| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395205 | A. Building<br>B. Wing | 11/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Neffsville Nursing and Rehabilitation | 2829 Lititz Pike<br>Lancaster, PA 17601 |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35913<br><br>Based on observation, review of clinical records, and staff interviews, it was determined that the facility failed to ensure assessments accurately reflected the resident's status for three of the 35 residents reviewed (Residents 2, 67, and 123).<br><br>Findings include:<br><br>Review of Resident 2's Quarterly Minimum Data Set (MDS - A standardized assessment tool that measures health status in long-term care residents) dated September 10, 2024 revealed Resident 2 had an indwelling urinary catheter (a thin, flexible tube that drains urine from the bladder into a bag outside the body).<br><br>Review of Resident 2's clinical record failed to reveal evidence of an indwelling urinary catheter.<br><br>Interview with Licensed Employee E7 on November 15, 2024 at 11:00 confirmed Resident 2 did not have a urinary catheter and also confirmed Resident 2's Quarterly MDS dated [DATE] did not accurately reflect Resident 2's status and was completed incorrectly.<br><br>A review of Resident 67's Quarterly Minimum Data Set, dated dated dated [DATE], revealed resident was on Dialysis (A process of purifying the blood of a person whose kidneys are not working normally) while a resident (in the facility).<br><br>A review of Resident 67's clinical records failed to reveal documentation that resident was on Dialysis.<br><br>An interview with licensed nurse Employee E7 was conducted on November 14, 2024, at 1:48 p.m. Employee E7 confirmed Resident 67 was not on dialysis and that MDS was coded in error.<br><br>A review of Resident 123's Quarterly MDS dated [DATE], revealed that the resident had other restraints.<br><br>An observation conducted on November 12, 2024, at 12:30 p.m., revealed Resident 123 did not have any form of restraints.<br><br>(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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview with Employee E7 conducted on November 14, 2024, at 1:50 p.m., confirmed Resident 123 was not on any kind of restraints and that MDS was coded in error.<br><br>The above was conveyed to the Director of Nursing on November 15, 2024, at 10:00 a.m.<br><br>The facility failed to ensure residents' assessments were completed accurately.<br><br>28 Pa. Code 211.5(f) Clinical Records<br><br>28 Pa. Code 211.12(d)(1)(5) Nursing Services |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41765<br><br>Based on clinical record review and staff interview, it was determined that the facility failed to ensure a baseline care plan for pressure ulcers was developed timely for one of seven residents reviewed (Resident 85).<br><br>Findings include:<br><br>A review of Resident 85's clinical records revealed resident was admitted to the facility on [DATE], with a right heel Unstageable Pressure Ulcer (Obscured full-thickness skin and tissue loss) measuring 3.8 x 3.2 x 0. 2 cm.<br><br>Clinical records review revealed Resident 85's pressure ulcer baseline care plan was not developed until July 2, 2024, a week after a resident was admitted and assessed with the presence of an unstageable pressure ulcer to the right heel.<br><br>An interview conducted with the Director of Nursing (DON) on November 15, 2024, at 11:00 a.m., confirmed that Resident 85's baseline care plan for unstageable pressure ulcers was not developed until a week after it was identified.<br><br>The facility failed to ensure Resident 85's unstageable pressure ulcer baseline care plan was developed timely.<br><br>28 Pa. Code 211.5(f) Clinical records<br><br>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>35913<br><br>Based upon clinical record review, it was determined the facility failed to develop comprehensive care plans for a foley catheter and a wound vac for two of eighteen residents reviewed (Resident 78 and Resident 123) .<br><br>Findings include:<br><br>Review of Resident 78's diagnosis list revealed diagnoses including a history of prostate cancer and an enlarged prostate (gland in men encompasing the urethra when enlarged can restrict the flow of urine from the bladder out of the body).<br><br>Review of Resident 78's clinical record revealed Resident 78 had a urinary catheter (a thin, flexible tube that drains urine from the bladder into a bag outside the body).<br><br>Further review of Resident 78's clinical record failed to reveal evidence of a care plan for the urinary catheter.<br><br>Interview with the Nursing Home Administrator on November 15, 2024 at 10:00 a.m. confirmed that Resident 78 did not have a comprehensive care plan for the foley catheter.<br><br>A review of Resident 123's physician order dated October 3, 2024, revealed an order for a Wound vac (A device that uses negative pressure to help wounds heal) to the right AKA (above the knee amputation) stump.<br><br>An observation conducted on December 12, 2024, at 10:58 a.m., revealed the presence of a wound vac machine attached to Resident 123's right AKA stump.<br><br>Clinical records review failed to reveal that a comprehensive care plan was developed for the resident's wound vac treatment to the right AKA stump surgical wound.<br><br>An interview with the Director of Nursing (DON) conducted on November 15, 2024, at 11:00 a.m., confirmed that a comprehensive care plan for Resident 123's wound vac treatment was not developed until November 14, 2024, after the surveyor had asked for it.<br><br>The facility failed to ensure Resident 123's wound vac treatment for the right AKA stump surgical wound care plan was developed timely.<br><br>28 Pa. Code 211.5(f) Clinical Records<br><br>28 Pa. Code 211.12(d)(1)(5) Nursing Services<br><br>28 Pa. Code 211.11(c)(d) Resident care plans |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>41765<br><br>Based on a review of the facility's policy, observation, clinical records review, and staff interview, it was determined that the facility failed to timely notify the physician of a change in condition and follow a medication order for two of 35 residents reviewed (Residents 67 and 345).<br><br>Findings include:<br><br>A review of the facility's policy titled Weight Assessment and Intervention, dated March 2019, revealed any weight change of five pounds or more since the last weight assessment will be retaken for confirmation. Nurses will notify the Physician and dietitian.<br><br>A review of Resident 67's diagnosis list includes Cerebral Vascular Accident (CVA- An interruption in the flow of blood to cells in the brain) and Congestive Heart Failure (CHF-A weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs).<br><br>An observation conducted on November 12, 2024, at 1:50 p.m., revealed Resident 67 was lying in bed, the left arm was observed swollen from the hands to the upper arm.<br><br>An interview conducted with Resident 67 revealed left arm had been swollen but was unsure when it started. The resident denied pain.<br><br>A review of weights and vitals revealed a weight of 165.8 pounds on October 6, 2024, and 184.4 pounds on November 6, 2024, an 18.5 pounds (11.22%) significant weight gain in a month period.<br><br>A review of the dietitian's progress notes dated November 7, 2024, at 6:39 p.m., revealed + 5 changes over 30 days, reweight requested.<br><br>Clinical records review failed to reveal that Resident 67 was reweighed despite the dietitian's request for a reweight to confirm the significant weight change. Clinical records also failed to reveal that the physician was notified of the significant weight change.<br><br>A review of the Dietitian's progress notes dated November 13, 2024, at 7:15 p.m., revealed the weight was obtained, 184 pounds showing significant weight gain. Will notify nursing of the significant weight gain.<br><br>A review of the nursing progress notes dated November 14, 2024, at 11:45 a.m., revealed Nurse Practitioner (NP) was aware and gave new verbal orders: Lymphedema (A swelling most often in an arm or leg, caused by a lymphatic system blockage) clinic appointment; Ultrasound of the left arm due to increased edema; Chest x-ray 2 views.<br><br>An interview conducted with the Director of Nursing on November 15, 2024, at 10:20 a.m., revealed that the resident's significant weight change should have been rechecked within 48 hours for confirmation. The DON also reported that nursing should have notified the physician of the significant weight change identified on November 6, 2024.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Clinical records review revealed Resident 67's change in condition was not addressed until November 14, 2024, eight days after a significant weight change was identified on November 6, 2024.<br><br>A review of Resident 345's diagnosis list includes Osteomyelitis (Bone infection) of the left foot.<br><br>A review of Resident 345's physician order dated November 2, 2024, revealed an order for Meropenem Intravenous Solution (Antibiotic) 1 gram intravenously (Administer into the vein) every 12 hours for Bacteremia (Infections of blood caused by blood-borne pathogens) until November 29, 2024. Start date: November 2, 2024, 8:00 p.m.<br><br>A review of November 2024, Medication Administration Record (MAR) revealed Meropenem medication was not administered on the following dates: November 2, 2024, at 8:00 p.m., November 3, 2024, at 8:00 a.m., and November 3, 2024, at 8:00 p.m.<br><br>A review of the nursing progress notes dated November 2, 2024, at 9:02 p.m., revealed Meropenem medication was not available yet.<br><br>A review of the pharmacy documentation, and emergency medication list, revealed Meropenem medication was available in the facility.<br><br>An interview with the Director of Nursing (DON) conducted on November 15, 2024, confirmed that Meropenem medication was available in the facility but the agency nurse working at that time reported not seeing it since the medication was not premixed (In-stock medication comes in a vial that needed to be mixed with an IV solution).<br><br>Clinical records review revealed physician was not notified of the missed Meropenem medication until November 4, 2024.<br><br>On November 7, 2024, at 8:00 p.m., Meropenem medication was not administered. The nursing progress notes dated November 7, 2024, at 8:45 p.m., revealed that medication was unavailable, awaiting pharmacy delivery.<br><br>An interview with the DON conducted on November 15, 2024, confirmed Meropenem was available as an In-stock facility medication. The DON confirmed physician should have been notified of the missed medications timely.<br><br>The facility failed to ensure Resident 67's change in condition was timely addressed and Resident 345's medication order was followed.<br><br>28 Pa. Code 211.5(f) Clinical Records<br><br>28 Pa. Code 211.12(d)(1)(5) Nursing Services |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough food/fluids to maintain a resident's health.<br><br>35913<br><br>Based on facility policy, clinical record review, and staff interview, it was determined the facility failed to monitor weights and notify the physician of significant weight changes for six of 10 residents reviewed for nutrition (Residents 2, 6, 43, 161, 173, and 174).<br><br>Findings include:<br><br>Review of facility policy, Weight Assessment and Intervention, dated March 2019, indicated that any weight change of 5 pounds or more since the last weight assessment will be retaken for confirmation, if the weight is verified, nursing will notify the Physician and Dietitian. Further review of the policy indicated that The Dietitian and /or Certified Dietary Manager will review the individual weight records to follow individual weight trends over time, making recommendations as appropriate. Negative trends will be evaluated for whether or not the criteria for significant weight change has been met.<br><br>Review of Resident 2's Weight Summary revealed Resident 2 weighed 217 pounds on October 5, 2024.<br><br>Further review of Resident 2's Weight Summary revealed Resident 2 weighed 184 pounds on November 4, 2024.<br><br>Review of Resident 2's dietitian progress notes dated November 6, 2024, revealed the dietitian requested Resident 2 be re-weighed to verify weight changes.<br><br>Review of Resident 2's clinical record revealed Resident 2 was reweighed on November 8, 2024, four days after the original weight loss was noted.<br><br>Further review of Resident 2's clinical record failed to reveal evidence that interventions were put into place to correct Resident 2's weight loss.<br><br>Review of Resident 6's Weight Summary revealed on August 23, 2024, Resident 6 weighed 110.7 pounds.<br><br>Further review of Resident 6's Weight Summary revealed on August 30, 2024, Resident 6 weighed 94.4 pounds which represented a 14.72 percent weight loss in one week.<br><br>Review of Resident 6's dietitian progress notes on August 30, 2024, revealed a reweight was requested to confirm the 16-pound weight loss in 7 days.<br><br>Review of Resident 6's Weight Summary revealed a reweight was not completed until September 3, 2024.<br><br>Review of Resident 6's dietitian progress notes dated September 6, 2024, revealed Resident 6's weight loss was confirmed. Interventions were not put into placed until September 6, 2024, two weeks after Resident 6's original weight loss was noted.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview with the Director of Nursing (DON) on November 15, 2024, at 11:00 a.m. confirmed the above-mentioned weight losses and the lack of timely reweights and interventions.<br><br>Review of Resident 43's weight summary revealed a weight of 121.6 pounds on July 10, 2024. Resident's weight was 114.4 pounds on August 1. 2024 (loss of 7.2 pounds or 5.9%). Weight loss was confirmed on August 4, 2024, at 114.0 pounds. Review of the clinical record revealed that the weight loss was not addressed until August 25, 2024 (21 days after the confirmed weight loss).<br><br>Interview with the DON on November 15, 2024, at 11:45 a.m. confirmed that Resident 43's significant weight loss was not addressed in a timely manner.<br><br>A review of Resident 161's weights and vitals dated October 21, 2024, revealed a weight of 285 pounds and 252.5 pounds on November 11, 2024, a 32.5 (11.40 %) significant weight loss in three weeks.<br><br>The clinical records review failed to reveal that Resident 161 was re-weighed to confirm a significant weight change.<br><br>The clinical records review failed to reveal dietitian and physician were notified of Resident 161's significant weight change. Clinical records failed to reveal that significant weight loss was addressed.<br><br>Review of Resident 173's clinical record revealed an admission weight on September 5, 2024, of 206.4 pounds. Resident's weight was recorded as 227.5 pounds on October 4, 2024, a gain of 21.1 pounds or 10. 22%. Further review of the clinical record revealed that a re-weight was obtained on October 11, 2024, with a weight of 227.5 pounds. Resident's weight was recorded as 232.8 pounds on November 4, 2024. Further review of the clinical record revealed that there was no documentation of the Resident 173's physician being notified of the resident's weight gain.<br><br>Interview with the DON on November 15, 2024, at 10:30 a.m. revealed that Resident 173's physician should have been notified of the weight gain and the Dietitian should have made recommendations to prevent further weight gain.<br><br>A review of Resident 174's weights and vitals dated October 21, 2024, revealed a weight of 101.2 pounds and 94.2 pounds on October 31, 2024, a seven-pound (6.92%) significant weight loss in ten days.<br><br>Clinical records review failed to reveal Resident 174 was reweighed to confirm the significant weight loss identified on October 31, 2024.<br><br>A review of the Dietitian's notes dated November 3, 2024, revealed weight change, re weight requested.<br><br>Clinical records review failed to reveal resident was reweighed despite the Dietitian's request for a reweight. Clinical records also failed to reveal that the physician was notified of the significant weight loss.<br><br>28 Pa. Code 211.5(f) Clinical Records<br><br>28 Pa. Code 211.10(c) Resident Care Policies<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>41765<br><br>Based on observations, and staff interviews, it was determined that the facility failed to properly store frozen food in the main kitchen, and properly serve meals on one of five units observed (Rehab unit).<br><br>Findings include:<br><br>An observation of the walk-in freezer in the main kitchen was conducted on November 12, 2025, at 9:38 a.m. , in the presence of the Assistant Food Service Director Employee E3. The observation revealed the following: Three boxes of frozen cookie dough in plastic bags, all were opened and unsealed; Unsealed frozen potatoes in a plastic bag; Unsealed frozen hamburger patties in a plastic bag; Unsealed frozen carrots in a plastic bag; and two plastic bags of chopped frozen chicken meat, both were opened and unsealed.<br><br>An interview with Employee E3 conducted on November 12, 2024, confirmed that frozen food in a plastic bag should have been re-sealed after use.<br><br>An observation of the meal pass was conducted on November 12, 2024, at 12:56 p.m., in the front hall Rehab Unit. The meal tray observation revealed peaches placed on a small bowl were uncovered. Apple juice poured on small Styrofoam cups were also uncovered. The observation revealed food cart was stationed at the end of the hallway, the staff took each resident's meal tray from the cart and then delivered it to residents' rooms with uncovered dessert and juice drinks.<br><br>A meal observation was conducted on November 13, 2024, at 12:50 p.m., at the front hall Rehab Unit. The coleslaw and apple juice in the meal tray were uncovered. Observation revealed that while the food cart was stationed at the end of the hallway, staff took residents' meal trays from the cart and delivered them to their rooms with uncovered coleslaw and apple juice.<br><br>An interview with Nursing Assistant, Employee E6 conducted on November 13, 2024, confirmed that the food served to the residents should have been covered.<br><br>The above was discussed with the Nursing Home Administrator on November 15, 2024, at 11:00 a.m.<br><br>28 Pa. Code: 201.18(b)(3) Management<br><br>28 Pa. Code 211.6(d) Dietary services |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35913<br><br>Based on a review of the facility's policy, observations, clinical record reviews, and staff interviews, it was determined the facility failed to ensure Enhanced Barrier Precautions (EBP-infection control prevention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) were in place for residents requiring enhanced barrier precautions for ten of ten residents reviewed (Residents 2, 21, 24, 28, 66, 70, 78, 123, 161, 170).<br><br>Findings include:<br><br>A review of the facility's policy titled Enhanced Barrier Precautions (EBP), dated August 2022, revealed EBP's employees targeted gown and gloves use during high contact resident care activities when contact precautions do not otherwise apply. EBP's are indicated for residents with wounds and indwelling medical devices regardless of MDRO (Multi Resistance Drug Organisms) colonization. Communication related to EBP precautions will be via signage, Kardex, or assignment sheets. PPE (Personal Protective equipment) is available in the resident's room for use.<br><br>Review of Resident 2's clinical record revealed Resident 2 has a cholecystostomy tube (tube inserted into gallbladder to drain fluid) in place.<br><br>Observation of Resident 2's room failed to reveal evidence of Personal Protective Equipment (PPE) or any evidence that Enhanced Barrier Precautions were in place for staff during direct care and emptying of the cholecystostomy drainage.<br><br>Review of Resident 21's quarterly MDS (Minimum Data Set - periodic assessment of resident needs) dated August 29, 2024, revealed that the resident had an in-dwelling catheter (a flexible tube inserted into the bladder for removing fluid).<br><br>Observations on all days of the survey of Resident 21's room failed to reveal evidence of EBP signage/communication or PPE.<br><br>Review of Resident 24's clinical record revealed Resident 24 with a diagnosis of Retention of Urine (accumulation of urine within the bladder because of the inability to urinate). Review of MDS-significant change in status assessment dated [DATE], revealed that the resident had an in-dwelling catheter.<br><br>Observation of Resident 24 and 28's room revealed indwelling catheters draining to gravity and failed to reveal evidence of PPE or EBP signage/communication for staff providing direct care.<br><br>A review of Resident 66's clinical records revealed a surgical wound to the left foot.<br><br>An observation on November 13, 2024, at 12:26 p.m., revealed that licensed Employee E4 was performing wound care on Resident 66's left foot. Further observation revealed Employee E4 was only wearing gloves on both hands without wearing a gown while performing a wound care. The room does not have an EBP sign/communication and no PPE is available in the room.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395205 | A. Building<br>B. Wing | 11/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Neffsville Nursing and Rehabilitation | 2829 Lititz Pike<br>Lancaster, PA 17601 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | An interview with Employee E4 was conducted on November 13, 2024, at 12:30 p.m. Employee E4 reported that she/he was not told what PPE to use (during wound care) and that there was no PPE available so she/he just used the gloves.<br><br>Review of Resident 78's clinical record revealed Resident 78 had a foley catheter in place for urinary drainage.<br><br>Observation of Resident 78's room failed to reveal evidence of PPE or any evidence that EBP were in place for staff during direct care of the foley catheter and emptying of the foley catheter drainage bag.<br><br>Review of Resident 70's clinical record revealed Resident 70 has a pressure wound in the right gluteal area.<br><br>Observation of Resident 70's room during interview failed to reveal evidence of PPE or any evidence that EBP were in place for staff during wound dressing changes.<br><br>A review of Resident 123's clinical records revealed resident had a right above-knee amputation with the presence of a surgical wound.<br><br>An observation conducted on November 12, 2024, at 11:00 a.m., revealed Resident 123 had a wound vacuum machine (A device that uses negative pressure to help wounds heal) on the right thigh stump. Further observation failed to reveal the presence of EBP signs/communication and PPEs in the room.<br><br>A review of Resident 161's clinical records revealed resident had a PICC line (Peripherally Inserted Central Catheter- a thin, flexible tube inserted into a vein in the vein near the arm and threaded into a large near the heart) and a surgical wound to the left foot.<br><br>An observation conducted on November 13, 2024, at noon, revealed a PICC line on Resident 161's left upper arm and a wound dressing to the left foot. Further observation failed to reveal the presence of EBP sign/communication and PPEs in Resident 161's room.<br><br>Review of Resident 170's clinical record revealed Resident 170 had a Percutaneous Endoscopic Gastrostomy tube (feeding tube that is inserted through the abdomen wall and into the stomach). Resident 170 required EBP due to tube feedings.<br><br>Observation of Resident 170 revealed a PEG tube and foley catheter. Resident 170's room failed to reveal evidence of PPE or EBP were in place for staff providing direct care to PEG tube or foley catheter.<br><br>An interview with the Infection Preventionist, licensed Employee E5 conducted on November 13, 2024, at 12:35 p.m., revealed that for residents requiring an EBP, signage/communication are placed by the door and assignment sheets and PPEs are placed by the door. Employee E5 reported that none of the residents on the Rehab unit required EBP's.<br><br>The above was discussed with the Director of Nursing on November 15, 2024, at 10:00 a.m.<br><br>28 Pa. Code 201.18(b)(1) Management<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 28 Pa. Code 211.5(f) Clinical records<br><br>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services |