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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395208	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belair Healthcare and Rehabilitation Center	100 Little Drive Lower Burrell, PA 15068

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on a review of facility provided documentation and staff interview, it was determined the facility failed to issue an accurate Skilled Nursing Facility Advanced Beneficiary Notice form (SNF ABN CMS-10055) for one of three residents (Resident R163). Findings include: Review of the Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN CMS-10055) form provides information to residents/resident representatives that skilled nursing services may not be paid by Medicare and so that the resident/resident representative can decide if they wish to continue receiving skilled nursing services and assume financial responsibility. Review of Resident R163's clinical record documented the resident was admitted to the facility on [DATE], and readmitted [DATE], and remained in the facility until 3/14/24. Review of the facility provided Beneficiary Notice list, which includes residents who were discharged from Medicare Part A with benefit days remaining, and remained in the facility indicated Resident R163's last covered day was 2/29/24. Review of Resident R163's record revealed a SNF ABN CMS-10055 form signed on 2/27/24, failed to include the accurate cost for Skilled Nursing Services. It was indicated it was $361.00 per day not including ancillary charges. Review of Resident R163's statement dated 3/1/24, indicated the total amount due for the month of March was $11,815.00. It was indicated room and board charged were $379.00 per day. During an interview with Social Worker, Employee E2 confirmed the costs listed on the SNF ABN CMS-10055 were incorrect. During an interview on 5/15/24, at 10:22 a.m. the Nursing Home Administrator confirmed the facility failed to issue an accurate Skilled Nursing Facility Advanced Beneficiary Notice form (SNF ABN CMS-10055) for one of three residents (Resident R163). 28 Pa. Code 201.18(e)(1) Management.

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of facility policies, facility documents, clinical records, and resident and staff interviews, it was determined that the facility failed to make certain residents were free from neglect for one of eight residents (Resident R49). Findings include: Review of facility policy Identifying Types of Abuse dated 3/4/24, indicated neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary. It was indicated neglect occurs when the facility is aware of, or should have been aware of goods and services that a resident requires, but the facility fails to provide them. Review of the facility policy Resident Rights dated 3/4/24, stated residents will be free from neglect. Review of admission record indicated Resident R49 was admitted to the facility on [DATE]. Resident R49's care plan initiated 10/2/22, indicated the resident is at risk for alteration in skin integrity. Interventions indicated to observe for changes in skin condition and report abnormalities and administer treatment per physician orders. Review of Resident R49's Minimum Data Set (MDS- periodic assessment of care needs), dated 4/29/24, indicated the diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), high blood pressure, and anxiety. Review of Resident R49's physician order dated 5/12/24, indicated to cleanse right hand with normal saline (wound cleanser), pat dry, apply TAO (Triple Antibiotic Ointment) and cover with bordered gauze every shift for skin tear. Review of Resident R49's May 2024 Treatment Administration Record (TAR) indicated the dressing was changed on 5/12/24, for day and night shift. During an observation and interview on 5/13/24, at 12:06 p.m. Licensed Practical Nurse (LPN), Employee E6 confirmed Resident R49's right hand dressing was dated 5/11/24. During an interview on 5/13/24 12:12 p.m. the Director of Nursing confirmed the facility failed to protect Resident R49 from neglect. During an interview on 5/15/24, at 11:05 a.m. LPN, Employee E6 stated a treatment is not signed off in the TAR until it is completed. 28 Pa Code 211.12(c)(d)(1)(2)(5) Nursing services 28 Pa. Code: 211.10 (c)(d) Resident Care Policies (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code 201.14(a) Responsibility of licensee. 28 Pa Code 201.18(a)(b)(1)(e)(1) Management. 28 Pa Code 201.29(a)(j) Resident rights.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on a review of facility policies, resident record review, observation, and staff interviews it was determined the facility failed to prevent the misappropriation of resident medications for one of three residents (Resident R112). Findings include: Review of the facility policy Resident Rights dated 3/4/24, stated residents will be free from abuse, neglect, misappropriation of property, and exploitation. Review of facility policy titled Controlled Substances last reviewed 3/4/24, informed the facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Scheduled II-IV of the Comprehensive Drug Abuse Prevention Program and Control Act of 1976.) Controlled substances are counted upon delivery. If the count is correct, an individual resident controlled substance record is made for each resident who will be receiving a controlled substance. This record contains the name of the resident, quantity received, number on hand, time of administration, and signature of nurse administering the medication. Controlled substance inventory is monitored and reconciled to identify potential loss or diversion. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: records of personal access and usage and medication usage records. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. Review of Resident R112's record indicated the resident was admitted to the facility on [DATE]. Diagnoses included depression, anxiety, anorexia (a serious and potentially life-threatening - but treatable - eating disorder. It's characterized by extreme food restriction and an intense fear of gaining weight.), hypertension (high blood pressure), and Alzheimer's Disease (a brain disorder that gets worse over time. It's characterized by changes in the brain that lead to deposits of certain proteins.) Review of Resident R112's Minimum Data Set (MDS - a periodic assessment of needs) dated 12/5/23, indicated the diagnoses remained current. Review of Resident R112's physician orders dated 11/29/23, included Morphine Sulfate (Concentrate) Oral Solution (opioid used to treat pain) 20MG/ML give 0.50 ml by mouth every hour as needed for shortness of breath), and Morphine Sulfate (Concentrate) Oral Solution 20MG/ML give (0. 50ml by mouth every hour as needed for moderate pain. Review of Resident R112's physician orders dated 11/29/23, included Acetaminophen Suppository (medication administered rectally) 650 mg, insert one suppository rectally every four hours as needed for pain, and Acetaminophen Suppository 650 mg, insert one suppository rectally every four hours as needed for temperature greater than 100.4. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R112's physician orders dated 11/29/23, included Atropine Sulfate Ophthalmic Solution 1% (used to help reduce saliva, mucus, or other secretions in your airway), give two drops by mouth every four hours as needed for secretions. Review of Resident R112's physician orders dated 11/29/23, included Lasix (used to reduce extra fluid in the body (edema) caused by conditions such as heart failure, liver disease, and kidney disease) 40 mg, give one tablet every 24 hours for congestion. Review of Resident R112's physician orders dated 11/29/23, included Lorazepam Concentrate 2mg/ml, give 0.5 ml by mouth every four hours as needed for terminal agitation, and Lorazepam Concentrate 2mg/ml, give 0.5 ml by mouth every four hours as needed for anxiety. Review of Resident R11's physician orders dated 11/29/24, included Zofran (anti-nausea medication) 4mg, one tablet by mouth every six hours as needed for nausea. Review of Resident R112's investigation revealed the resident's was delivered a comfort kit on 11/29/23, that contained the resident's Acetaminophen suppository, atropine, Lasix, Zofran, morphine, and Ativan. Registered Nurse (RN), Employee E16 signed the medication in and RN, Employee E17 placed it in the fridge in the East Wing Medication Room at 7:22 p.m. Review of RN, Employee E18's witness statement dated 12/7/23, indicated RN, Employee E18 stated I always check hospice residents medication. When RN, Employee E18 checked for the medications, there was an empty bag without any medications in it. RN, Employee E18 looked in the cart and the medications weren't in there. Review of Resident R112's Investigation failed to include the Controlled Drug Receipt/Record/Disposition form for the resident's comfort kit. During an interview on 5/17/24, at 11:38 a.m. RN, Employee E16 indicated the Hospice Kits must be signed in by two nurses and upon change of shift both nurses should complete a controlled substance count, and signed off by both nurses. RN, Employee E16 confirmed Resident R112's Hospice Kit medications went missing on the evening shift on 12/7/23. It was indicated RN, Employee E18 was the alleged perpetrator and was not allowed back into the facility. During an interview on 5/17/24, at 11:46 a.m. Assistant Director of Nursing, Employee E11 confirmed the facility failed to prevent the misappropriation of resident medications. 28 Pa. Code 201.18(b)(1)(2) Management. 28 Pa. Code 201.29(a)(c)(d)(j)(m) Resident Rights.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 46167 Based on review of facility policy, newly hired personnel records and staff interviews it was determined that the facility failed to conduct a current FBI (Federal Bureau of Investigation) background check on an employee prior to her date of hire for one out of five personnel records (Licensed Practical Nurse Employee E3). Findings include: The facility Abuse Prevention Program policy dated 3/4/24, indicated that the resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The facility Background Check Procedures policy dated 3/4/24, indicated that facility conducts employment background screening checks on all applicants, to include current employees as needed, in compliance with Federal and State requirements and regulations. All offers of employment are contingent upon clear results of a thorough criminal background check. All background checks must be completed; results received; reviewed and determination made before beginning employment. Review of Licensed Practical Nurse Employee E3's personnel record indicated she was hired on 5/3/24. Review of Licensed Practical Nurse Employee E3's personnel record revealed resident has not lived in Pennsylvania for 2 consecutive years and indicated a home address that was out of the state. Review of Licensed Practical Nurse Employee E3's personnel record did not reveal that a current FBI background check was completed prior to her start date of employment. During an interview on 5/15/24, at 8:50 a.m. Human Resource Employee E4 stated, It was an oversight on my part. During an interview on 5/15/24, at 1:06 p.m. the Director of Nursing confirmed that the facility failed to conduct a current FBI background check on an employee prior to her date of hire for one out of five personnel records (Licensed Practical Nurse Employee E3) as required. 28 Pa Code: 201.14(a) (c)(d)(e) Responsibility of licensee 28 Pa Code: 201.19 Personnel policies and procedures 28 Pa Code: 201.20 (a)(b)(c)(d) Staff development 28 Pa Code: 201.29 (d) Resident Rights 28 Pa Code 201.18(b)(1)(2)(e)(1) Management

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on clinical record review and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for three out of five residents sampled with facility-initiated transfers (Residents R16, R24, and, R212). The findings include: Review of Resident R16's clinical record indicated the resident was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses of COPD, (chronic obstructive pulmonary disease- a group of progressive lung disorders characterized by increasing breathlessness), high blood pressure, and heart failure (a progressive heart disease that affects pumping action of the heart muscles. This causes fatigue, shortness of breath.) Review of Resident R16's clinical record revealed that the resident was transferred to the hospital on 10/11/23, and returned to the facility on [DATE]. Review of Resident R16's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of Resident R24's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R24's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 4/1/24, indicated diagnoses heart failure (a progressive heart disease that affects pumping action of the heart muscles), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) and, multiple sclerosis (a disease that affects central nervous system). Review of Resident R24's clinical record revealed that the resident was transferred to the hospital on 3/22/24 and returned to the facility on [DATE]. Review of Resident R24's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R212 was admitted to the facility on [DATE]. Review of Resident R212's MDS dated [DATE], indicated diagnoses of high blood pressure, seizure disorder, and pneumonia (lung inflammation caused by bacteria or viral infection). (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R212's clinical record indicated the resident was transferred to the hospital on 4/22/24, and returned to the facility on [DATE]. Review of Resident R212's clinical record failed to reveal a physician order to transfer the resident to the hospital on 4/22/24. During an interview on 5/17/24, at 10:22 a.m. the Director of Nursing (DON) confirmed that the facility failed to obtain and document a physician order to send Resident R212 to the hospital on 4/22/24. Review of Resident R212's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. During an interview on 5/15/24, at 11:13 a.m. the DON stated, We send the information with them but we do not have it documented. During an interview on 5/15/24, at 11:15 a.m. the DON confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for three out of five residents sampled with facility-initiated transfers (Residents R16, R24, and, 212). 28 Pa. Code 201.29 (a)(c.3)(2) Resident rights.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of resident clinical records, and staff interviews, it was determined that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for three of four residents (Resident R16, R24, and R212). Findings Include: A review of the facility policy Transfer and Discharge-30 day reviewed 3/4/24, indicated that the a copy of the transfer and discharge notice will be sent to the Office of the State Long-Term Care Ombudsman. Review of Resident R16's clinical record indicated the resident was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses of COPD, (chronic obstructive pulmonary disease- a group of progressive lung disorders characterized by increasing breathlessness), high blood pressure, and heart failure (a progressive heart disease that affects pumping action of the heart muscles. This causes fatigue, shortness of breath.) Review of Resident R16's clinical record revealed that the resident was transferred to the hospital on 10/11/23, and returned to the facility on [DATE]. Review of Resident R16's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE]. Review of Resident R24's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R24's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 4/1/24, indicated diagnoses heart failure (a progressive heart disease that affects pumping action of the heart muscles), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) and, multiple sclerosis (a disease that affects central nervous system). Review of Resident R24's clinical record revealed that the resident was transferred to the hospital on 3/22/24, and returned to the facility on [DATE]. Review of Resident R24's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE]. Review of the clinical record indicated Resident R212 was admitted to the facility on [DATE]. Review of Resident R212's MDS dated [DATE], indicated diagnoses of high blood pressure, seizure disorder, and pneumonia (lung inflammation caused by bacteria or viral infection). (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R212's clinical record indicated the resident was transferred to the hospital on 4/22/24, and returned to the facility on [DATE]. Review of Resident R212's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE]. During an interview on 5/15/24, at 11:50 a.m. the Director of Nursing (DON) stated, We do not send anything to the Ombudsman's Office. During an interview on 5/15/24, at 11:54 a.m. the DON confirmed that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for three of four residents (Resident R16, R24, and R212). 28 Pa. Code 201.29 (a) (c.3) (2) Resident rights.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for three of four resident hospital transfers (Residents R16, R24, and R212). Findings Include: Review of the facility policy Leave Day-Bed Hold Policy dated 3/4/24, indicated that the facility establish procedures that ensure residents and/or responsible parties are properly informed of bed hold options, potential financial obligations, and processes to be followed in order to guarantee a bed upon the resident's return to the facility should a resident need to be absent from the facility for a period of time for hospitalization or other medical or therapeutic leave. Notification of bed hold options is required each time a resident will be absent from the facility for hospitalization s. Review of Resident R16's clinical record indicated the resident was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses of COPD, (chronic obstructive pulmonary disease- a group of progressive lung disorders characterized by increasing breathlessness), high blood pressure, and heart failure (a progressive heart disease that affects pumping action of the heart muscles. This causes fatigue, shortness of breath.) Review of Resident R16's clinical record revealed that the resident was transferred to the hospital on 10/11/23, and returned to the facility on [DATE]. Review of Resident R16's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 10/11/23. Review of Resident R24's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R24's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 4/1/24, indicated diagnoses heart failure (a progressive heart disease that affects pumping action of the heart muscles), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) and, multiple sclerosis (a disease that affects central nervous system). Review of Resident R24's clinical record revealed that the resident was transferred to the hospital on 3/22/24 and returned to the facility on [DATE]. Review of Resident R24's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 3/22/24. Review of the clinical record indicated Resident R212 was admitted to the facility on [DATE]. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R212's MDS dated [DATE], indicated diagnoses of high blood pressure, seizure disorder, and pneumonia (lung inflammation caused by bacteria or viral infection). Review of Resident R212's clinical record indicated the resident was transferred to the hospital on 4/22/24, and returned to the facility on [DATE]. Review of Resident R212's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 4/22/24. During an interview on 5/15/24, at 11:54 a.m. the Director of Nursing confirmed that the facility failed to notify the resident or resident's representative of the facility bed-hold policy for three of four resident hospital transfers (Residents R16, R24, and R212). 28 Pa. Code: 201.29(b)(d)(j) Resident rights.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on a review of Resident Assessment Instrument (RAI) User's Manual, clinical records, and staff interviews, it was determined that the facility failed to ensure that MDS assessments accurately reflected the resident's status for one of six residents (Resident R25). Findings include: The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, indicated the following instructions: -Observation (Look-Back, Assessment) Period is the time period over which the resident's condition or status is captured by the MDS assessment. Most MDS items themselves require an observation period, such as 7 or 14 days, depending on the item. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the observation period must also cover this time period. A standard 7-day look-back period counts back from and includes the Assessment Reference Date (ARD+6 previous days). Review of the admission record indicated Resident R25 was admitted to the facility on [DATE]. Review of Resident R25's progress note dated 4/24/24, indicated the resident was very combative with care. It was indicated the resident tries to physically swing at the nurse aides during care. Review of Resident R25's progress note dated 4/25/24, indicated the resident is still a little combative with aides when doing care. Review of Resident R25's MDS dated [DATE], included diagnoses of high blood pressure, altered mental status, and urinary tract infection. Review of Section E-Behavior, Question E0200 indicated that Resident R25 did not exhibit physical behavioral symptoms directed toward others. During an interview on 5/17/24, at 9:58 a.m. the Director of Nursing confirmed the facility failed to ensure that MDS assessments accurately reflected the resident's status for one of six residents (Resident R25). 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing Services.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to ensure that a resident and a resident's representative was provided a summary of their completed baseline care plan for two of six residents (Resident R21 and R33). Findings include: Review of the facility policy Careplans-Baseline, last reviewed 4/3/24, indicated that a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight hours of admission. The resident and their representative will be provided a summary of the baseline care plan. Review of Resident R21's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R21's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 4/18/24, indicated diagnoses of depression, dysphasia (difficulty swallowing), and schizoaffective disorder (a mental disorder in which a person experiences a combination of schizophrenia and mood disorder symptoms). Review of Resident R21's clinical record failed to produce documentation that a resident and resident representative was provided with a summary of the baseline care plan. Review of Resident R33's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R33's MDS dated [DATE], indicated diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles, hypertension, and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of Resident R 33's clinical record failed to produce documentation that a resident and resident representative was provided with a summary of the baseline care plan. During an interview on 5/16/24, at 1:48 p.m. the Nursing Home Administrator confirmed that the facility failed to ensure that a resident and a resident representitive was provided a summary of their completed baseline care plan for two of six residents (Resident R21 and R33). 28 Pa. Code: 211.11 (a)(c)(d) Resident care plan 28 Pa. Code: 211.12(d)(1)(5) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to develop and implement comprehensive care plans to meet care needs for three of ten residents (Residents R21, R25, R34). Findings include: Review of facility policy Care Planning - Interdisciplinary Team dated 3/4/24, indicated the facility's care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident. The care plan is based on the resident's comprehensive assessment. Review of Title 42 Code of Federal Regulations (CFR) S483.21 - Comprehensive Care Plans, the facility must develop and implement a comprehensive care plan for each resident that includes measurable objectives, and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment, and must be culturally competent and trauma informed. Review of the clinical record indicated Resident R21 was admitted to the facility on [DATE]. Review of Resident R21's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 4/18/24, indicated diagnoses of depression, dysphasia (difficulty swallowing), and thyroid disorder (a dysfunction of the thyroid gland of the base of the neck). Review of Resident R21's care plan dated 4/15/24, indicated to evaluate the effectiveness and side effects of medication for possible decrease or elimination of psychotropic (a medication that affects behavior, mood, thoughts or perception) drugs. Review of Resident R21's clinical record indicate the facility failed to monitor medication side effects and resident behaviors. Review of the admission record indicated Resident R25 was admitted to the facility on [DATE]. Review of Resident R25's progress note dated 4/24/24, indicated the resident was very combative with care. It was indicated the resident tries to physically swing at the nurse aides during care. Review of Resident R25's progress note dated 4/25/24, indicated the resident is still a little combative with aides when doing care. Review of Resident R25's care plan revised 5/2/24, failed to include interventions to address Resident R25's behaviors. Review of the clinical record indicated Resident R34 was admitted to the facility on [DATE]. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R34's MDS dated [DATE], indicated diagnoses of high blood pressure, anxiety (a feeling of worry, nervousness, or unease), and Post Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and may have triggers that can bring back memories of trauma accompanied by intense emotional and physical reactions). Review of Resident R34's care plan dated 10/11/23, indicated the resident was a survivor of abuse and that the facility should assist with appropriate coping methods as needed and encourage discussing individual triggers, but failed to identify what the triggers were and how to avoid them. During an interview on 5/17/24, at 10:57 a.m. Social Worker Employee E2 confirmed that the facility failed to implement Resident R34's care plan for PTSD by failing to assist Resident R34 with identifying triggers for PTSD and appropriate coping methods. During an interview on 5/17/24, at 2:30 p.m. the Director of Nursing confirmed that the facility failed to develop and implement comprehensive care plans to meet care needs for four of ten residents (Residents R21, R25, R34, and R49). 28 Pa. Code: 211.10(c) Resident care policies 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 211.11(a) Resident care plan.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of clinical records, observation, and staff interviews, it was determined that the facility failed to follow physician orders for one of eight residents (Resident R49). Findings include: Review of admission record indicated Resident R49 was admitted to the facility on [DATE]. Resident R49's care plan initiated 10/2/22, indicated the resident is at risk for alteration in skin integrity. Interventions indicated to observe for changes in skin condition and report abnormalities and administer treatment per physician orders. Review of Resident R49's Minimum Data Set (MDS- periodic assessment of care needs), dated 4/29/24, indicated the diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), high blood pressure, and anxiety. Review of Resident R49's physician order dated 5/12/24, indicated to cleanse right hand with normal saline (wound cleanser), pat dry, apply TAO (Triple Antibiotic Ointment) and cover with bordered gauze every shift for skin tear. During an observation and interview on 5/13/24, at 12:06 p.m. Licensed Practical Nurse, Employee E5 confirmed Resident R49's right hand dressing was dated 5/11/24. The dressing was not completed as ordered on 5/12/24, or 5/13/24, day shift. During an interview on 5/13/24 12:12 p.m. the Director of Nursing confirmed the facility failed to follow physician orders for one of eight residents (Resident R49). 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa Code 211.12(d)(1)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46337 Based on review of clinical records and staff interviews, it was determined that the facility failed to change an indwelling catheter (insertion of a tube into the bladder to drain urine) as ordered for one of three residents (Resident R14), and failed to obtain a valid medical diagnosis for an indwelling urinary catheter and develop and implement a comprehensive plan of care related to urinary catheter usage for one of three residents (Resident R52). Findings include: Review of Title 42 Code of Federal Regulations (CFR) S483.25(e) Incontinence indicated if the facility provides care for a resident with an indwelling catheter, in collaboration with the medical director and director of nurses, and based upon current professional standards of practice, resident care policies and procedures must be developed and implemented that address catheter care and services, including but not limited to: timely and appropriate assessments related to the indication for use of an indwelling catheter; identification and documentation of clinical indications for the use of a catheter; as well as criteria for the discontinuance of the catheter when the indication for use is no longer present; insertion, ongoing care and catheter removal protocols that adhere to professional standards of practice and infection prevention and control procedures; response of the resident during the use of the catheter; and ongoing monitoring for changes in condition related to potential CAUTI's (catheter-associated infections) and recognizing, reporting and addressing such changes. Review of the clinical record indicated that Resident R14 was admitted to the facility on [DATE]. Review of Resident R14's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/2/24, indicated diagnoses of high blood pressure, paraplegia (paralysis on lower half of the body), and obstructive uropathy (occurs when urine can't flow either partially or completely, resulting in swelling and damage to kidneys). Section H-Bowel Bladder and Bowel indicated the resident had an indwelling catheter. Review of Resident R14's physician order dated 2/19/24, indicated foley catheter 20 French with 30 cc (milliliter) balloon to be changed every thirty days and as needed for dislodgement for obstructive uropathy. Review of Resident R14's care plan dated 6/24/21, indicated the resident required the use of indwelling urinary catheter. Interventions indicated to change the catheter as per physician order. Review of Resident R14's March 2024 Treatment Administration Record (TAR) revealed the order to change the foley catheter every thirty days was left blank and not signed off for completion. Review of Resident R14's April 2024 TAR revealed the order to change the foley catheter every thirty days was left blank and not signed off for completion. Review of Resident R14's clinical record from 3/1/24, through 4/31/24, failed to indicate the resident's catheter was changed as ordered. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/24, at 2:19 p.m. the Director of Nursing confirmed the facility failed to change a foley catheter as ordered for one of three residents (Resident R14). Review of the clinical record indicated that Resident R52 was admitted to the facility on [DATE]. Review of Resident R52's MDS dated [DATE], indicated diagnoses of high blood pressure, hemiplegia (paralysis on one side of the body), and muscle weakness. Review of a physician order dated 5/6/24, indicated foley catheter 16 French with 10 cc (milliliter) balloon to straight bag gravity drainage. Review of Resident R52's care plan failed to reveal goals and interventions related to use of an indwelling urinary catheter. During an interview on 5/17/24, at 10:22 a.m. the Director of Nursing confirmed that the facility failed to obtain a valid medical diagnosis for an indwelling urinary catheter and failed to develop and implement a comprehensive plan of care related to urinary catheter usage for Resident R52. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.11(d) Resident care policies.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of facility policy, observations, interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care for one of four residents (Residents R16). Findings include: Review of facility policy Oxygen Administration dated 3/4/24, indicated to check the mask, tank, and humidifying jar to be sure they are in good working order. Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through. Periodically re-check the water level in humidifying jar. Review of the clinical record indicated that Resident R16 was admitted to the facility on [DATE], with diagnosis of COPD, (chronic obstructive pulmonary disease- a group of progressive lung disorders characterized by increasing breathlessness), high blood pressure, and heart failure (a progressive heart disease that affects pumping action of the heart muscles. This causes fatigue, shortness of breath.) Review of Resident R16's physician's order dated 10/14/23, indicated to administer oxygen at 4 lpm (liter per minute) via nasal cannula continuously. Review of Resident R16's physician's order dated 10/14/23, indicated to change oxygen tubing and canister every night shift every Saturday. Review of Resident R16's care plan revised 4/26/24, indicated to administer oxygen at 4 l/m and to administer treatment and medications per order. During an observation on 5/13/24, at 1:21 p.m. Resident R16 was receiving 4 l/m of oxygen via nasal cannula. The resident's humidification canister was observed to be empty. During an interview on 5/13/24, at 11:20 a.m. Licensed Practical Nurse Employee E8 confirmed Resident R16's humidification canister was empty, and confirmed the facility failed to provide appropriate respiratory care for one of four residents (Residents R16). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0699

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide care or services that was trauma informed and/or culturally competent.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48546

Based on review of facility policy, resident record review, and staff interviews, it was determined that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for one of two residents (Resident R34).

Findings include:

Review of facility policy Trauma Informed Care dated 3/4/24, indicated the facility will deliver care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally-competent and account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization. Facilities should use a multi-pronged approach to identifying a resident's history of trauma, this would include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event. Facilities must identify triggers which may re-traumatize residents with a history of trauma. The facility should collaborate with resident trauma survivors, and as appropriate, resident's family, friends, and any other health care professionals to develop and implement individualized interventions.

Review of the clinical record indicated Resident R34 was admitted to the facility on [DATE].

Review of Resident R34's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/19/24, indicated diagnoses of high blood pressure, anxiety (a feeling of worry, nervousness, or unease), and Post Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and may have triggers that can bring back memories of trauma accompanied by intense emotional and physical reactions).

Review of Resident R34's care plan dated 10/11/23, indicated the resident was a survivor of abuse and that the facility should encourage discussing individual triggers, but failed to identify what the triggers were and how to avoid them.

During an interview on 5/17/24, at 10:57 a.m. Social Worker Employee E2 confirmed that the facility failed to identify PTSD triggers for Resident R34 in order to eliminate or mitigate any triggers that may cause re-traumatization for Resident R34.

28 Pa. Code: 201.14(a) Responsibility of licensee.

28 Pa. Code: 201.18(b)(1) Management.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46337 Based on clinical record reviews, observations, and staff interviews, the facility failed to ensure residents with dementia receive the appropriate treatment and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being for two of four residents reviewed (Resident R1 and R49). Findings include: Review of federal guidance S483.40(b)(3) a resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. The regulations associated with medication management include consideration of: o Indication and clinical need for medication; o Dose (including duplicate therapy); o Duration; o Adequate monitoring for efficacy and adverse consequences; and o Preventing, identifying, and responding to adverse consequences. Review of the facility Dementia-Clinical Protocol reviewed 3/4/24, indicated the interdisciplinary [NAME] will identify and document the resident's condition and level of support needed during care planning and review changes as they arise. Review of the admission record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS- a periodic assessment of care needs) dated 3/18/24, indicated the diagnoses of dementia, bipolar (a mental illness that causes unusual shifts in a person ' s mood, energy, activity levels, and concentration), anxiety, and depression. Review of Resident R1's physician order dated 12/7/23, indicated to administer 0.25 mg Risperidone (antipsychotic medication), one tablet by mouth, two times a day. Review of Resident R1's care plan dated 12/2/20, last revised 12/26/23, indicated the resident was at risk for adverse effects related to use of antipsychotic medication. Interventions indicated to evaluate for effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs (i.e. AIMS-Abnormal Involuntary Movement Scale). (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R1's clinical record on 5/15/24, failed to reveal the facility completed an ongoing assessment to evaluate for the effectiveness and side effects for the resident's prescribed Risperidone. Review of the admission record indicated Resident R49 was admitted to the facility on [DATE]. Review of Resident R49's 4/29/24, indicated the diagnoses of dementia, high blood pressure, and anxiety. Review of Resident R49's physician order dated 10/20/23, indicated to administer Seroquel (antipsychotic medication) 12.5 mg by mouth at bedtime for dementia with psychosis. Review of Resident R49's physician order dated 4/26/24, indicated to administer Seroquel 12.5 mg by mouth at bedtime for dementia. Review of Resident R49's care plan revised on 5/2/24, indicated the resident was at risk for behavior symptoms related to dementia. The care plan failed identify Resident R49's behaviors and non-pharmacological interventions to address the behaviors. Resident R49's care plan failed to include interventions to address the resident's risk for developing adverse effects related to use of antipsychotic medication. Review of Resident R49's clinical record on 5/15/24, failed to indicate an AIMS test was performed. During an interview on 5/16/24, at 1:18 p.m. the Director of Nursing confirmed the facility failed to ensure residents with dementia receive the appropriate treatment and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being for two of four residents reviewed (Resident R1 and R49). 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the physician responded timely pharmacy medication recommendations for one out of five sampled residents (Resident R49). Findings include: The facility Medication Regimen Review policy dated 8/17/23, indicated the consultant pharmacist will conduct Medication Regimen Review (MRR) and will make recommendations based on the information available in the resident's health record. If an irregularity does not require urgent action, it should be addressed before the consultant pharmacist's next monthly MRR. The facility should alert the Medical Director when MRR's are not addressed by the attending physician in a timely manner. Review of admission record indicated Resident R49 was admitted to the facility on [DATE]. Review of Resident R49's Minimum Data Set (MDS- periodic assessment of care needs), dated 4/29/24, indicated the diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), high blood pressure, and anxiety. Review Resident R49's Medication Regimen Review Recommendations dated 3/7/24, indicated the resident was on Risperdal (antipsychotic medication used to treat certain mental/mood disorders) and recommended that due to the potential for antipsychotic to cause extrapyramidal (involuntary and uncontrollable movement disorders caused by certain drugs) side effects, it is important to monitor for potential of involuntary muscle movements to assess for the presence or worsening of these symptoms. It was recommended that nursing perform an AIMS (Abnormal Involuntary Movement Scale) test now and then every six months and report to the physician immediately if any signs or symptoms are noted or worsening. It was indicated a note was written to the physician. Review of Resident R49's clinical record on 5/15/24, failed to indicate an AIMS test was performed as recommended. During an interview on 5/16/24, at 1:19 p.m. the Director of Nursing confirmed the facility failed to ensure that the physician responded timely pharmacy medication recommendations for one out of five sampled residents (Resident R49). 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code 211.5(f) Clinical records. 28 Pa. Code 211.12(c)(d)(1)(2)(5) Nursing 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on clinical record review and staff interview, it was determined that the facility failed to ensure a medication regime was free from potentially unnecessary medication for two of five residents (Resident R21 and R25). Findings include: Review of the facility policy Psychotropic Medication Use dated 3/4/24, indicated residents will not receive medications that are not clinically indicated to treat a specific condition. Review of Resident R21's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R21's MDS (Minimum Data Set - assessment of a resident's abilities and care needs) dated 4/18/24, indicated diagnoses of depression, dysphasia (difficulty swallowing), and schizoaffective disorder (a mental disorder in which a person experiences a combination of schizophrenia and mood disorder symptoms). Review of Resident R21's care plan dated 4/15/24, indicated to evaluate effectiveness and side effects of medication for possible decrease/elimination of psychotropic drugs. Review of Resident R21 ' s physician orders dated 4/14/24, indicated she was prescribed the following medications: Seroquel 500 milligrams(mg) at bedtime for schizoaffective disorder Seroquel 75 mg twice a day for bipolar (a manic depression) Lithium 450 mg daily for depression Buspirone 20 mg three times a day for anxiety Trazodone 150 mg at bed time for insomnia (difficulty falling asleep) Paroxetine 40 mg daily for depression Clonazepam 1mg three times a day for schizoaffective disorder Review of Resident R21' s clinical record failed to reveal documentation that the facility was monitoring medication side effects of psychotropic medications ordered by physician. Review of Resident R21's clinical record failed to reveal documentation of monitoring resident behaviors while using psychotropic medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the admission record indicated Resident R25 was admitted to the facility on [DATE], with diagnoses that included high blood pressure, altered mental status, and urinary tract infection. Review of Resident R25's MDS dated [DATE], indicated the diagnoses were current. Review of a physician order dated 5/3/24, through 5/15/24, indicated to give 10 mg of Aripiprazole (an anti-psychotic medication used to for the short-term treatment of agitation that occurs with certain mental/mood disorders) in the evening for altered mental status. Review of Resident R25's Psychiatric Evaluation & Consultation dated 5/6/24, indicated a recommendation to discontinue aripiprazole. Review of Resident R25's physician order for 10 mg of aripiprazole revealed it was discontinued on 5/15/24, 11 days after the psychiatric consult recommendations. The facility failed to address the psychiatric evaluations recommendations in a timely manner. During an interview on 5/17/24 at 9:58 a.m., the Director of Nursing confirmed the facility failed to ensure a medication regime was free from potentially unnecessary medication for two of five residents (Resident R21 and R25). 28 Pa. Code 211.9(a)(1) Pharmacy services. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48546 Based on review of facility policy, observation, and staff interviews, it was determined that the facility failed to date opened medications and properly store medications in one of two medication carts (West Assignment). Findings include: Review of facility policy Storage of Medications dated 3/4/24, indicated medications are stored safely, securely, and properly, following manufacture's recommendations or those of the supplier. Review of Title 42 Code of Federal Regulations (CFR) S483.45(g) Labeling of Drugs and Biologicals indicated if a multi-dose vial has been opened of accessed (e.g., needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. During an observation on 5/15/24, at 9:16 a.m. of the [NAME] Assignment medication cart indicated the following medications stored in one compartment without individual packaging or separation from other residents medications: - Resident R10's Lantus (prefilled pen to inject long acting insulin under the skin) pen not in a box or individual bag - Two of Resident R10's Lantus pens not in a box or individual bag - R46's Lantus pen not in a box or individual bag - R213's Lantus pen not in a box or individual bag Continued observation indicated the following medications not dated upon opening: - Resident R10's Lantus pen, no date opened. - Two of Resident R30's Lantus pens, no date opened. - Resident R46's Lantus pen, no date opened. - Resident R46's atropine (a medication used to treat swelling in the eyes) drops, no date opened. - Resident R213's Lantus pen, no date opened. - Two of Resident R213's Admelog (a rapid-acting insulin) vials, no date opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/24, at 9:23 a.m. Licensed Practical Nurse Employee E1 confirmed the findings noted above. During an interview on 5/15/24, at 1:48 p.m. the Director of Nursing confirmed that the facility failed to date opened medications and properly store medications in one of two medication carts (West Assignment). 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1)(e)(1) Management. 28 Pa. Code: 211.9 (a)(1) Pharmacy services. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on a review of facility policy, clinical records, and resident and staff interviews it was determined that the facility failed to ensure that emergency dental care was provided for one of two residents (Resident R19). Findings include: Review of facility policy Dental Services, dated 3/4/24, indicated that routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. Social Services representatives will assist residents with appointments, transportation arrangements, and reimbursement of dental services under the state plan, if eligible. Review of the clinical record revealed that Resident R19 was admitted to the facility on [DATE]. Review of Resident 19's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 4/8/24, indicated diagnoses of high blood pressure, dementia (neuro-cognitive disorder impacting reasoning, judgment, and memory), and mild intellectual disabilities. Review of Resident R19's clinical record revealed a physician's order dated 5/1/23 for dental consult as needed. During an interview on 5/14/24, at 9:52 a.m. Resident R19 stated, My tooth hurts. It needs fixed. Review of Resident R19's clinical record revealed documentation on 5/3/24, that Resident R19 was seen by the Nurse Practitioner for a toothache. The note stated Seen today per staff request, patient complains of toothache. He reports left lower molar pain. Tooth is grey in color without redness or swelling noted to gum line. Staff reports on list to get appointment for outpatient dentist. Dental consult for possible extraction. Ibuprofen (a medication used to treat pain) 400 mg (milligrams) twice a day for five days was ordered, as well as Orajel (an ointment that is applied to the mouth to help relieve pain) as needed. Review of Resident R19's clinical record revealed documentation on 5/6/24, that Resident R19 was seen again by Nurse Practitioner for toothache and facial swelling. The note stated Tooth is grey in color without redness now with facial swelling. Staff reports on list to get appointment for outpatient dentist. He states he is able to eat/chew on other side. Dental consult for possible extraction. Amoxicillin (an antibiotic medication used to treat infection) 500 mg twice a day for seven days, Orajel, and a soft diet were ordered. Review of Resident R19's clinical record revealed documentation on 5/10/24, that Resident R19 was seen again by Nurse Practitioner for monthly review of acute and chronic conditions. The note stated Patient acutely seen for toothache, waiting for dentist appointment. Eating and drinking without difficulty. Dental consult for possible extraction. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/24, at 12:40 p.m. Social Worker Employee E2 stated that she did not make a dentist appointment for Resident R19, but that Central Supply Employee E7 schedules those particular types of appointments. During an interview on 5/15/24, at 12:45 p.m. Central Supply Employee E7 stated I don't believe I did. In regards to making Resident R19 a dentist appointment. Central Supply Employee E7 then looked at her calendar and confirmed that she had not received notification to make Resident R19 a dentist appointment. Central Supply Employee E7 stated that typically staff would place a paper in her mailbox that an appointment needed to be made, but stated that she had not received any such notification. During an interview on 5/15/24, at 1:02 p.m. Resident R19 stated that his tooth only hurts when he chews on that side, but can chew on the other side without difficult. Resident R19 confirmed that he has not yet been notified about any upcoming dentists appointments. During an interview on 5/15/24, at 1:40 p.m. Director of Nursing confirmed that the facility failed to provide emergency dental care and stated that Central Supply Employee E7 is calling around now. It's hard to find a dentist that accepts MA (medical assistance) . 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(3)(5) Nursing services 28 Pa. Code 211.15(a) Dental services

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 46167 Based on a review of facility documents, and staff interviews, it was determined that the facility failed to employ staff with the required skills and competencies to carry out the daily functions of the Dietary Department (Food Service Director Employee E9) for six of twelve months. Findings include: A review of facility document Dietary Supervisor Job Description indicated that a qualified candidate must have successful completion of a reputable course in food service operation, or a college degree in culinary arts management. During an interview on 5/13/24, at 9:45 a.m. Food Service Director Employee E9 stated that he started at the facility in November 2023, and did not possess qualifications of a certified dietary manger or have any related degrees. During an interview on 5/13/23, at 3:00 p.m. Nursing Home Administrator (NHA) confirmed that Food Service Director Employee E9 failed to meet the state agency requirements for a food service director. 28Pa. Code: 211.6(c)(d) Dietary services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46167 Based on review of facility policies, observations and staff interview, it was determined the facility failed to properly date and store food products, and maintain clean equipment in a manner to prevent foodborne illness in the main kitchen. Findings include: Review of facility policy Food Receiving and Storage dated 3/4/24, indicated foods shall be received and stored in a manner that complies with safe food handling practices. Review of facility policy Sanitization, dated 3/4/24, indicated that the food service area is maintained in a clean and sanitary manner. During observation and interview in the dry storage room on 5/13/24, at 9:58 a.m. opened packages of macaroni, spaghetti, and egg noodles were noted to have not been dated. Food Service Director (FSD) Employee E9 confirmed that the facility failed to properly label and date opened food packages to prevent foodborne illness. During observation on 5/14/24, at 11:17 a.m. a fan that was pointed towards the tray line, was covered in a gray, fuzzy substance. During an interview on 5/14/24, at 11:20 a.m. FSD Employee E9 confirmed that the facility failed to maintain clean equipment to prevent foodborne illness. 28 Pa. Code: 201.14(a) Responsibility of licensee 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.6(c) Dietary services.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 46167 Based on review of facility documents, employee education records, and staff interview, it was determined that the facility failed to provide training on effective communication for one of five direct care staff members (Nurse Aide Employee E10). Findings include: Review of the Nurse Aide Job Description, indicated that nurse aide employees shall participate in required trainings and complete all related clinical competencies. Review of Nurse Aide (NA) Employee E10's facility provided staff list indicated she was hired on 3/9/81. Review of NA Employee E10's training record for 3/9/23, through 3/9/24, did not include training on effective communication. During an interview on 5/16/24, at 2:42 p.m. Assistant Director of Nursing (ADON)Employee E11 confirmed that the facility failed to provide training on effective communication for one of five staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 46167 Based on review of facility documents, employee education records, and staff interview, it was determined that the facility failed to provide training on QAPI (Quality Assurance and Performance Improvement) for five of five staff members (Employees E10, E12, E13, E14. E15). Findings include: Review of the Nursing Home Administrator (NHA) Job Description dated 9/1/23, indicated that the NHA will ensure all compliance with required trainings and in-services. Review of Nurse Aide (NA) Employee E10's facility provided staff list indicated she was hired on 3/9/81. Review of NA Employee E10's training record for 3/9/23, through 3/9/24, did not include training on QAPI. Review of Licensed Practical Nurse (LPN) Employee E12's facility provided staff list indicated she was hired on 2/4/02. Review of LPN Employee E12's training record for 2/4/23, through 2/4/24, did not include training on QAPI. Review of NA Employee E13's facility provided staff list indicated she was hired on 5/3/17. Review of NA Employee E13's training record for 5/3/23, through 5/3/24, did not include training on QAPI. Review of NA Employee E14's facility provided staff list indicated she was hired on 5/6/14. Review of NA Employee E14's training record for 5/6/23, through 5/6/24, did not include training on QAPI. Review of the NA Employee E15's facility provided staff list indicated she was hired on 6/23/94. Review of NA Employee E15's training record for 6/23/22, through 6/23/23, did not include training on QAPI. During an interview on 5/16/24, at 2:42 p.m. Assistant Director of Nursing Employee E11 confirmed that the facility failed to provide training on QAPI for five of five staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on review of facility documents, employee education records, and staff interview, it was determined that the facility failed to provide training on behavioral health for one of five staff members (Nurse Aide Employee E10). Findings include: Review of the Facility assessment dated [DATE], indicated staff training/education and competencies will be completed during general orientation upon hire, and annually. Education listed included, but not limited to: -Alzheimer's disease and related disorders -Dementia Care Review of Nurse Aide (NA) Employee E10's facility provided staff list indicated she was hired on 3/9/81. Review of NA Employee E10's training record for 3/9/23, through 3/9/24, did not include training on behavioral health. During an interview on 5/16/24, at 2:42 p.m. Assistant Director of Nursing Employee E11 confirmed that the facility failed to provide training on behavioral health for one of five staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.