:38 p.m. and a statement signed by Licensed Practical Nurse 3 confirmed that there was no documented evidence that accu checks were obtained per physician's orders for the dates listed above. The facility's policy regarding medication administration, dated December 20, 2024, indicated that the bowel protocol was implemented with a physician's order upon admission to the facility or when the resident experienced constipation unless otherwise indicated. The facility's bowel protocol policy, dated December 20, 2024, included orders for the resident to receive 30 cubic centimeters (cc) of Prune whip (remedy for constipation) as needed for constipation if no bowel movement by the second day and one Glycerin suppository (a laxative inserted rectally) as needed if no bowel movement by the third day, and one soaps suds enema (a liquid inserted rectally to stimulate a bowel movement) as needed for constipation if no bowel movement by the fourth day. Physician's orders for Resident 52, dated May 9, 2022, included orders for the resident to receive 30 cubic centimeters (cc) of Prune whip (remedy for constipation) as needed for constipation if no bowel movement by the second day and one Glycerin suppository (a laxative inserted rectally) as needed if no bowel movement by the third day. Physician's orders, dated October 14, 2024, included orders for one soaps suds enema (a liquid inserted rectally to stimulate a bowel movement) as needed for constipation if no bowel movement by the fourth day. Resident 52's bowel records for February 2025 revealed that the resident did not have a bowel movement from February 1-8, 2025. The MAR's revealed that staff did not administer any laxative on February 4 and 5, 2025. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 52's bowel records for March 2025 revealed that the resident did not have a bowel movement from March 1-6, 2025. The MAR's revealed that staff did not administer a soaps suds enema on March 4, 2025, and did not administer any laxative on March 5, 2025. Resident 52's bowel records for March 2025 revealed that the resident did not have a bowel movement from March 12-23, 2025. The MAR's revealed that staff did not administer a soaps suds enema on March 4, 2025, and did not administer any laxative on March 13, 15, and 16, 2025. Interview with the Director of Nursing on March 27, 2025, confirmed that Resident 52's physician's orders for bowel medications were not followed. A quarterly MDS assessment for Resident 102, dated March 5, 2025, revealed that the resident was cognitively intact, was understood and understood others, and was receiving opioid (a controlled substance) medication for pain. Physician's orders for Resident 102, dated February 10, 2025, included an order for the resident to receive one 5-325 milligram (mg) tablet of Oxycodone-Acetaminophen (a controlled substance to treat pain) every six hours as needed for pain. The resident's MAR for February 2025 indicated that a dose of Oxycodone-Acetaminophen was administered to the resident on February 5, 2025, at 8:32 a.m. and 3:59 p. m.; February 6, 2025 at 10:15 a.m.; and February 14, 2025, at 6:00 p.m. and 8:00 p.m. However, according to Resident 102's controlled medication record for February 2025 there was no documented evidence that the doses of Oxycodone-Acetaminophen were signed out at these times, indicating that 5-325 mg Oxycodone-Acetaminophen was not administered as documented on the MAR. Interview with the Director of Nursing on March 27, 2025, at 11:21 a.m. confirmed that there was no documented evidence of the removal of 5-325 mg Oxycodone-Acetaminophen for Resident 102 on the controlled medication record; therefore, the 5-325 mg Oxycodone-Acetaminophen could not have been administered to the resident at the above times. 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. 42079 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that pressure ulcer dressing changes were completed as ordered to prevent skin breakdown for one of 44 residents reviewed (Resident 106). Findings include: A facility policy regarding treatment of wounds, dated December 20, 2024, revealed that the facility had a no touch care policy and that staff were to clean and dry a wound and surrounding skin with gauze without letting any unsterile item touch the wound. An admission Minimum Data assessment Set (MDS) (a mandated assessment of a resident's abilities and care needs) for Resident 106, dated March 13, 2025, revealed that the resident was understood; could sometimes understand; was dependent on staff for turning, transfers, and lower body care; had diagnoses that included a stroke; and had one unstageable pressure ulcer (unable to determine the depth of the wound due to slough or eschar) that was present on admission. A care plan for Resident 106, dated March 6, 2025, revealed that she had an unstageable ulcer of the left heel and a diabetic foot ulcer of the right plantar heel that was at risk for further skin breakdown. Staff were to provide treatments a ordered. Physician's orders for Resident 106, dated March 7, 2025, included an order to cleanse the left heel with wound cleanser, then apply medical grade honey (a wound treatment), and cover with a bordered foam dressing once a day and as needed. Physician's orders for Resident 106, dated March 11, 2025, included an order to cleanse the right plantar heel with wound cleanser and cover with a bordered foam dressing once a day and as needed Observations of Resident 106 on March 24, 2025, at 9:39 a.m. revealed that Licensed Practical Nurse 4 entered the room with two bordered gauze dressings in her hand. One had a brown substance on it. Licensed Practical Nurse 4 donned gloves and then picked up Resident 106's left ankle and placed the bordered gauze with the brown substance on the left heel, then picked up the right ankle and placed bordered gauze on the right heel. Both of Resident 106's heels were in direct contact with a red blanket. Licensed Practical Nurse 4 said at that time, she was cleaned up earlier, I am just putting on her dressings. Interview with Licensed Practical Nurse 4 on March 24, 2025, confirmed that she did not use wound cleanser to cleanse Resident 106's right and left heels prior to putting on the dressings, and she assumed that the resident was cleaned when the nurse aide provided morning care. A bottle of wound cleanser was available in the cart. Interview with the Nursing Home Administrator on March 24, 2025, at 2:29 p.m. confirmed that Resident 106's wound treatments should have been completed as ordered by the physician. 28 Pa. Code 201.18(e)(1) Management. (continued on next page)

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F 0686 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 0689 Level of Harm - Minimal harm or potential for 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 review of clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that the residents' environment remained free of accident hazards for one of 44 residents reviewed (Resident 90) who resides on the alarmed unit. Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 90, dated February 3, 2025, indicated that the resident was cognitively impaired, was understood and could sometimes understand others, and was ambulatory with a walker or wheelchair. The current care plan for resident 90 revealed that she self-propels in the facility and will take herself to and from activities A nursing note for Resident 90, dated November 2, 2025, at 2:23 p.m. revealed that the resident was found in the basement of the facility. A progress note for Resident 90, dated November 4, 2025, at 10:59 a.m. revealed that the resident was alert to person only, does not follow commands, and was found in the basement over the weekend. Interview with the Director of Therapy on March 25, 2025, at 11:15 a.m. revealed that Resident 90 liked to wander around the unit and was able to propel herself in her broda chair. As of March 25, 2025, there was no documented evidence in Resident 90's clinical record to indicate that interventions were put in place to prevent her from further elopements from her unit. Interview with the Director of Nursing on March 25, 2025, at 12:13 p.m. revealed that they did not consider the incident an elopement since the resident did not leave the building. She stated that the resident left the second floor and was found in the basement. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.10(d) Resident Care Policies. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 31760 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders were followed for the care and maintenance of intravenous catheters and failed to ensure that intravenous catheters were flushed according to facility policy for three of 44 residents reviewed (Residents 1, 45, 255). Findings include: The facility's policy regarding intravenous fluid/medication administration, dated December 20, 2024, indicated that if administering only, flush before and after each infusion or per protocol for the access device. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 1, dated February 26, 2025, revealed that the resident was cognitively intact, was understood, could understand others, and was receiving intravenous (IV-into the vein) medications. Physician's orders for Resident 1, dated February 20, 2025, included an order for the resident to receive a 10 milliliter (ml) flush with normal saline every shift for 12 days for IV patency. Physician's orders for Resident 1, dated February 28, 2025, included an order for the resident to receive one gram (gm) of Vancomycin (an antibiotic) IV in the morning. Resident 1's Medication Administration Record (MARs) for February and March 2025 revealed that staff administered the IV Vancomycin on February 28, 2025, through March 4, 2025. Physician's orders for Resident 1, dated March 4, 2025, included an order for the resident to receive 750 milligrams (mg) of Vancomycin intravenously in the morning. Resident 1's MAR for March 2025 revealed that staff administered the Vancomycin on March 5 and 6, 2025; March 8, 9, and 10, 2025; and March 14, 15, and 16, 2025. Physician's orders for Resident 1, dated March 19, 2025, included an order for the resident to receive one gram Vancomycin intravenously every other day. Resident 1's MAR for March 2025 revealed that staff administered the Vancomycin on March 19 and 21, 2025. Physician's orders for Resident 1, dated March 22, 2025, included an order for the resident to receive 1250 mg of Vancomycin intravenously every other day. Resident 1's MAR for March 2025 revealed that staff administered the Vancomycin on March 22, 26, and 27, 2025. Physician's orders for Resident 1, dated March 27, 2025, included an order for the resident to receive 1500 mg Vancomycin every other day. Resident 1's MAR for March 2025 revealed that the staff administered the Vancomycin on March 27, 2025. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence that staff flushed the Resident 1's peripherally inserted central catheter (PICC - a long, thin, flexible tube inserted into a vein in the upper arm and threaded to a large vein near the heart, used for long-term IV access, medication administration, and blood draws) with normal sterile saline solution before and after the administration of the Vancomycin on the above dates. Interview with the Nursing Home Administrator on March 27, 2025, at 12:50 p.m. confirmed that there was no documented evidence that Resident 1's PICC was flushed with the 10 ml of normal saline before and after the administration of the Vancomycin. Physician's orders for Resident 45, dated February 20, 2025, included an order for the resident to receive a 10 ml normal saline flush every shift for IV patency. Resident 45's MARs for March 2025 revealed that there was no document evidence that staff administered the 10 ml normal saline flush during the dayshift on March 3, 4, 7, 11, 12, and 13, 2025; during the evening shift on March 7, 2025; and during the night shift on March 13 and 19, 2025. Physician's orders for Resident 45, dated February 22, 2025, included an order for the resident to receive two gm of Ceftriaxone (an antibiotic) intravenously in the afternoon. Resident 45's MARs for February and March 2025 revealed that staff administered the IV Ceftriaxone on February 22 through 28, 2025, and on March 1, 2, 8 through 10, and 14 through 26, 2025. However, there was no documented evidence that staff flushed the resident's PICC with normal sterile saline solution before and after the administration of the Ceftriaxone. Interview with the Nursing Home Administrator on March 27, 2025, at 8:50 a.m. confirmed that there was no documented evidence that Resident 45's PICC was flushed with the 10 ml of normal saline during the dayshift on March 3, 4, 7, 11, 12,and 13, 2025; during the evening shift on March 7, 2025; and during the night shift on March 13 and 19, 2025, and that there was no documented evidence that the resident's PICC was flushed with normal sterile saline solution before and after the administration of the Ceftriaxone. An admission noted, dated March 23, 2025, at 9:50 a.m., indicated that Resident 255 was admitted to the facility with a right knee infection and was to continue IV Rocephin (antibiotic medication), and he had a single lumen PICC line in place. Physician's orders for Resident 255, dated March 23, 2025, included an order for the resident to receive a 10 ml normal saline flush every shift for IV patency. Physician's orders for Resident 255, dated March 24, 2025, included an order for the resident to receive two gm of Ceftriaxone intravenously in the afternoon for a septic right knee joint. Resident 255's MAR March 2025 revealed that staff administered the IV Ceftriaxone on March 24 through 26, 2025. However, there was no documented evidence that staff flushed the resident's PICC with normal sterile saline solution before and after the administration of the Ceftriaxone. (continued on next page)

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Windber Woods Senior Living & Rehabilitation Ctr	277 Hoffman Avenue Windber, PA 15963

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Nursing Home Administrator on March 27, 2025, at 12:08 p.m. confirmed that that there was no documented evidence that the Resident 255's PICC was flushed with normal sterile saline solution before and after the administration of the Ceftriaxone 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48809 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain a complete and accurate accounting of controlled medications (medications with the potential to be abused) for one of 33 residents reviewed (Resident 46). Findings include: The facility's policy regarding medication administration, dated December 20, 2024, indicated that medications are to be administered in a safe and legal manner. Medications given need to follow the 5 Rights, right resident, right time, right drug, right frequency, and right route. Recently a sixth right was implemented, the right documentation. Staff must sign out the narcotic on the controlled drug record prior to administration of the medication and electronically record their signature in the resident's Medication Administration Record (MAR) after the resident takes the medication. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 102, dated March 5, 2025, revealed that the resident was cognitively intact, was understood, could understand others, and was receiving an opioid (a controlled substance) medication for pain. Physician's orders for Resident 102, dated February 10, 2025, included an order for the resident to receive one 5-235 milligram (mg) tablet of Oxycodone-Acetaminophen (a controlled substance to treat pain). The resident's controlled drug records for February and March 2025 indicated that 5-325 mg Oxycodone-Acetaminophen was signed out on February 23, 2025, at 8:00 p.m. and March 1, 2025, at 7:25 p. m.; however, there was no documented evidence in the resident's MAR that the medication was administered. Interview with the Director of Nursing on March 27, 2025, at 11:21 a.m. confirmed that there was no documented evidence that the signed-out doses of Oxycodone-Acetaminophen for Resident 102 were administered on the above dates and times. 28 Pa. Code 211.9(h) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 31760 Based on review of manufacturer's directions for use, facility policies, and clinical records, as well as staff interviews, it was determined that the facility failed to follow the manufacture's direction for use, resulting in a significant medication error for one of 44 residents reviewed (Resident 85), which resulted in Resident 85 requiring medical intervention to correct a critically low blood sugar. Findings include: The manufacturer's direction for use for Insulin Lispro (a rapid acting insulin), dated July 2023, indicated to administer the dose of Insulin Lispro within 15 minutes before a meal or immediately after a meal. The facility's policy regarding medication administration, dated December 20, 2024, indicated that medications are to be administered in a safe and legal manner. Medications given need to follow the 5 Rights: right resident, right time, right drug, right frequency, and right route. Pour the medication reading each order on the computer screen and comparing the directions on each medication box. That manufacturer's guidelines will be followed for all rapid, short, intermediate, and long-acting insulin. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 85, dated February 3, 2025, revealed that the resident was understood, could understand others, and had a diagnosis which included diabetes. A care plan for the resident, dated February 24, 2025, revealed that the resident has diabetes with hyperglycemic (high blood sugar) and hypoglycemic (low blood sugar) readings. Physician's orders for Resident 85, dated February 6, 2025, included an order for the resident to receive 22 units of Insulin Lispro in the evening for diabetes. Information provided by the facility revealed that the first meal cart was delivered to Resident 85's unit at 5:15 p.m. and the second meal cart was delivered to the unit at 5:20 p.m. A nursing note for Resident 85, dated February 17, 2025, at 5:00 p.m. completed by Registered Nurse 1 revealed that the resident's accu-check at 5:00 p.m. was 35 milligrams per deciliter (mg/dL) (a normal range is generally considered to be 70 to 100 mg/dL). The resident is lethargic (feeling tired, lacking energy, and sluggish) and diaphoretic (profuse sweating, or being covered in sweat). The resident will open eyes and respond minimally verbally. The resident was administered Glucagon (used along with emergency medical treatment to treat very low blood sugar) and per the physician, recheck the resident's accu-check in 15 minutes. The rechecked accu-check was 49 mg/dL. The resident was given another administration of Glucagon. The accu-check was checked again in 15 minutes and was 59 mg/dL. At this time the resident was awake and alert and becoming more to her baseline. The resident was being fed by staff at this time. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	A Medication Administration Audit Report for Resident 85, dated February 17, 2025, revealed that Licensed Practical Nurse 2 administered the 22 units of Insulin Lispro to the resident at 4:05 p.m. (more than one hour prior to the meal delivery). The physician was advised that prior to the hypoglycemic episode, the resident received 22 units of her Insulin Lispro, and that the resident had not eaten within 15 minutes to 30 minutes of receiving her insulin. Registered Nurse 1 stated that a rule of thumb is to not administer the resident their insulin until the trays hit the hall, especially if they are unfamiliar with the resident to avoid this in the future. Interview with the Nursing Home Administrator on March 26, 2025, at 1:55 p.m. confirmed that per the manufacturer's instructions, Licensed Practical Nurse 2 should have waited until 15 minutes before the meal or until immediately after the meal to give the 22 units of Insulin Lispro to Resident 85. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(3)(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. 31760 Based on review of facility policies, manufacturer's instructions, and clinical records, as well as observations and staff interviews, it was determined that the facility failed to store unopened (unused) multi-dose containers of insulin according to manufacturer's instructions for two of 44 residents reviewed (Residents 74, 85), and failed to label multi-dose containers of medications with the date they were opened in one of two medication carts observed (First-Floor medication cart). Findings include: The facility's policy regarding medication labeling and storage, dated December 20, 2024, revealed that multi-dose vials that have been opened or accessed were to be dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. Manufacturer's directions for the use of Lantus insulin (a long-acting insulin used to lower blood sugar levels), dated September 2023, revealed that unused Lantus should be stored in a refrigerator between 36 degrees F to 46 degrees F. After initial use it may be kept at temperatures below 86 degrees F for up to 28 days. Physician's orders for Resident 74, dated December 5, 2024, included an order for the resident to receive 14 units of Lantus insulin one time a day for diabetes. Observations of the Spruce back medication cart on March 27, 2025, at 9:03 a.m. revealed an opened and undated pen injector of Lantus insulin for Resident 74. Interview with Licensed Practical Nurse 5 at the time of observation confirmed that the pen injector of Lantus insulin for Resident 74 was not dated with the date it was opened and it should have been. Manufacturer's directions for the use of Humalog/Lispro insulin (a fast-acting insulin used to lower blood sugar levels), dated July 2023, revealed that unused Humalog/Lispro should be stored in a refrigerator between 36 degrees F to 46 degrees F. After initial use it may be kept at temperatures below 86 degrees F for up to 28 days. Throw away all opened vials after 28 days of use, even if there is insulin left in the vial. Physician's orders for Resident 85, dated February 18, 2025, included an order for the resident to receive 12 units of Lispro insulin three times a day for diabetes. Observations of the Maple medication cart on March 27, 2025, at 9:35 a.m. revealed an opened and undated Lispro Kwik pen for Resident 85. Interview with Licensed Practical 6 at the time of observation confirmed that the opened Lispro Kwik pen for Resident 85 was not dated with the date it was opened and it should have been. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Manufacturer's directions for use of Aplisol (tuberculin purified protein derivative), dated March 2016, indicated that the vials in use more than 30 days should be discarded due to possible oxidation and degradation, which may affect potency. Observations of the medication refrigerator in the nursing supervisors office on March 27, 2025, at 9:27 a.m. revealed an opened and undated bottle of Aplisol solution. Interview with Registered Nurse 7 at the time of observation confirmed that the opened bottle of Aplisol solution should have been labeled with the date it was opened. Interview with the Nursing Home Administrator on March 27, 2025, at 10:04 a.m. confirmed that the opened pen injector of Lantus insulin, Lispro Kwik pen, and bottle of Aplisol solution should have been dated when they were opened. Manufacturer's directions for Trelegy Ellipta (a combination medication used to treat chronic obstructive pulmonary disease (COPD) and asthma), dated January 7, 2019, indicated that Trelegy Ellipta should be stored inside the unopened moisture-protective foil tray and only removed from the tray immediately before initial use. Discard Trelegy Ellipta six weeks after opening the foil tray or when the counter reads 0, whichever comes first. Write the Tray opened and Discard dates on the inhaler label. The Discard date is six weeks from the date you open the tray. Physician's orders for Resident 120, dated March 20, 2025, included an order for the resident to receive one 100-62.5-25 microgram (mcg)/activation puff from the Trelegy Ellipta inhaler once a day. Observations of the First-Floor medication cart on March 27, 2025, at 1:01 p.m. revealed that the 100-62.5-25 mcg/activation Trelegy Ellipta inhaler for Resident 120 was opened and not dated with the date that it was opened. Interview with Licensed Practical Nurse 8 at the time of observation confirmed that the inhaler for Resident 120 was opened and not dated with the date it was opened, and it should have been dated. 28 Pa. Code 211.9(h) Pharmacy Services. 28 Pa. Code 211.12(d)(1) Nursing Services.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. 31760 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to obtain laboratory studies as ordered by the physician for one of 44 residents reviewed (Resident 1), and failed to obtain a physician's order for an invasive procedure to collect a specimen for a laboratory test for two of 44 residents reviewed (Residents 6, 41). Findings include: An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 1, dated March 5, 2025, revealed that the resident was cognitively intact, was understood and understood others, and had a diagnosis of atrial fibrillation (an abnormal heart rhythm). The resident's care plan, dated March 5, 2025, indicated that she was at risk for bleeding due to anticoagulant therapy (providing medication to thin the blood), and she was to have blood tests and medications as ordered by the physician and was to be observed for any bruising or bleeding. Physician's orders for Resident 1, dated March 17, 2025, included an order for the resident to receive 5.0 milligrams (mg) of Coumadin (medication that thins the blood) daily. The resident was also ordered to have blood drawn for prothrombin time and international normalized ratio (PT/INR - blood tests that determine how long it takes the blood to clot) to monitor the therapeutic levels (appropriate range) of Coumadin to be completed on March 24, 2025. There was no documented evidence that the PT/INR tests were completed on March 24, 2025, as ordered by the physician. Interview with Nursing Home Administrator on March 27, 2025, at 1:20 p.m. confirmed that the PT/INR tests ordered by the physician for March 24, 2025, were missed and were never obtained. The facility's policy regarding catheter insertion (insertion of a plastic tube into the bladder), dated December 20, 2024, revealed that staff were to verify the physician's order. A quarterly MDS assessment for Resident 6, dated February 2, 2025, revealed that the resident was understood, could understand others, and had diagnoses that included renal insufficiency (a condition where the kidneys do not function properly, leading to a decreased ability to filter waste products and excess fluid from the blood). Physician's orders for Resident 6, dated March 3, 2025, included an order for a urinalysis and culture and sensitivity (UA/C&S tests to determine if there is a urinary infection and which antibiotics will work to treat it). A progress note for Resident 6, dated March 3, 2025, revealed that the urine was collected via straight catheterization (intermittently inserting a plastic tube into the bladder to drain urine). (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence that staff obtained a physician's order to obtain Resident 6's urine specimen via straight catheterization. Interview with the Director of Nursing on March 27, 2025, at 11:42 a.m. confirmed that there was no documented evidence that a physician's order was obtained for Resident 6 to be straight catheterized in order to obtain the urine specimen. A quarterly MDS assessment for Resident 41, dated December 23, 2024, revealed that the resident was understood, could usually understand others, and had diagnoses that included renal insufficiency. Physician's orders for Resident 41, dated March 22, 2025, included an order for a UA/C&S. A progress note for Resident 41, dated March 23, 2025, revealed that the writer attempted to obtain the UA/C&S via straight catheterization due to resident being incontinent two times, once at 1:30 a.m. and again at 3:30 a.m. Did not get enough urine to send to the lab, and the resident refused the third straight catheterization at this time. There was no documented evidence that staff obtained a physician's order to obtain Resident 41's urine specimen via straight catheterization. Interview with the Nursing Home Administrator on March 26, 2025, at 9:15 a.m. confirmed that there was no documented evidence that a physician's order was obtained for Resident 41 to be straight catheterized in order to obtain the urine specimen. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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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. 42079 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 April 18, 2024, and a complaint investigation survey ending October 23, 2024, 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 March 27, 2025, identified repeated deficiencies related to revision of care plans, accident hazards, and pharmacy procedures, services, and records. The facility's plan of correction for a deficiency regarding a failure to update residents' care plans, cited during the survey ending April 18, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F657, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding updating residents' care plans. The facility's plan of correction for a deficiency regarding accident hazards, cited during the surveys ending on April 18, 2024, and October 23, 2024, 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 F689, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding accident hazards. The facility's plan of correction for a deficiency regarding pharmacy procedures, services, and records, cited during the survey ending April 18, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F755, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding pharmacy procedures, services, and records. Refer to F657, F689, F755. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) 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. 42079 Based on review of established infection control guidelines, facility policy, and residents' clinical records, as well as observations and staff interviews, it was determined that the facility failed to follow infection control guidelines from the Centers for Medicare/Medicaid Services (CMS) and the Centers for Disease Control (CDC) to reduce the spread of infections and prevent cross-contamination for three of 36 residents reviewed (Residents 47, 106). Findings include: CDC guidance on isolation precautions and Implementation of Personal Protective Equipment (PPE) use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDRO's - bacteria that have become resistant to certain antibiotics, and these antibiotics can no longer be used to control or kill the bacteria), dated July 12, 2022, indicates that MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. CMS updated its infection prevention and control guidance effective April 1, 2024. The recommendations now include the use of EBP during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, in addition to residents who have an infection or colonization with a CDC-targeted or other epidemiologically important MDRO when contact precautions do not apply. The facility's policy regarding EBP, dated December 20, 2024, referred to the use of gown and gloves for use during high contact resident care activities for residents known to be colonized or infected with MDRO as well as those at increased risk of MDRO acquisition (e.g. residents with wounds or indwelling medical devices). Clear signage would be posted on the door or wall outside of the resident room indicating the type of precautions, required PPE, and the high contact resident care activities that require the use of gowns and gloves. An orange-colored sticker would be placed on the resident name on the door to alert staff of EBP. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 47, dated February 24, 2025, revealed that the resident was cognitively impaired, required assistance from staff with care, and had pressure sores. Physician's orders for Resident 47, dated February 18, 2025, included orders for the resident to have the wound on her sacrum cleaned with wound cleanser and hydrogel applied daily. A wound note, dated March 25, 2025, revealed that the resident had a Stage 3 pressure ulcer (involves full-thickness skin loss, extending into the subcutaneous tissue layer, but not exposing bone, tendon, or muscle) of the sacrum. Observation of Resident 47 on March 24, 2025, at 8:50 a.m. revealed that the resident was in bed, and there was no sign to indicate the resident was on EBP or PPE supplies outside of her door. Interview with the Nursing Home Administrator on March 25, 2025, at 3:03 p.m. revealed that the resident did not have EBP in place and should have due to having a pressure sore. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An admission MDS for Resident 106, dated March 13, 2025, revealed that the resident was cognitively impaired, required assistance from staff with care, and had one unstageable pressure ulcer (unable to determine the depth of the wound due to slough or eschar) present on admission. A care plan for Resident 106, dated March 6, 2025, revealed that she had a left heel unstageable ulcer and right plantar heel diabetic foot ulcer that was at risk for further skin breakdown. Staff were to provide treatments a ordered. Physician's orders for Resident 106, dated March 7, 2025, included an order to cleanse the left heel with wound cleanser, then apply medical grade honey (a wound treatment), and cover with a border foam dressing, changed once a day and as needed. Physician's orders for Resident 106, dated March 11, 2025, included an order to cleanse the right plantar heel with wound cleanser and apply with a border foam dressing, changed once a day and as needed Observation of Resident 106's on March 24, 2025, at 9:30 a.m. revealed that the resident was in bed, and there was no signage to indicate the resident was on EBP or PPE supplies outside of her door. Observations of Resident 106 on March 24, 2025, at 9:39 a.m. revealed that Licensed Practical Nurse 4 entered the room with two dressings in her hand. Licensed Practical Nurse 4 put on gloves but did not put on a gown to complete the wound care. Interview with the Nursing Home Administrator on March 24, 2025, at 2:29 p.m. revealed that the resident did not have EBP in place and should have due to having a pressure sore, and staff should have worn a gown while performing wound care. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.