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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Rehabilitation & Healthcare Center	225 Park Street Montrose, PA 18801

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on a review of clinical records, and resident and staff interviews, it was determined the facility failed to provide care in a manner and environment that promotes each resident's quality of life by failing to ensure that one resident (Resident 18) had the right to a dignified dining experience and failed to respond timely to residents' requests for assistance, as evidenced by experiences reported by seven out of the 15 residents sampled (Residents 18, 28, 15, 6, 5, 3, and 13) Findings include: A review of the clinical record revealed that Resident 18 was admitted to the facility on [DATE], with diagnoses to include amputation of the left leg above the knee, need for assistance with personal care, and muscle weakness. A quarterly Minimum Data Set assessment (MDS- standardized assessment completed at specific intervals to plan care) dated, September 9, 2024, indicated the resident had a BIMS score of 12 (Brief Interview for Mental Status-a tool to assess the resident's attention, orientation, and the ability to register and recall new information, a score of 8-12 equates to moderate cognitive impairment). Observation of Resident 18's room on November 5, 2024, at 11:35 AM revealed the resident's lunch tray, which consisted of a cheeseburger, cooked carrots, pudding and water, was delivered and placed on top of the resident's over-the-bed table tray. The resident's table tray was pushed against the wall to the right of the resident's bed, not within the resident's reach. The resident was awake and lying in bed on top of a mechanical lift sling (a hammock-type sling that connects to a mechanical device used to lift and transfers residents). Interview with Resident 18 at the time of the observation revealed that she was waiting for staff to come back to get her out of bed for lunch. The resident stated that her lunch tray was delivered a few minutes ago but no one offered to reposition her upright in bed or to get her out of bed into her wheelchair so that she can eat her lunch. Further observation revealed that the resident's call bell was wrapped around the left bed rail and out of reach of the resident. The resident stated that she was unable to locate or reach her call bell and was unable to notify staff that she needed assistance. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continued interview with Resident 18 revealed that when she does have access to the call bell, she frequently waits long periods of time, 45 minutes or more, for the call bell to be answered. She reported that she has urinated in her brief due to excessive wait times for staff to respond to her call for assistance. Continued observation revealed no staff member returned to Resident 18's room to get her out of bed or set her up with her lunch tray. The time was 12:15 PM, 40 minutes after the surveyor entered the room and approximately 45 minutes since her lunch tray was delivered. Interview with the Director of Nursing on November 5, 2024, at 12:16 PM confirmed that Resident 18 was not provided with her lunch meal in a dignified and timely manner and that her call bell was not within reach. During an interview with Resident 28 on November 5, 2024, at 1:20 PM the resident expressed concern and frustration with staff's response to call bells. He reported that sometimes he has to wait 30 minutes or more and reported that a few days ago, he waited almost two hours. He stated that he asked the staff why are you making me wait so long? and they responded you have to wait your turn. Resident 28 stated I can't hold my bowels that long; 10-15 minutes is okay but to wait almost two hours is not okay!. Observation during the time of the interview revealed Resident 28 did not have his call bell within reach. Resident 28 was seated in his wheelchair along the right side of his bed. The resident's call bell was located under the pillow and blankets and out of sight and reach of the resident. During an interview with Resident 28 at the time of the observation he stated, this isn't the first time I can't find my call bell, it happens from time to time. During a group interview with alert and oriented residents on November 6, 2024, at 11:00 AM, five out of the five residents in attendance indicated they rely on staff for care (Residents 15, 6, 5, 3, and 13). All five residents explained they experience long wait times for staff assistance. The residents in attendance indicated that concerns with staffing have been brought up during Resident Council meetings over the past few months, but the long wait times for care remain a problem at the facility. Resident 13 indicated that when she activates her call bell for staff assistance, staff come into her room, turn off the call bell, say that they will be right back, but never come back. She reported that it happens quite a lot. Residents 5 and 6 also indicated that they have waited 30 minutes or longer for staff assistance. Both residents expressed frustration over the long wait times especially when they need to go to the bathroom. Resident 5 further added the adult briefs are thin and when I have a wet diaper and have to wait even longer to be changed, I end up peeing again in my adult brief and then it's a mess. During an interview on November 6, 2024, at approximately 2:00 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) verified all residents at the facility should be treated with dignity and respect. The NHA and DON were unable to explain why residents are reporting untimely staff responses to residents' requests for assistance and care which is negatively affecting their quality of life in the facility. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 201.29 (a) Resident Rights 28 Pa. Code 211.12 (c)(d)(4)(5) Nursing Services.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 48277 Based on observation and resident and staff interviews, it was determined the facility failed to reasonably accommodate residents' need for call bell accessibility for three out of 15 residents sampled (Residents 42, 18, and 28). Findings include: Observation on November 5, 2024, at 11:29 AM revealed that Resident 42 was seated on the left side of her bed, facing the wall. The call bell was observed draped over the headboard on the right side of the bed and not within the resident's reach. The resident was unable to locate or access her call bell to call for assistance. An interview with Employee 2 RN (registered nurse) on November 5, 2024, at 11:32 AM confirmed the observation and that Resident 42 did not have access to a call bell for staff assistance. Observation on November 5, 2024, at 11:35 AM revealed Resident 18 was lying in bed. The resident's call bell was wrapped around the left bed rail and out of reach of the resident. During an interview at the time of the observation, Resident 18 stated that she uses the call bell to alert staff to her needs for assistance and confirmed that her call bell was not accessible to her at the time of the observation. An interview with the Director of Nursing, on November 5, 2024, at 12:16 PM confirmed the observation that Resident 18 did not have access to a call bell to call for staff assistance if needed and verified that call bells are to be placed within reach of the residents at all times. Observation on November 5, 2024, at 1:30 PM revealed that Resident 28 was seated in a wheelchair along the right side of his bed. The resident's call bell was located under the pillow and blankets and out of sight and reach of the resident. During an interview with Resident 28 at the time of the observation he stated, this isn't the first time I can't find my call bell, it happens from time to time. An interview with Employee 3 (registered nurse) confirmed the observation that Resident 28 did not have access to a call bell to call for staff assistance. An interview with the Nursing Home Administrator on November 7, 2024, at approximately 10:30 AM verified that call bells are to be placed within reach of each resident at all times. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing Services. 28 Pa. Code 201.29 (a) Resident Rights

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on a review of clinical records, information submitted by the facility and the facility's abuse prohibition policy, resident interviews, and staff interviews, it was determined the facility failed to ensure that one resident (Resident 24) was free from sexual abuse perpetrated by another resident (Resident 35) out of 15 sampled residents. Findings include: A review of the current facility policy titled Abuse Policy, last reviewed by the facility on August 27, 2024, indicated that residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. The facility defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Willful, as used in the definition of abuse, means the individual must have intended to inflict injury or harm. Sexual abuse is non-consensual sexual contact of any type with a resident, including sexual harassment, sexual coercion, or sexual assault. Sexual contact or assault that results from threats, force, or the inability of the person to give consent and involving a range of activities. Additionally, anytime the facility has reason to suspect that a resident may not have the capacity to consent to sexual activity, the facility must take steps to ensure that the resident is protected from abuse. Additionally, the facility policy indicated that abuse prevention included assessing, care planning, and monitoring residents with needs and behaviors that may lead to conflict or neglect. Assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issues. The facility will strive to maintain adequate staffing on all shifts to ensure the needs of each resident are met. A review of Resident 35's clinical record revealed admission to the facility on [DATE], with diagnoses that included muscular dystrophy (is a group of diseases that cause progressive weakness and loss of muscle mass. In muscular dystrophy, abnormal genes (mutations) interfere with the production of proteins needed to form healthy muscle) and major depressive disorder. Resident 35's comprehensive person-centered plan of care was initiated on February 23, 2024, and revised on April 11, 2024, and indicated the resident had behaviors related to inappropriate sexual behaviors (making sexually inappropriate statements to caregivers) and desires to be sexually active or show sexual expression. Planned interventions to manage sexual behaviors included to attempt to redirect the resident when exhibiting these behaviors and re-approach when the resident has deescalated, monitor and document episodes of inappropriate behaviors and notify physician/nurse practitioner/physician assistant when behaviors persist or won't deescalate, and to monitor behavior episodes and attempt to determine underlying cause with consideration of location, time of day, persons involved, and situations. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 35's Quarterly MDS (Minimum Data Set - a federally mandated standardized assessment process conducted periodically to plan resident care) assessment dated [DATE], section C Cognitive Patterns revealed the resident had a BIMS score (Brief Interview for Mental Status is a tool used to evaluate cognitive impairment and assist with dementia diagnosis) of 12, which indicated the resident had moderate cognitive impairment. Additionally, the resident used an electric wheelchair for mobility. A review of Resident 24's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included Alzheimer's dementia (most common cause of dementia, a general term for memory loss and other cognitive abilities serious enough to interfere with daily life), anxiety (a feeling of fear, tension, or worry that occurs as a response to real or perceived threats), and major depressive disorder. Additionally, the resident had severe cognitive impairment and utilized a wheelchair for mobility as indicated by her quarterly MDS assessment dated [DATE] as evidenced by a BIMS score of 2 (score of 00-07 severe cognitive impairment). A review of nursing documentation on September 28, 2024, at 3:07 PM for Resident 35's revealed social services was alerted due to the resident caressing a nurse aide's (NA) arm while providing care, making her feel uncomfortable. However, Resident 35's clinical record failed to reveal documented evidence that social services followed up with the resident post the inappropriate sexual behavior toward the staff member and failed to reveal that his person-centered plan of care was reviewed and revised with new goals and approaches to manage his sexual behaviors. A review of a facility provided documentation completed by the Director of Nursing (DON), dated October 21, 2024, at 2:55 PM, revealed that Employee 1, a NA, alerted the IDT (Interdisciplinary Team) staff to resident Resident 35 who was in the activity area holding the hand of female Resident 24 and rubbing his private parts and top of thigh over clothing with Resident 24's hand. Three other residents were in the activity area at time of the incident. Resident 35's description of the incident, I didn't do anything. The report indicated the incident was unwitnessed with no injuries noted. Further review of the incident investigation report revealed the facility's immediate action taken was immediately removing the female resident, Resident 24, from the area and Resident 35 was sent back to his room. Resident 35 was placed on 1:1 (one-to-one staff supervision) while statements were obtained from involved parties in the area during the time of the incident. Resident 35 sat with a NA in the Social Services Department office while interviews were being conducted. The Department of Aging and State Police were notified and the responsible party (RP) of female resident Resident 24 was notified. The facility's immediate interventions were to replace Resident 35's motorized wheelchair for a manual wheelchair while awaiting a therapy evaluation and every fifteen-minute checks were also initiated while Resident 35 was OOB (out of bed). A review of Employee 1's, nurse aide witness statement dated October 21, 2024, no time specified, revealed that on Monday October 21, Employee 1 was walking down the north hall and observed Resident 35 holding Resident 24 by her wrist and rubbing his private area and the top of his leg. Employee 1 called out to Resident 35 who then removed his hand from Resident 24. Resident 24 was removed from the situation and Employee 1 asked Resident 35 to return to his room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to protect and ensure that Resident 24 was free from sexual abuse from Resident 35 who had a known documented history of sexual inappropriate behaviors. Applying the reasonable person concept, in the case of Resident 24, who is unable to speak for herself, and the assessment of how most people would react to the situation of being sexually abused by Resident 35, Resident 24 would have suffered psychosocial harm and humiliation. An interview with the Director of Nursing (DON) and in the presence of Nursing Home Administrator (NHA) on November 7, 2024, 2024, at 1:05 PM, revealed that that they were not aware of Resident 8's history of sexually inappropriate encounters/behaviors with female staff and residents as noted in his person -centered plan of care and clinical record by staff and contracted psychiatric services. Further interview with the DON and NHA confirmed the facility failed ensure proper staff supervision of Resident 35, a resident with a known history of sexually inappropriate behaviors and ensure that Resident 24 was free from sexual abuse. The facility failed to fully investigate this incident of sexual abuse of Resident 24. The facility failed to develop and implement necessary interventions for a resident with a known history of sexual inappropriate behaviors to prevent the sexual abuse of Resident 24. The facility failed to develop and implement interventions after the sexual abuse occurred to prevent further incidents of sexual abuse. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 201.29 (a)(c) Resident Rights 28 Pa. Code 211.12(c)(d)(5) Nursing Services

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on a review of clinical records, the facility's abuse prohibition policy, information provided by the facility, and resident and staff interviews, it was determined the facility failed to promptly conduct a thorough investigation to rule out abuse and implement the facility's established procedures and corrective action and submit the results of the completed investigation to the State Survey Agency within five working days of the incident as evidenced by one of 15 residents reviewed (Resident 35) Findings included: A review of the current facility policy titled Abuse Policy, last reviewed by the facility May 10, 2024, indicated that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in the regulation. Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends, or other individuals. Each resident has the right to be free from mistreatment, neglect, and misappropriation of property. This includes the facility's identification of residents whose personal histories render them at risk for abusing residents, and development of intervention strategies to prevent occurrences, monitoring for changes that would trigger abusive behavior, and reassessment of the interventions on a regular basis. The Abuse Policy indicated the facility's abuse prevention/intervention program included training all staff and practitioners' and ways to resolve conflicts appropriately. Assessing, care planning, and monitoring residents with needs and behaviors that may lead to conflict or neglect and assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issues. Additionally, the facility's response to abuse includes an assessment and assessment data will include injury assessment, signs of recent fall, pain assessment, current behavior, all current medications, vital signs, behaviors over the past 24-hours, all active diagnoses, and any recent labs. The nurse will report any findings to the physician. As a part of the initial assessment, the physician will help identify risk factors for abuse within the facility, for example, significant number of residents with unmanaged and problematic behaviors A review of a policy entitled Abuse Policy last reviewed by the facility on August 27, 2024, indicated that the facility will report alleged and substantiated incidents to the Pennsylvania Department of Health, additional state agencies and/or local authorities per federal and state requirements. The facility will analyze the occurrences to determine what changes are needed, of any, to policies and procedures to prevent further occurrences. Any report or allegations of abuse/neglect, misappropriation, or exploitation will be reported initially by the Administrator (NHA), Director of Nursing (DON), Assistant Director of Nursing (ADON), or delegated supervisor as follows: Within 24-hours of knowledge of the event to the Pennsylvania Department of Health through the electronic reporting system: Immediately to the Area Agency on Aging (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Local police department The Pennsylvania Department of Health will be notified of the reports of abuse involving the following and will be reported by the Administrator (NHA), Director of Nursing (DON), Assistant Director of Nursing (ADON), or delegated supervisor as required to The Pennsylvania Department of Aging for the following reasons: Serious bodily injury Serious physical injury Sexual abuse, assault, rape Suspicious death The appropriate agencies listed above will be notified of the results and outcomes of the investigation by the NHA or his/her designee. The mandatory reporting form will be submitted to the local Area Agency on Aging (AAA) with 48-hours, the NHA will complete the PB-22 within five (5) working days of the incident and any supplemental information to the AAA. If abuse is substantiated, the NHA and/or designee will notify the appropriate agencies and/or licensing board(s). A review of Resident 35 was admitted to the facility on [DATE], with diagnoses that included muscular dystrophy (is a group of diseases that cause progressive weakness and loss of muscle mass. In muscular dystrophy, abnormal genes (mutations) interfere with the production of proteins needed to form healthy muscle) and major depressive disorder. Resident 35's comprehensive person-centered plan of care was initiated on February 23, 2024, and revised on April 11, 2024, and indicated the resident had behaviors related to inappropriate sexual behaviors (making sexually inappropriate statements to caregivers) and desires to be sexually active or show sexual expression. Planned interventions to manage sexual behaviors included to attempt to redirect the resident when exhibiting these behaviors and re-approach when the resident has deescalated, monitor and document episodes of inappropriate behaviors and notify physician/nurse practitioner/physician assistant when behaviors persist or won't deescalate, and to monitor behavior episodes and attempt to determine underlying cause with consideration of location, time of day, persons involved, and situations. Review of Resident 35's Quarterly MDS (Minimum Data Set - a federally mandated standardized assessment process conducted periodically to plan resident care) assessment dated [DATE], section C Cognitive Patterns revealed that the resident had a BIMS score (Brief Interview for Mental Status is a tool used to evaluate cognitive impairment and assist with dementia diagnosis) of 12, which indicated that the resident had moderate cognitive impairment. Additionally, the resident used an electric wheelchair for mobility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on review of clinical records and select resident incident/accident reports and staff interview, it was determined that the facility failed to implement effective interventions, timely re-evaluate the effectiveness of planned safety interventions and revise the resident's fall prevention plan to include the provision of supervision necessary to prevent falls for one of 15 residents sampled (Resident 46) and failed to assess resident's safety with the use of motorized wheelchairs for two (Resident 35 and Resident 25) residents out of 15 sampled residents. Findings include: A review of the clinical record revealed that Resident 46 was admitted to the facility on [DATE], with diagnoses to include dementia and a history of falls. A review of a quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment completed at specific times to identify resident care needs) dated May 27, 2024, revealed that the resident's cognition was severely impaired, and he was independent with ambulation with a BIMS score of 4 (Brief Interview for Mental Status. The BIMS test is used to get a quick snapshot of how well you are functioning cognitively at the moment. A score of 1-7 indicated severe cognitive impairment). A review of Resident 46's care plan, initiated May 21, 2024, revealed the resident was at risk for falls related to impaired cognition with decreased safety awareness, inability to use call light due to confusion, medications prescribed including psychoactive drug use and wandering. A care plan for activities of daily living dated September 9, 2024 revealed the resident required distant supervision when ambulating throughout facility. Additional Initial interventions included, Non-Skid Footwear, keep bed in lowest position, keep environment free of clutter, family education on resident's safety interventions and maintain call light within reach. A review of nursing documentation and incident reports dated between July 19, 2024, and October 28, 2024, revealed that Resident 46 incurred nineteen falls in the facility during that time period, one in July, two in August, six in September and ten in October. The interventions planned for fall prevention during this timeframe included, providing clear pathways, keep personal belongings within reach on left side of bed, assist resident with toileting every one hour while awake, maintain call light within reach and medication review related to frequent falls. A review of activity of daily living records for August through October 2024 did not indicate that every one hour toileting was attempted by nursing staff. A review of select incident reports during July 2024, and nursing documentation revealed the following: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Rehabilitation & Healthcare Center	225 Park Street Montrose, PA 18801

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On July 19, 2024 at 7:10 AM, Resident 46 was found on the floor in his room. The resident had an increase in his antianxiety medication July 14, 2024. Select incident reports during August 2024, and nursing documentation revealed the following: On August 28, 2024 at 6:15 AM, Resident 46 was sitting on the side of his bed and slid to the floor. He was incontinent of urine at the time. New interventions at that time to prevent falls were to educate the resident's family regarding fall prevention, On August 28, 2024 at 11:55 P.M., the resident was found on the floor between the two beds with the room armchair tipped over underneath him. He was noted to be incontinent of urine at that time. He was placed back to bed by staff and non skid socks were applied at that time by staff. According to review of select incident reports and nursing documentation completed during September 2024, revealed the following: On September 1, 2024 at 8 AM, Resident 46 was found on the floor in his room. The arm chair again was tipped on its side next to him. He was incontinent of a large amount of urine at the time. No new interventions were put into place at that time to prevent falls. On September 3, 2024 at 7 A.M., the resident was found on the floor in his room. He was noted to be incontinent of urine at that time. His brief was noted to be saturated with urine and there was a pool of urine on the floor. There were no new interventions put into place at that time to prevent falling. On September 5, 2024 at 2 A.M., the resident was found on the floor in his room. He was noted to be incontinent of urine at that time. No new interventions put into place at that time, to prevent falling. On September 8, 2024 at 2:15 A.M., the resident was found on the floor in his room. He was noted to be incontinent of urine at that time. There was no indication that the facility devised new interventions to address the resident's frequent falls. On September 9, 2024 at 7:40 A.M., the resident was found on the floor in his room. He was again noted to be incontinent of urine at that time. A liquid was also identified on the floor at that time. There were no indication that new interventions were put into place at that time, to prevent falling. A new intervention was noted on the resident's care plan dated September 11, 2024, and consisted of assisting the resident with toileting every 1 hour while awake. On September 16, 2024 at 4:45 P.M., the resident was observed in the lobby area by staff. His shorts were falling down. The resident bent over to pick up his pants, lost his balance and fell to the floor. There were no new interventions put into place at that time to prevent falling. According to review of select incident reports and nursing documentation completed during October 2024, revealed the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On October 14, 2024 at 5:30 PM, Resident 46 was found on the floor in his room in front of the heater. He stated I slid off the bed again. The resident slid off the bed when he leaned over to remove his sneakers. No new interventions were put into place at that time to prevent falls. On October 15, 2024 at 1:29 P.M., the resident was found on the floor in his room. He had been previously in his bed. The resident stated I slid off my bed again. There were no new interventions put into place at that time to prevent falling. On October 18, 2024 at 10:35 A.M., the resident was found on the floor in his room. The resident's bed linens were saturated at that time. A new intervention dated October 18, 2024 to conduct a medication review related to frequent falls, was put into place at that time. On October 19, 2024 at 9:32 AM, Resident 46 was found on the floor in his room. He stated I slid off the bed again. He was noted to have an 8 cm x 8 cm area bruise to his sacrum. No further description of this area was available at the time of the survey. The resident was noted to have a perimeter mattress (A bed mattress with bolsters, designed to minimize the risk of a fall by guiding the sleeper away from the side of the bed and toward the middle of the mattress) in place on top of his bed. He was noted to be incontinent of urine at the time of the fall. New interventions implemented at that time, to prevent falls included, replace underwear with disposable briefs for incontinence care. On October 22, 2024 at 11 A.M., the resident was found on the floor in his room. He was noted to be incontinent of urine at that time. There were no new interventions put into place at that time to prevent falling. On October 22, 2024 at 6:15 P.M., the resident was found on the floor in his room. Again the resident was noted to be incontinent of urine at that time. The only new intervention in response to that fall, was to order a urology consult in response to family concerns for increased incontinence. On October 24, 2024 at 7:15 A.M., the resident was found on the floor in his room. He was noted to be incontinent of urine at that time. There were no new interventions put into place at that time to prevent falling. The investigation concluded that the resident's perimeter mattress did not fit the bed frame properly, his bed was not made and he had on silky shorts. During an interview November 6, 2024 at 2 P.M., the Director of Nursing was unaware that Resident 46's perimeter mattress did not fit the residents bed as stated in the incident investigation. On October 27, 2024 at 9:30 A.M., the resident was found on the floor in his room. He was noted to be incontinent of urine at that time. At the time of the fall the resident was dressed in a brief and regular socks. He had been previously dressed by direct care staff. It was noted that the resident had taken his clothing off and he was incontinent of urine. The floor was noted to be wet with urine. When examined it was noted the resident sustained a 2 cm x 2 cm abrasion to his right elbow, a 9 cm x 6 cm ecchymotic (black and blue bruise) area to his right forearm and a 1 cm x 1 cm abrasion to his right knee. Interventions were limited to notification to the Physician and a treatment to the affected areas was ordered. On October 28, 2024 at 6:30 P.M., the resident was independently ambulating in the facility and was found laying on the floor by the main entrance. When interviewed related to the fall he stated that he was tired. The residents physican was notified. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On October 29, 2024 at 4:40 PM, Resident 46 was found on the floor in his room on his side with the perimeter mattress flipped up on him on the floor. He was noted to be incontinent of urine. There was no indication that additional interventions were put into place at that time related to this additional fall. During an interview completed on November 6, 2024 at approximately 2 P.M., the Nursing Home Administrator and Director of Nursing confirmed that Resident 46 was incontinent of bladder. The NHA stated that this resident was a big man and nursing staff were intimidated by him. They confirmed that he wandered in the hallways and staff was often afraid to approach him to redirect or to toilet him. The NHA stated that the facility had been attempting to transfer him to a facility with a dedicated dementia unit in an attempt to provide him with the level of care he required. She confirmed that staff supervision was not attempted for this resident with repeated falls. The facility failed to provide effective interventions to include, supervison, a toileting program or a review of resident devices/ mattresses in an attempt to prevent the resident's repeated falls. The facility failed to timely revise the resident's safety plan and include the resident's need for increased staff supervision and a toileting program in response to the resident's known incontinence, behaviors and repeated falls. A review of Resident 35's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included muscular dystrophy (is a group of diseases that cause progressive weakness and loss of muscle mass. In muscular dystrophy, abnormal genes (mutations) interfere with the production of proteins needed to form healthy muscle) and major depressive disorder. Resident 35's comprehensive person-centered plan of care was initiated on February 23, 2024, and revised on April 11, 2024, indicated that the resident had behaviors related to exhibiting behaviors related to unsafe choices such as operating motorized wheelchair at increased speed beyond manufacturers recommendations and failure to observe safe distances from peers. Planned interventions included to monitor and document episodes of inappropriate behaviors and notify physician/NP (nurse practitioner)/PA (physician's assistant) when behaviors persisted or when the resident resisted efforts to deescalate. Planned interventions included attempts to redirect resident when exhibiting behaviors; re-approach when resident deescalated, and offer psychologist/psychiatrist services as needed. Review of Resident 35 ' s Quarterly MDS (Minimum Data Set - a federally mandated standardized assessment process conducted periodically to plan resident care) assessment dated [DATE], section C Cognitive Patterns revealed that the resident had a BIMS score (Brief Interview for Mental Status is a tool used to evaluate cognitive impairment and assist with dementia diagnosis) of 12, which indicated that the resident had moderate cognitive impairment. Additionally, the resident used an electric wheelchair for mobility. A review of a Contractual License signed by Resident 35 on June 4, 2023, revealed that nursing or any member of the IDT (interdisciplinary team) may restrict driving privileges due to unsafe practices by the driver which include but not limited to: overall health, alertness, issues with vision, endangering other people in the facility, endangering oneself, excessive speed, failure to stop and ask for assistance when there are obstacles, reckless driving, and after causing an accident. Further review of the contractual license indicated the following actions related to unsafe operating practices with motorized wheelchair use included the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	First offense - license will be suspended for up to three days until an interdisciplinary conference is conducted to determine the course of the offense and course of action. Second offense - license will be suspended, and resident will be reassessed by therapy and finding reported to the IDT for course of action. Third offense - license will be suspended, and therapy will re-evaluate the resident's ability to utilize motorized equipment and if deemed unsafe an alternative mode of transportation and least restrictive seating system would be evaluated. A review of a facility provided witnessed incident report completed by Employee 4, a Licensed Practical Nurse (LPN), dated June 21, 2024, at 11:20 PM, revealed that she heard another resident {Resident 12} yell ouch and looked down the hall and witnessed the resident {Resident 35} in his electric (motorized wheelchair) up against Resident 12 while trying to pass her in the fall. No injuries obtained. Resident 35 stated I didn't do it; she ran into me. The immediate action taken was to take away his motorized wheelchair for three days as per signed {signed by Resident 35} therapy agreement and for the IDT (interdisciplinary team) to address. Subsequently, Resident 35's clinical record failed to reveal that therapy services performed a thorough assessment of the resident's safety while using his personal motorized wheelchair. A review of Resident 25's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included anxiety disorder, depression, and diabetes. Review of Resident 25 ' s Quarterly MDS (Minimum Data Set - a federally mandated standardized assessment process conducted periodically to plan resident care) assessment dated [DATE], section C Cognitive Patterns revealed that the resident had a BIMS score (Brief Interview for Mental Status is a tool used to evaluate cognitive impairment and assist with dementia diagnosis) of 15, which indicated that the resident was cognitively intact. Additionally, the resident used an electric wheelchair for mobility. A review of the resident's clinical record failed to reveal that Resident 25 had periodic safety assessments to evaluate safety while using a personal electric wheelchair. During an interview with the Director of Therapy Service on November 6, 2024, at 2:45 PM, revealed that Resident 35 received therapy services from May 16, 2024, through June 16, 2024, and from August 26, 2024, through September 20, 2024, and reported that treatments included operating and maneuvering his electric wheelchair. Additionally, the PT director reported that the facility did not have a specific policy for the use of motorized wheelchairs in the facility and indicated that therapy included their safety evaluation for safe use of motorized wheelchairs in the resident's therapy evaluations and treatment plan documentation. The facility could not provide documented evidence that periodic safety evaluations/demonstrations were completed with Resident 35 and Resident 25 that utilized motorized wheelchairs. cross refer F690 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on review of select facility policy and clinical records, and staff interview, it was determined that the facility failed to develop and implement an individualized plan to meet the resident's toileting needs, including timely staff assistance with toileting and incontinence management for four residents out of 15 sampled residents (Residents 16, 7, 28, 46). Findings include: A review of facility policy titled Urinary Continence and Incontinence - Assessment and Management last reviewed August 27, 2024, revealed that it was the policy of the facility to identify, assess, and provide the appropriate treatment and services to achieve or maintain as much normal urinary function as possible. A three-day bladder diary will be completed for every resident upon admission, readmission, and as needed to determine if the resident requires a toileting plan or a every two-hour check and change program. A review of Resident 16's clinical record revealed that she was admitted to the facility on [DATE], with diagnoses that included metachromatic leukodystrophy (a rare hereditary (genetic) disorder that causes fatty substances (lipids) to build up in cells, particularly in the brain, spinal cord and peripheral nerves and the brain and nervous system progressively lose function because the substance that covers and protects the nerve cells (myelin) is damaged) and muscle weakness. A review of the resident's quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 9, 2024, revealed that the resident was cognitively intact, required substantial/extensive assistance from staff for bed mobility, transfers, and toileting, was always incontinent of urine, always incontinent of bowel, and was not on a toileting program. A review of a completed Bladder and Bowel assessment dated [DATE], revealed that Resident 16 was a candidate for scheduled toileting. However, the facility could not provide documented evidence that a scheduled bladder and bowel program was evaluated to determine a pattern of incontinence or to assess if more frequent check and changes should be offered to the resident to keep her dry. A review of documentation reports for August through October 2024, revealed no documented evidence that the facility implemented or offered the resident more frequent incontinence checks or incontinence care due to the resident consistently being incontinent. The facility completed a Bladder and Bowel Assessment on August 15, 2024, that indicated that Resident 16 was a candidate for scheduled toileting. However, the facility could not provide documented evidence that a scheduled bladder and bowel program was assessed to determine a pattern of incontinence or assess more frequent check and changes offered to resident to keep her dry. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A reviewed of survey documentation reports (task record) dated August 2024, through October 2024, revealed no documented evidence that the facility implemented or offered the resident more frequent incontinence checks and incontinence care due to the resident always being incontinent. An interview with the Director of Nursing (DON) on November 7, 2024, at 11:15 AM, confirmed that the facility could not provide documented evidence that a scheduled bladder and bowel program evaluation was completed to determine a pattern of incontinence or to determine if more frequent check and changes were required tto keep the resident dry. A review of Resident 7's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included urinary tract infections (UTI - is an infection in any part of the urinary system), major depressive disorder, and anxiety. A review of the resident's quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 2, 2024, revealed that the resident had severe cognitively impairment, required substantial/extensive assistance from staff for bed mobility, transfers, and toileting, was always incontinent of urine, frequently incontinent of bowel, and was not on a toileting program. A review of Resident 7's person-centered plan of care that was initiated on January 5, 2024, and last revised on February 14, 2024, identified that the resident has episodes of bladder and bowel incontinence related to generalized weakness, prostate cancer, stress incontinence, unable to feel urge to have BM (bowel movement), and unable to verbalized need to be toilet. Noted resident goals included for the resident to be comfortable, clean, dry, and free from skin breakdown and that the resident would be at a reduced risk for complications from incontinence through next review. Planned interventions included to provide peri care after each incontinent episode and apply house barrier after incontinence care, periodically evaluate residents pattern of urination and episodes of incontinence, implement toileting schedule as indicated, and check and change every two hours and PRN (as needed). A review of Resident 7's most recent Bladder and Bowel Assessment completed on October 12, 2024, revealed that the resident was to be toileted every two hours and noted that the resident was consistently incontinent of bowel and bladder. The interventions included to continue to check and change every-two hours and apply barrier cream with after each incontinence. Further review of Resident 7's clinical record failed to reveal documented evidence that the planned incontinence management to check and change every-two hours and apply barrier cream with after each incontinence was consistently performed by staff. Additionally, the resident's Kardex (a nursing information system used to obtain specific care information for each resident) failed to include the resident's incontinence management needs. An interview with the DON on November 7, 2024, at 11:15 AM, confirmed that the facility could not provide documented evidence that planned incontinence management to check and change every-two hours and apply barrier cream with after each incontinence was consistently performed by staff. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 28's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses to include hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following a cerebral infarction (stroke), and benign prostatic hyperplasia (prostate gland enlargement that can cause urination difficulty). A review of the quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 8, 2024, revealed that the resident was moderately cognitively impaired, required extensive assistance from staff for bed mobility, transfers and toileting, was always incontinent of urine, frequently incontinent of bowel, and was not on a toileting program. A review of Resident 28's Quarterly Bowel and Bladder assessment dated [DATE], revealed that the resident voided appropriately without incontinence less than daily, was incontinent of stool daily, was immobile or required two person assist to transfer to the toilet, was forgetful but followed commands, was sometimes aware of the need to toilet, and had no redness of skin on private areas. The comment section stated, check and change 2qh (every two hours). The evaluation concluded that the resident was a potential candidate for a scheduled toileting program. A review of the resident's Kardex (a nursing information system used to obtain specific care information for each resident) in effect at the time of the survey ending November 7, 2024, revealed the toileting plan was to monitor for bowel and bladder continence. There was no documented evidence on the Kardex that staff were instructed to provide the resident with a two-hour check and change program. A review of the resident's plan of care in effect at the time of the survey ending November 7, 2024, revealed that the resident was identified as having episodes of bladder and bowel incontinence with interventions to monitor for signs and symptoms of a UTI (urinary tract infection), monitor peri-area for redness, irritation and skin excoriation/breakdown, provide peri-care after each incontinence episode, apply house barrier after incontinence care and report if resident has no output. There was no documented evidence that a two-hour check and change program was developed and implemented on the care plan. A review of the facility Documentation Survey Report v2 (general care nursing tasks completed for the resident) for the task of Monitor B&B Continence for October 2024, revealed Resident 28 was incontinent of urine 83 times out of the 87 documented episodes of bladder function for the month of October 2024. There was no evidence that the facility had developed and implemented a plan to address the resident's toileting needs based on an evaluation of the resident's habits and voiding patterns and assure timely care was provided to meet the resident's toileting needs and manage the resident's urinary incontinence to prevent extended periods of time without toileting, checking for incontinence and changing the resident. A review of the clinical record revealed that Resident 46 was admitted to the facility on [DATE], with diagnoses to include dementia and a history of falls. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment completed at specific times to identify resident care needs) dated August 14, 2024, revealed that the resident's cognition was severely impaired, and he was independent with ambulation, with a BIMS score of 4 (BIMS stands for Brief Interview for Mental Status. The BIMS test is used to get a quick snapshot of how well you are functioning cognitively at the moment. A score of 1-7 indicated severe cognitive impairment) and was occasionally incontinent of bladder. A review of a care plan dated Resident has an ADL self-care performance deficit related to Alzheimer's dementia dated May 14, 2024, revealed, resident 46 had potential for episodes of incontinence related to cognitive impairment and generalized weakness. Interventions were to include, assist resident with toileting needs. His toileting plan was to, offer set-up help if needed. A review of a current care kardex (Kardex is a documentation system that enables nurses to write, organize, and easily reference key patient information that shapes their nursing care plan) initiated May 14, 2024 revealed the resident to be independent for toileting, offer set-up help if needed. No bladder assessments were available at the time of the survey. There was no evidence of a three-day bladder diary (a bladder diary is kept by nursing for the resident over the course of three to seven days, and allows the healthcare provider to evaluate the patient ' s bladder function) completed for this resident upon admission, readmission, and as needed to determine if he required a toileting plan or a every two-hour check and change program. Further, there was no assessment and determination of the type of incontinence noted for this resident. A review of monthly ADL records dated August through October 2024 were inconclusive as many of the days noted in each month were blank. The urinary activity was not documented. Resident 46 was noted to have had 19 falls from July 2024 through October 2024. It was noted that in 14 of the 19 falls, Resident 46 was noted to incontinent of bladder. A review of a care plan meeting note dated August 28, 2024 at 3:19 P.M., an increase in the residents urinary incontinence was noted. This was to be evaluated by the RN nurse practioner (CRNP). There was no documented evidence at the time of the survey that the CRNP evaluated Resident 46's increase in urinary incontinence. A Physicians order dated August 30, 2024 at 11:46 A.M. revealed, Complete a bladder tracker (three day) and enter it in the electronic medical record. Record bladder function every 2 hours for 72 hours for fall prevention. There was no evidence at the time of the survey that this task was completed. There was no evidence at the time of the survey that Resident 46 was assessed for increasing bladder incontinence and a plan was implemented to maintain or improve his bladder function. Interview with the Nursing Home Administrator on November 7, 2024, at approximately 1:00 PM confirmed that the facility was unable to provide evidence that the facility had consistently provided timely care for the resident's toileting needs, including incontinence management, the type and frequency of physical assistance necessary to assist the resident's incontinence needs. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services 28 Pa. Code 211.10(a)(d) Resident care policies

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Meadow View Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 225 Park Street Montrose, PA 18801	

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

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of clinical records and staff interview, it was determined that the facility failed to develop and implement an individualized person-centered plan to address a resident's dementia-related behavioral symptoms for one out of 15 residents reviewed (Resident 46) Findings include: A review of the clinical record revealed that Resident 46 was admitted to the facility on [DATE], with diagnoses to include dementia and a history of falls. A review of a quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment completed at specific times to identify resident care needs) dated May 27, 2024, revealed that the resident's cognition was severely impaired, and he was independent with ambulation. with a BIMS score of 4 (BIMS stands for Brief Interview for Mental Status. The BIMS test is used to get a quick snapshot of how well you are functioning cognitively at the moment. A score of 1-7 indicated severe cognitive impairment). A review of a care plan initiated on July 22, 2024, revealed behaviors related to wandering throughout facility with no sense of direction, expressions of delusions of needing an ambulance due to cancer, intentionally placing linens on floor to discard, exposing himself while urinating on the floor, exhibiting a failure to comply with safety measures (appropriate footwear) related to cognitive impairment, The resident's current care plan, in effect at the time of the survey of November 7, 2024, did not identify all of the resident's specific dementia related behaviors exhibited or individualized person-centered interventions to address each of these behaviors. Interventions were limited to include, administer medications per physician order. Monitor for effectiveness and side effects, apply non-skid socks after dinner, apply sock and sneakers upon resident arising in am, approach resident in a calm manner to avoid frustration and behavior escalation; If the resident becomes agitated and shows signs of escalation, re-approach later, attempt to redirect resident when exhibiting behaviors; re-approach when resident has deescalated, give non-judgmental support, if resistive to redirection: acknowledge resident's concerns, reassure that physician is updated as appropriate, Offer to contact support person (spouse), Offer preferred activities (discussing NY Nicks, snack of choice) Review of Resident 46's nursing progress notes during the months of May 2024 through the resident's discharge to another facility on November 6, 2024, revealed that the resident displayed increasing behaviors of verbal aggressiveness with staff, with seeking behavior and multiple falls in the facility. Resident 1 was the aggressor in all the verbal resident to staff incidents between May 14, 2024 and November 6, 2024. (continued on next page)

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	395092	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note dated May 15, 2024 at 08:50,A.M, revealed, Resident 46 came out of his room this AM around 0830 and walked straight to the main doors to exit. The social worker (SW)intervened when resident walked past her office door. Resident stated he wanted a soda. The SW redirected with soda options. The Resident went back out in the lobby heading towards the back door hallway within minutes after receiving the soda in his room. He told this writer he did not need anything and turned back to his room. A nursing note dated May 22, 2024 at 08:56 A.M., revealed, Resident 46 was hovering at nurses medication cart, expressing concerns that too many medications being given to other residents in the facility. He refused to take his medications. The Resident was exit seeking and pacing. A nurses note dated May 22, 2024 at 11:30 A.M. revealed, resident continued to pace and refuse medications, kept pacing around the facility. The therapy staff stated that Resident 46 was ambulating into the therapy department and hovering over the computer screens and making paranoid statements regarding residents in the room. He continued to pace the hallway towards the exit doors. A nurses note dated May 22, 2024, at 12:40 PM revealed, Resident 46 was pacing the hall again. When he approached the nurses station again he stated What is going on with the meds, I did not know there was a problem? He stated: Well look at that big box! pointing to the medication cart, Who needs that many meds?Nursing attempted to explain to the resident that the medication cart contained all the meds in the building for the residents. The resident stated I don't trust anyone! I am not taking those meds!Nursing staff reassured the resident that no one would force him to take medications. He then asked about the nail of the pointer finger on his left hand. He asked nursing staff, Do you have a tweezers, I want to pull this off! Nursing examined finger. The resident denied pain, but insisted that there is something in his finger. Nursing attempted to redirect the resident but he approached everyone in the hallway with the same issues. He was polite, and non-threatening. Yet, due to his size, and the tense stance, he appeared imposing. The staff was told to stay calm and not startle him. A nurses note dated June 12, 2024 at 08:56 A.M., revealed, resident became agitated and anxious this AM regarding his cancer and wanted to go to the hospital immediately. The resident did not have a cancer diagnosis and was fixated on same. The Physician was in and examined the resident and ordered Ativan (antianxiety medication) 1mg every 6 hours as needed for anxiety. A nurses note dated July 7, 2024 at 2:15 P.M. revealed, nurse aide reported that the resident was going through the food cart after lunch, and eating food discarded by other residents. The resident was pacing from his room to the lobby, fixated on his medications and other residents needs. A nursing note dated July 19, 2024 at 08:09 A.M., revealed, resident was noted sitting on the couch in the common area. At 0800 A.M. the resident stood up and walked down the hallway with his penis out and began urinating down the hallway. When attempting to redirect resident began squeezing his penis and yelling What?Resident replaced his penis back in his shorts and went to his room. A nurses note dated July 21, 2024 10:18 A.M., revealed, Resident 46 was extremely anxious and agitated and exit seeking. Nursing documentation dated July 21, 2024 at 1 P.M., revealed, Resident 46 attempted to follow a visitor out facility door, (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing documentation dated July 21, 2024 at 3:10 P.M., revealed, Resident 46 raced towards the exit door again when visitor was leaving. Nursing stood in front of door and redirected the resident to stay in the facility. The resident then followed the nurse around. Resident 46 put his arm around the nurse twice. Nursing attempted to redirect the resident but he would refused to remove his arm from the nurse. The Resident then stood next to this nurse and put his hand down his pants. The nurse asked resident if he needed to urinate. Resident did not answer and just stared at the nurse. Nursing attempted to redirect the resident. He refused to respond and started manipulating his penis in the hall. Nursing redirected the resident and the involved nurse removed herself from the situation. The resident continued to exhibit behaviors in August and September 2024. A review of nursing documentation and incident reports dated between July 19, 2024, and October 28, 2024, revealed that Resident 46 incurred nineteen falls in the facility during that time period, one in July, 2 in August, 6 in September and 10 in October 2024. The facility was monitoring the resident's behavioral symptoms via nursing documentation during the months of May 2024 through November 2024, however, there was no documented evidence of the behavioral management or behavior modification interventions developed for use by staff to respond to the resident's dementia related behavioral symptoms. The facility failed to fully develop and implement an individualized person-centered plan to address, modify and manage the residents' dementia-related behaviors. The resident's care plan for behavioral symptoms failed to include individualized interventions based on an assessment of the resident's preferences, social/past life history, customary routines, and interests in an effort to manage the resident's dementia-related behavioral symptoms. Interview with Director of Nursing and the Nursing Home Administrator on November 6, 2024, at approximately 2 p.m., confirmed that the facility was unable to provide evidence of the development and implementation of an individualized person-centered plan to address dementia-related behaviors and consistent and accurate monitoring of the resident's dementia related behaviors and any approaches used to manage or modify those behaviors. cross refer F689 28 Pa Code 211.12 (d)(3)(5) Nursing services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 43944 Based on review of clinical records and controlled drug records, and staff interview, it was determined the facility failed to implement pharmacy procedures to promote accurate accounting of controlled medications for one resident of 15 sampled (Resident 52). Finding include: A review of the clinical record revealed that Resident 52 had a physician order dated August 6, 2024, for Oxycodone HCl oral tablet 10 mg (an opioid pain medication used to treat moderate to severe pain), give one tablet by mouth every 8 hours as needed for moderate pain 5-7 (pain scale, 1-10, 1 equivalent to least pain and 10 most pain). A review of the controlled substance record accounting for the above narcotic medication revealed that on August 8, 2024, at 6:30 AM, and on August 10, 2024, at 1:43 AM, nursing staff signed out a dose of the resident's supply of Oxycodone 10 mg. However, the administration of the controlled medication to the resident was not recorded on the resident's Medication Administration Record (MAR) on those dates and times. During an interview on November 7, 2024, at approximately 12:45 PM, the Nursing Home Administrator confirmed the inconsistencies in the accounting and administration of the opioid pain medication for Resident 52 and indicated that the controlled substance record be documented clearly and accurately. 28 Pa Code 211.5 (f)(x) Medical records 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services 28 Pa Code 211.9(a)(1)(k) Pharmacy services