STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395203	A. Building B. Wing	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at Prospect	815 Chester Pike Prospect Park, PA 19076

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 36609 Based on review of resident records, facility policy, and interviews with resident and facility staff, it was determined that the facility failed to ensure the resident was informed of his medical condition for one of 30 resident record reviewed. (Resident R83). Finding includes: Review of the facility's Resident Rights policy revised in August 2022, states all residents will be treated with kindness, and respect, and be informed of his/or her medical condition. Review of Resident R83's Quarterly MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated February 4, 2024, revealed the resident was cognitively intact diagnosed with Heart failure, high blood pressure, schizophrenia (mental illness associated with loss of reality contact, delusions, and hallucinations) and history of an ileus (a painful obstruction of the ileum or other parts of the intestine with signs of nausea, vomiting, constipation and abdominal cramps). Review of Resident R83's physician progress notes revealed on February 26, 2024, the resident complained of nausea, vomiting and and abdominal discomfort. On March 1, 2024, the resident complained of constipation, nausea and abdominal pain and the physician ordered an abdominal xray to rule out an ileus. During an interview with Resident R83 on March 13, 2024, at 10:30 a.m. indicated no one told him the results of the abdominal exray, done almost two weeks ago. Review of the results dated March 1, 2024, revealed no documented evidence the resident was informed of the results. 28 Pa Code 201.18(b)(2) Management 28 Pa Code 211.12(d)(1) 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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 41471 Based on review of facility policy, resident council documents, resident council group interview, resident interview, and staff interview it was determined that the facility failed to respond to concerns from resident council and failed to respond to concerns in a timely manner for three out of nine months (November 2023, December 2023, January 2024, and February 2024). Findings include: Review of Resident council minutes dated November 2023, December 2023, January 2023 and February 2024 identified a request from council to address concerns about portions size during meals. The documentation did not indicate follow-up actions or communication from nursing home administration to address the portion size. A resident group meeting was conducted on March 13, 2024, at 11:30 a.m. Residents R68, R12, R16, 35, 66, 51, 143 and 34 were present during the meeting. During the resident council group interview on March 13, 2024, at 11:30 a.m. 8 of 8 residents voiced a concern with the facility administration not resolving their request for large portion during meals, residents stated they did not receive enough food during meals and they have asked for large portion size. During an interview on March 13, 2024, at 1:18 p.m. the Nursing Home Administrator, Employee E1 confirmed that the facility failed to respond to concerns from resident council and failed to respond to concerns/requests in a timely manner for four months. 28 Pa. Code 201.18(b)(1) Management

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident has the right to receive notices in a format and a language he or she understands. 41471 Based on observations and interviews with staff, it was determined that the facility failed to post how to file a complaint with the State Survey Agency as required for three of three nursing units. (First, Second and Third floor nursing) Findings include: Observation on March 13, 2024, at 1:18 p.m. of the main lobby area as well as the First and Second floor nursing units revealed that the complaint hotline number for the State Survey Agency was not posted. Interview on March 13, 2024, at 1:18 p.m. the Nursing Home Administrator confirmed that the complaint hotline number for the State Survey Agency was not posted. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(2) Management

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 41471 Based on a review of clinical records and facility provided documentation, and interview with staff, it was determined that the facility failed to provide the required advanced notice, through a Notice of Medicare Non-Coverage (CMS 10123), regarding the termination of Medicare services for three of three residents sampled (Residents R355, R356 and R357) Findings include: The form Notice of Medicare Non-Coverage (NOMNC) CMS-10123, is a notice that informs the recipient when care received from the skilled nursing facility is ending; and how to contact a Quality Improvement Organization to appeal. The Medicare provider must ensure that the notice is delivered at least two calendar days before covered services end. Review of Resident R355's Notice of Medicare Non-Coverage (NOMNC) cms-10123 revealed that the Medicare skilled A services will end on November 18, 2023. Review of Resident R356's Notice of Medicare Non-Coverage (NOMNC) cms-10123 revealed that the Medicare skilled A services will end on January 5, 2024. Review of Resident R357's Notice of Medicare Non-Coverage (NOMNC) cms-10123 revealed that the Medicare skilled A services will end on January 26, 2024. Interview with the Nursing Home Administrator on March 15, 2024, at 12:30 p.m. confirmed the facility did not ensure to that notice was delivered at least two calendar days before Resident R355, R356 and R357's covered services ended. 28 Pa Code 201.29(a) Resident rights

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 41471 Based on review of select facility policy and the minutes from Residents' Council meetings and staff interviews, it was determined that the facility failed to put forth sufficient efforts to promptly resolve resident complaints/grievances expressed by a resident for one of 30 residents reviewed. (Resident R66) Findings include: Review of the facility policy Resident Rights, dated August 2022, indicated that. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: u. voice grievances to the facility, or other agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal; v. have the facility respond to his or her grievances. A resident group meeting was conducted on March 13, 2024, at 11:30 a.m. Resident R68, R12, R16, 35, 66, 51, 143 and 34 were present during the meeting. During the resident council group interview on March 13, 2024, at 11:30 a.m. 8 of 8 residents voiced a concern with the facility administration not resolving their grievances in a timely manner and residents stated they did not hear back from the staff after grievances were filed. During the resident council group, Resident R66 stated he has raised some concerns to facility staff for few months and the issues were not resolved. Resident was interviewed after the meeting, he stated he voiced his concern to facility staff including nurses and supervisors for months and he did not hear any response from staff, or the issues were not resolved. Resident stated staff did not provide him medications as ordered by the physician and often times the medications were late. Resident stated he did not receive ensure as ordered by the physician. Continued interview with the resident stated he voiced the concern to the social worker on March 8, 2024, and she gave him a concern form to fill out. Interview with the social service director, Employee E7, on March 13, 2024, at 2:02 p.m. stated resident did want to raise concerns to the facility staff on March 8, 2024. Employee E7 stated she gave him a grievance form to fill out, however she did not have the concern form, or she did not know about the concerns. Employee E7 confirmed that she did not follow up with the resident about the grievance or his concerns and no immediate interventions were implemented to prevent any violations. 28 Pa. Code 201.18 (b)(1)(3)(2.1)(4) Management 28 Pa. Code 201.29 (a) Resident Rights

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609 Based on clinical record review, review of facility policies and staff interview determined that the PASRR (Preadmission Screening and Resident Review) was not appropriately completed according to the resident assessment for three of 30 residents reviewed related to PASRR assessments (Resident R83, R148 and R13) Findings include: The PASRR (Preadmission Screening Resident Review) was created in 1987 through language in the Omnibus Budget Reconciliation Act (OBRA) and it has three goals: to identify individuals with mental illness and/or intellectual disability, to ensure they are placed appropriately, whether in the community or in a nursing facility, and to ensure they receive the services they require for their mental illness or intellectual disability. The PASRR Level 1 must be completed on all persons who are considering admission to a Medicaid certified nursing facility. A Level II PASRR evaluation must be completed if the Level 1 PASRR determined that the person is a targeted person with mental illness or an intellectual disability. The Level II PASRR would determine if placement or continued stay in the requested or current nursing facility is appropriate. Review of the facility's Admission policy revised August 2022 states the facility admits only resident who's medical and nursing care needs can be met. The same policy states that all new admissions are screened for mental disorders (MD) intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. Review of Resident R83's Quarterly MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated February 4, 2024, revealed that the resident was admitted to the facility on [DATE], diagnosed with schizophrenia (mental illness associated with loss of reality contact, delusions, and hallucinations). Review of Resident R83's PASRR Level I assessment, dated January 26, 2023, failed to include schizophrenia as the resident's mental disorder and the resident was not listed as having a serious mental illness. Interview on March 12, 2024, at 12:54 p.m. Employee E7, Social Service Director, confirmed that Resident R83 PASRR assessment was not completed accurately and failed to include mental health diagnoses. Review of Resident R148's Admission MDS dated [DATE] revealed the resident was admitted to the facility on [DATE] diagnosed with a neurological traumatic brain injury with a subdural hemorrhage and loss of consciousness. Further review of Resident R148's clinical record revealed the resident's diagnosis of his neurological condition effected the resident's memory, attention, language, perception, and social cognition. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R148's PASRR dated February 1, 2024, was not accurately complete and failed to include the resident's neurocognitive disorder. Interview on March 12, 2024, at 12:54 p.m. Employee E7, Social Service Director, confirmed that Resident R148's PASRR assessment was not accurately completed . Review of Resident R13's clinical record revealed that the resident was admitted [DATE] with the diagnoses of psychotic disorder with delusions due to known physiological condition; post-traumatic stress disorder; other recurrent depressive disorders; alcohol dependence with alcohol-induced anxiety disorder; delusional disorders; personal history of suicidal behavior and peripheral vascular disease. Review of Resident R13 's clinical health record revealed a PASARR screen with another resident's name. Interview on March 14, 2024 at 1:30 p.m. with the Director of Nursing, Employee E2 confirmed that it was the incorrect form. The facility was not able to provide evidence that a PASRR was completed for Resident R13. 28 Pa. Code 201.8(b)(1) Management 28 Pa. Code 201.8(e)(1) Management

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 36609 Based on review of clinical records, interviews with facility staff and review of facility policy, it was determined the facility failed to develop a comprehensive care that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for one of 30 resident records reviewed (Resident R83). Findings include: Review of the facility's policy titled Care Plans, Comprehensive Person-Centered revised on March 16, 2024, states the comprehensive person-centered care plan is developed and implemented to include measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs. Review of Resident R83's Quarterly MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated February 4, 2024, revealed the resident was cognitively intact diagnosed with heart failure, high blood pressure, schizophrenia (mental illness associated with loss of reality contact, delusions, and hallucinations) and history of an ileus (a painful obstruction of the ileum or other parts of the intestine with signs of nausea, vomiting, constipation and abdominal cramps). Review of Resident R83's physician progress notes revealed on February 26, 2024, the resident complained of nausea and abdominal discomfort and had one episode of emesis (vomit). On March 1, 2024, the resident approached the physician and complained of constipation, nausea and abdominal pain and requested medication to help with his constipation. The same day the physician ordered a KUB (kidney ureter and bladder x-ray to assess the abdominal area) to rule out an ileus. Review of Resident R83's care plan revealed the facility failed to care plan the resident for his history of an ileus and constipation. Review of Resident R83's psychiatric note dated January 29, 2024, address the need to re-evaluate the resident's diagnosis of schizophrenia and psychotropic drug use since the staff reported episodes of patient eating cardboard and the resident having occasional auditory and visual hallucinations. Further review of Resident R83's care plan did not reveal a plan of care for the resident's diagnosis of schizophrenia. This was confirmed with the Director of Nursing on March 13, 2024, at 11:58 a.m. 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 36609 Based on observation, review of resident records, interviews with staff and review of facility policies, it was determined that the facility failed to provide treatment and care in accordance with professional standards of practice, for failing to monitor bowel movements and failure to follow physician orders related to a neck collar for two of 30 residents reviewed. (Resident R83 and Resident R146) Findings include: Review of the facility's Bowel Protocol, not dated, states the facility will assist the residents to assure regular bowel elimination to avoid complications associated with constipation or diarrhea. Each residents' bowel elimination is monitored and checked by the unit manager daily. The protocol further list medication and interventions for bowel elimination and to notify the physician for additional instructions if a bowel movement does not occur. The policy further states that the unit manager will be responsible for ensuring appropriate interventions are on the plan of care with input from all applicable disciplines. Review of Resident R83's quarterly MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated February 4, 2024, revealed the resident was cognitively intact and inlcuded the diagnoses of heart failure, high blood pressure, and history of an ileus (a painful obstruction of the ileum or other parts of the intestine with signs of nausea, vomiting, constipation and abdominal cramps). Review of Resident R83's physician progress notes revealed on February 26, 2024, the resident complained of nausea and abdominal discomfort that started the night before and had one episode of emesis (vomit). On February 29, 2024, physician note indicated the resident approached the physician and complained of constipation, nausea and abdominal pain. His last bowel movement was two days ago and requested medication to help with his constipation. Further review of Resident R83's clinical record revealed no documentation the resident's bowel habits were monitored. The Director of Nursing on March 13, 2024, at 11:58 a.m. confirmed nursing failed to monitor and document Resident R83 daily bowel habits. Review of Resident R146's care plan, dated January 28, 2024, revealed that the resident had an nursing intervention to wear an Aspen Collar at all times related to chronic progressive disease, mobility deficit and spinal fusion. Observation of Resident R146 on March 12, 2024, at 9:35 a.m., revealed resident resting in bed without the Aspen collar in place. Interview with the Employee E26, confirmed that resident did not have the aspen collar in place. It was also stated that the nurse thought that the Aspen Collar was 'on order'. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident's clinical record revealed an order for Aspen Collar at all times following a spinal fusion dated January 27, 2024. The order was scheduled to be documented every shift. Continued review of Resident R146's February 2024 Treatment Administration Record noted under the Aspen Collar a code 16 'See Note' for February 4, 5, 6, 7, 10, 13, 19, 20, 21, 22, and 23, 2024 during the 11 p.m. to 7 a.m. shift Interview on March 13, 2024, at 11:30 a.m., with the Director of Nursing, Employee E2 confirmed that the Aspen Collar was not on order. The Director of Nursing (DON) stated resident had been pulling at the collar and not wearing it. DON stated that it should have been discontinued by hospice. 28 Pa. Code 211.10 (c) Resident care policies 28 Pa. Code 211.12(d)(1)(3) 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609 Based on observation, interviews with facility staff and review of clinical records and facility policy and documentation determined that the facility failed to ensure a cognitively impaired resident (Resident R148) received adequate supervision to prevent reoccurring falls for one of 30 resident records reviewed. Findings include: Review of the facility's policy titled, Managing Falls and Fall Risk revised in August 2022, states that based on previous evaluations, and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. If falls reoccur, staff will implement additional or different interventions. Review of Resident R148's Quarterly MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated February 14, 2024, revealed that the resident was admitted to the facility on [DATE], diagnosed with neurological conditions, fracture, aphasia (non-verbal), hemiplegia (one sided paralysis) , traumatic brain injury incontinent of bowel and bladder and completely dependent on staff for all activities of daily living bed mobility and transfers. Review of Resident R148's clinical records and facility documentation revealed three falls requiring emergency room evaluations. On February 2, 2024, at approximately 8:00 a.m. the resident had an unwitnessed fall , observed on the floor, on the right side of the bed. On February 16, 2024, the resident was transferred to the emergency room when at approximately 12:45 p.m. a nursing assistant (NA) was preparing to feed the resident lunch in his Geri-chair (reclining wheelchair) and turned away. The resident reached for his meal and fell to the floor, hitting the left side of his face and head. On February 17, 2024, the resident was transferred to the emergency room when he was found on the floor in the dinning room having a seizure. Resident R148's returned the same day and his care plan for falls was updated with new interventions that included 1:1 staff supervision while in his Geri-chair. On February 19, 2024, the resident had an unplanned transfer to the hospital when the resident was observed in the hallway lying face down on the floor at 4:25 p.m. During an interview with the Director of Nursing (DON) on March 13, 2024 at 1:30 p.m. confirmed Resident R148 was not properly supervised on February 19, 2024, when he fell from his Geri-chair in the main hallway. The DON stated at the time of the fall he was to have 1:1 supervision and the unit clerk who was watching him was on the computer working at the nurse station. The resident has a habit of flipping and jerking his body. When the unit clerk looked up the resident was already on the floor. The DON also confirmed the facility's 1:1 supervision policy is to assign one staff per shift no other job assignments other than the responsibility to watch/supervise the resident. 28 Pa. Code 201.18(a)(b)(1)(3) Management 28 Pa. Code 211.12(d)(1) Nursing Services

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 41471 Based on review of personnel files and staff interviews, it was determined that the facility failed to ensure that nurse aides were able to demonstrate competency in skills and techniques necessary to care for residents for 5 of 5 nursing staff reviewed (Employee E13, E14. E15, E16 and E17) Findings Include: Review of facility documentation revealed that the facility provided care residents received intravenous therapy and tracheostomy care. A request for competencies and skill sets related to the management of residents with tracheostomy, intravenous therapy and medication administration was made to the facility administration on March 12, 2024, for nursing staff Employee E13, E14. E15, E16 and E17 Facility did not submit staff competencies and skill sets related to the management of residents with restraints. Interview with the Nursing Home Administrator, Employee E1, and Regional staff, Employee E2 on March 15, 2024, at 12:00 p.m. confirmed that there was no documentation available to show that licensed nursing staff had been evaluated for competencies. 28 Pa Code 201.20(b) Staff development. 28 Pa Code 201.20(d) Staff development.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 41471 Based on the review of clinical records and interviews with staff and resident, it was determined that the facility failed to ensure each resident received the necessary behavioral health services in a timely manner to attain or maintain the highest practicable mental and psychosocial well-being for one of 30 residents reviewed (Resident 66). Findings include: Review of psychiatric consult note for Resident R66 dated January 29, 2024, revealed that the resident was re-evaluated for depression and bipolar disorder. Resident had a history of suicidal attempt in the past, multiple psychiatric hospitalization s were noted. Resident noted with clinical signs of depression, mood swings, verbal aggression. A recommendation was made for psychology consult. Review of care plan for Resident R66 initiated on May 31, 2023, revealed evidence that the facility implemented a behavioral care plan for Resident R66 for suicidal ideation with intervention. Further review of the entire clinical record revealed no evidence that the resident was seen by the psychology as recommended by the psychology on January 29, 2024. Interview with Psychology practitioner, Employee E18 on March 13, 2024, at 2:10 p.m. stated she came to the facility at least weekly and saw residents as requested by the staff. Employee E18 stated she did not see Resident R66 and was not aware of the consult made on January 29, 2024. Interview with the social service director, Employee E7, on March 13, 2024, at 2:02 p.m. stated resident did want to raise concerns to the facility staff on March 8, 2024. Employee E7 stated she gave him a grievance form to fill out, however she did not have the concern form, or she did not know about the concerns. Employee E7 confirmed that she did not follow up with the resident about the grievance or his concerns and no immediate interventions were implemented to prevent any violations. Review of social service progress note dated March 8, 2024, revealed that the social worker met with the resident to address a statement from resident about a statement he made about harming himself. The resident stated that he made statement of harming himself because he was frustrated about some concerns. Further review of the progress note revealed that social service department is in the process of addressing all the residents' concerns and notifying the appropriate departments. However, the note did not address the actual concerns resident had to make statement about harming himself or plans or interventions to address the concern 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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	395203	A. Building B. Wing	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at Prospect	815 Chester Pike Prospect Park, PA 19076

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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. 41471 Based on the review of facility documentation, clinical records review and staff interviews, it was determined that the facility failed to provide necessary pharmaceutical services for six medication doses ordered for Resident R66 and13 medication doses ordered for Resident R68. (Resident R66 and Resident R68) Findings include: Interview with Resident R66 on March 13, 2024, at 12:30 p.m., stated facility often ran out of his medications. Facility staff did not order it on time and the pharmacy did not deliver enough supply of the medication. Resident R68 stated he was ordered ear drops 3 weeks ago and he did not receive the medication. Review of physician order for Resident R66 dated February 22, 2024, revealed that the resident was ordered for Debrox Otic (safely removes excessive earwax through the power of microfoam cleansing) solution, 5 drops to both ears two times a day for 21 days. Review of Medication Administration Record for Resident R66 for the month of February and March 2024 revealed that the resident did not receive the medication on twice on February 24, once on 25, 29, March 7, 9, at 9:00 p.m. The reason was documented as medication not available. Interview with R68 on March 11, 2024, at 12:06 p.m., stated staff did not order medication appropriately and the facility often ran out of the supplies, and he missed several doses of medications. Review of physician order for Resident R68 dated January 22, 2024, revealed that the resident was ordered for Zaditor ophthalmic solution every 8 hours to both eyes for allergic conjunctivitis. Review of Medication Administration Record for Resident R68 for the month of February and March 2024 revealed that the resident did not receive the medication on February 3, 9, 13, 16, 26, March 1, 8, twice on March 9, 11, 13 28 Pa. Code: 201.14(a)Responsibility of licensee. 28 Pa. Code: 211.9(a)(1)(f)(2)(4)(k) Pharmacy services.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 41471 Based on clinical record reviews and staff interview, it was determined that the facility failed to ensure resident's medication regime was free from potential unnecessary medications for one of five residents reviewed (Resident R138). Findings include: Clinical record review for Resident 138 revealed a current physician's order dated February 23, 2024, for Clonazepam 1 milligrams to give 1 tablet by mouth every 8 hours as needed for anxiety for 14 Days only. Further review of the physician orders revealed that the order was renewed on March 10, 2024 Review of psychiatric consult report dated March 1, 2024, revealed that the resident was on a short trial of Clonazepam. Further review of the consult did not reveal any documentation related to the duration expected for the Clonazepam trial. Review of physician progress note dated March 11, 2024, revealed an order to continue Clonazepam twice daily. However, the physician progress did not include a reason for continuing Clonazepam as needed after 14 days and the expected duration of as needed order. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 41471 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that laboratory studies were promptly obtained as ordered by the physician for one of one resident reviewed for laboratory services (Resident 66). Findings include: Review of laboratory report for Resident R66 dated October 27, 2023, revealed that a valproic acid (It can treat seizures and bipolar disorder) level was completed. The specimen was collected on October 27, 2023, and result was reported on the same day. The result showed the valproic acid level was below therapeutic range) Further review of the clinical record revealed no evidence that the result was notified to the physician until October 30, 2023. Review of Resident R2's physician progress note dated October 30, 2023, revealed that the resident's valproic acid level was below therapeutic range, and a recommendation was made to recheck valproic acid level in 1 week. Review of clinical record for Resident R66 revealed no evidence that a valproic acid level test was completed after 1 week as ordered by the physician on October 30, 2023. Review of laboratory report for Resident R66 dated March 8, 2024, revealed that a valproic acid level was completed. The specimen was collected on March 8, 2024, and result was reported on the same day. The result showed the valproic acid level was low (below therapeutic range) Further review of the clinical record revealed no evidence that the facility staff obtained the result from laboratory system and notified the physician of the abnormal lab in a timely manner. Interview with the Assistant Director of Nursing on March 15, 2024, at 11:15 a.m., confirmed that Resident R66's labs results were not notified to the physician in a timely manner. 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(3) Nursing services 28 Pa. Coded 211.12(d)(5) Nursing services

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471 Based on the review of facility documents and resident clinical record and staff interviews, it was determined that the facility failed to ensure a resident had the capacity to understand the terms of a binding arbitration agreement for one of three residents reviewed (Resident R99). Findings Include: Review of Resident R99's admission Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated October 5, 2023, revealed the resident was admitted to the facility on [DATE], and had a diagnosis of altered mental status and cocaine abuse. Further review of the MDS, Section C - Cognitive Patterns (items in this section are intended to determine the resident's attention, orientation, and ability to register and recall new information - these items are crucial factors in many care-planning decisions), indicated that Resident R49 scored a 9 on the Brief Interview for Mental Status (BIMS), which indicated the resident had moderate cognitive impairment. Review of physician progress note dated September 29, 2023, revealed that the resident was poor historian and forgetful. Resident was alert and oriented x 2 (person and time) which indicated that the resident was not completely oriented to person, time, place, and situation. Review of psych consult dated October 5, 2023, revealed that resident was seen after he was seen by urinating in Styrofoam cup and drinking his urine. Resident was agitated and confused. Review of Resident R99's Binding Arbitration Agreement (a binding agreement by the parties to submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship, whether contractual or not. The decision is final, can be enforced by a court, and can only be appealed on very narrow grounds) indicated the resident signed the document on September 28, 2023. Further review of the Binding Arbitration Agreement revealed it was also signed by facility employee, Admission Director, Employee 19. Interview on March 15, 2024, at 12:00 p.m. with Employee E19, confirmed that he was not aware of the resident's mental status, and he usually ask the staff about residents mental status and he was not sure if there was any response he received of residents mental status. 28 Pa. Code 211.10 (d) Resident care policies

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471 Based on the review of facility policy, observations and staff interviews it was determined that the facility failed to ensure a safe environment related to the oxygen storage for one of two nursing unit reviewed. (First floor) Finding Include: Observation of the facility first floor nursing unit n March 11, 204 at 11:00 a.m. revealed that there were around 12 oxygen cylinders stored on the hallway in an open area between resident room [ROOM NUMBER] and 101. There were no signs at the door indicating of the oxygen storage. Interview with Nursing Assistant, Employee E20 on March 13, 2024, at 1:00 p.m. stated staff stored oxygen in the hallway space between room [ROOM NUMBER] and 101. She was not aware of the facility protocol of storing the cylinder in the locked oxygen storage room. Interview with the Nursing Home Administrator on March 13, 2024, at 1:00 p.m. confirmed that the staff stored oxygen cylinders unsafely. Administrator stated he was aware of the problem but did not implement and educate the staff about safe oxygen handling. Administrator also stated staff was expected to store oxygen cylinder in the locked room with signage of oxygen storage outside the room. 28 Pa. Code. 207.2(a) Administrator's responsibility.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 41471 Based on a review of facility documentation and staff interview, it was determined that the facility failed to ensure its nurse aide staff was receiving in-service training to be proficient and competent and that the training be no less than 12 hours annually for five of five nurse aide staff training information reviewed (Employees E21. E22, E23, E24 and E25). Findings Include: A request for nurse aides annual in-service training record for nurses' aides Employee E21, E22, E23, E24 and E25 was requested on March 13, 14, and 15, 2024 to ensure compliance with compliance with requirement of no less than 12 hours annual in service. Facility did not provide training record for the requested staff until at the end of survey. An interview with the Nursing Home Administrator on March 15, 2024, at 12:00 p.m. confirmed that the facility did not have the in-service training record for their nurses' aides Employee E21, E22, E23, E24 and E25 and confirmed that the facility documentation did not contain evidence of that the training for E21, E22, E23, E24 and E25 met the twelve hours of annual training requirement. 28 Pa. Code 201.14(a) responsibility of licensee.