STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395256	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harborview Rehabilitation and Care Center at Lansd	25 West Fifth Street Lansdale, PA 19446

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 36609 Based on interviews with residents and staff, review of clinical records, review of monthly resident council minutes and review of facility policy, it was determined that the facility did not ensure prompt efforts were made to resolve residents' grievances and/or concerns elated to, billing clarification, status of the activity van, request for room change and missing items for 11 of 11 residents attending resident council (Residents R10, R12, R16, R17, R38, R52, R66, R79, R90, R91 and R101) and two of 25 resident records reviewed (Resident R26 and R41). Findings include: Review of facility policy titled, Grievance/Concern Management not dated, states, Residents/patients have the right to present concerns on behalf of themselves and /or others to the staff and/or administrator of the facility, to governmental officials or to any other person . these rights also include the right to prompt efforts by the facility to resolve resident concerns. The same policy states, attempts to resolve concern are within 3 business days, and if unresolved within the 3-days it is reported to the Nursing Home Administrator (NHA). The policy further states the Social Service Representative maintains contact with the complainant providing updates and makes entries in the medical record under SS (Social Services) notes regarding the concern and will follow up with the reporter to confirm satisfaction with the outcome and document the resolution in the medical record. Review of clinical records revealed Resident R26 was admitted to the facility in November 2020, alert and oriented with a primary diagnosis of heart failure. Interview with Resident R26 on November 12, 2024, at 11:00 a.m. indicated her husband became a resident at the facility (Resident R80) and both have requested to share a room together. Resident R26 said the Social Worker, Employee E25 is supposed to help me, but she never gets back to me. The last time I spoke with her was at least two weeks ago. She told me there was a lot of work involved moving residents that made me feel that the move won't happen. During the same interview Resident R26 pointed to an orthopedic brace with an attached shoe and indicated the other shoe is missing. The resident stated, The facility wants me to buy new shoes when they're the ones that lost it. I also haven't heard back from the Social Worker for this too! (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R26's Social Services note from Social Worker, Employee E25 dated July 24, 2024, stated, Resident was made aware that when an appropriate room is available, they will be placed together and to be mindful of RM (roommate) when visiting with each other and to utilize MDR (main dining room) and TV room for visits. Review of Resident R80's clinical records revealed a physician note dated July 24, 2024, stating, While he is at this facility he wants to share a room with his wife. Review of Resident R26's Social Services note dated September 20, 2024, noted Resident was told again that there are currently no semi-private rooms available. Review of Resident R26's Occupational Therapy (OT) notes dated October 22, 2024, indicated Resident R26 was not able to transfer that day due to missing right shoe. OT note dated October 25, 2024, indicated Resident R26 was unable to address transfer goals until they get replacement left shoe, noted Social Worker is looking into another option of obtaining shoes and indicated the resident was going to be moved into bedroom with husband on Monday October 28, 2024. OT note dated November 3, 2024, stated would look into the status of shoes. OT discharge summary dated November 7, 2024, discharge recommendations stated, Resident needs to purchase shoes. On November 14, 2024, at 2:00 p.m. surveyor requested status and/or documentation related to Resident R24's move and missing shoe and the Nursing Home Administrator indicated he was aware and would supply additional documentation but failed to submit. Review of Resident R41's clinical record revealed the resident was admitted to the facility in September 2021 diagnosed with multiple sclerosis (an autoimmune disorder that effects the central nervous system). Interview with Resident R41 on November 12, 2024, at approximately 11:00 a.m. stated, The [Social Worker (SW) Employee E25] said she called my insurance company because I make appointments that aren't covered and I don't show up, so they charge the facility. That's not true because I don't make my appointments, I have the nurses at the front desk make my appointments and never cancel, I have been trying to talk to the SW for at least two weeks because if they (the facility) are being charged I told the SW I want to see those bills. On November 14, 2024, at 2:00 p.m. a request for further documentation received by the Nursing Home Administrator (NHA) revealed an outpatient test done was for Resident R41 on September 27, 2024, with a remaining balance at was not charged to the resident. On November 14, 2024, at 10:00 a.m., during a group meeting with 11 residents, all shared that the facility was not letting them know the status of the activity van. Resident R12 said they have not had the van since March. The NHA keeps telling us, Just two more weeks, just two more weeks. Recently the NHA said it needed a battery but that was weeks ago, it shouldn't take so long!. Review of the last three months of resident council minutes revealed on September 26, 2024, residents inquired about the status of the activity van and the facility documented response was the residents were Informed and updated without any additional specifics. Review of resident council minutes for October noted The resident are wondering when the van is coming back to do outing. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the NHA on November 14, 2024, at 11;00 a.m. indicated the van is still at the shop. The residents don't know this because it is not a regulation, we have a van for activities, but the van might be totaled. It was in an accident, and we might not be able to get it fixed. The NHA indicated needing to wait a few more days to see what happens before saying something to the residents. The facility did not ensure prompt efforts were made to resolve grievances and their concerns 28 Pa. Code 201.29(a)(i) Resident rights

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 36609 Based on interviews with residents and review of clinical records, it was determined that the facility failed to ensure residents receive proper treatment and care to maintain good foot health in accordance with professional standards of practice for two of 25 residents reviewed (Resident R26 and R41). Findings include: Review of Resident R26's clinical records revealed the resident was admitted to the facility in November 2020, alert and oriented with diagnoses of heart failure and Type II Diabetes (High blood sugar levels can damage nerves in feet, making it harder to sense pain increasing risk of injury). Interview with Resident R26 on November 12, 2024, at 11:00 a.m. with her roommate Resident R41 indicated they have not been seen by the podiatrist. I think they skipped over us. Documentation review of Resident R26's podiatry appointment dated April 19, 2024, noted the resident's toenails were professionally treated to relieve pain due to pressure and should be treated in 60 days due to systemic conditions or sooner if complications should arise. The following appointment dated, July 10, 2024, also indicated the resident should be treated in 60 days. Further review of Resident R26's clinical record revealed no evidence of any further appointments. Review of Resident R41's clinical record revealed the resident was admitted to the facility in September 2021 diagnosed with multiple sclerosis (an autoimmune disorder that effects the central nervous system, symptoms may include numbness and pain in feet). Evidence of Resident R41's podiatry appointment dated April 19, 2024, noted the resident's toenails were professionally treated to relieve pain due to pressure and should be treated in 60 days due to systemic conditions or sooner if complications should arise. The following appointment dated, July 10, 2024, also indicated the resident should be treated in 60 days. Further review of Resident R41's clinical record revealed no evidence of any further appointments. Based on the above documentation received by the Director of Nursing, confirmed on November 15, 2024, at 12:30 p.m., the facility failed to schedule further podiatrist appointments for the above residents. 28 Pa. Code 211.12(d)(3)(5) Nursing services

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38735 Based on review of clinical records, resident and staff interviews, review of facility policies and documentation, it was determined the facility failed to ensure a hot beverage was served at safe temperatures on one of three nursing floors (First Floor). This failure placed 23 of 24 residents on the First Floor in an Immediate Jeopardy situation where the temperature of the hot coffee was 178 degrees Fahrenheit. Further, the failure to ensure that hot beverages were served at safe temperatures resulted in Resident R97 sustaining a burn on the left hip for one of 25 residents reviewed. The facility also failed to properly supervise Resident R9 resulting in actual harm when Resident R9 consumed foods not in accordance with diet orders, experiencing a choking episode, which required the Heimlich maneuver, and developed aspiration pneumonia for one of 25 residents reviewed. (Resident R9). Findings include: Review of facility policy, Hot Liquid Management, dated March 2017, revealed that prior to delivering beverage carts to designated unit, dietary staff temp (take the temperature) to validate it is not > 165 F (Fahrenheit). If temp is > 165 F, allow to cool to 165 F and record temperature on the log. Review of Resident R97's quarterly Minimum Data Set assessment (MDS - an assessment of care needs) dated October 28, 2024, revealed the resident had a BIMS of 15 which indicated that the resident had no cognitive impairments. Continued review of the resident's MDS revealed the resident required set up or clean up for eating (helper sets up or cleans up; resident completes activity). Review of Resident R97's nursing note dated November 11, 2024, at 7:26 p.m. created by Licensed nurse, Employee E21, revealed at 6:30 p.m. the nurse aide reported the resident had a blister on the left hip/buttock area. The nurse aide reported to Licensed nurse, Employee E21 of the resident's coffee spill on the left side of the body at 7:30 a.m. and at that time no blisters were noted. The resident did not complain of pain or discomfort to the area. The blister measured 5.5 centimeters (cm) x 6.5 cm at left hip/buttock area. A new order from the nurse practitioner was obtain for Silvadene BID (twice a day) for 5 days. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with Nurse aide, Employee E22, on November 14, 2024, at 11:10 a.m. revealed that she was in Resident R97's room at 6:30 a.m. when the coffee spill incident happened. She stated that the resident had his/her coffee on the over the bed table and was reaching for the cell phone and knocked the coffee over and spilling it onto the bed. She stated that she went and got some paper towels and wiped up the coffee and wiped the resident's left thigh with wet paper towels and noted that it was pink, but not blistered. She said that she then got the nurse (Employee E23) to check on the resident. Employee E22 stated it was later, on her rounds after supper at 6:30 p.m. (she said that she worked a double shift that day) that she noticed the blister on Resident R97's left thigh and she told the nurse (Employee E23) who checked the resident's skin and who requested a second nurse (Employee E21) to write up the incident report. During a follow up interview with Employee E22 on November 26, 2024, she stated that she did not take the temperature of the coffee before serving it and did not know if anyone took the temperature to see if it was safe to serve. Interview with Resident R97 on November 14, 2024, at 1:45 p.m. confirmed the coffee spilled on Monday, November 11, 2024, at breakfast resulted in a blister on the left side of his/her leg which was being treated by nursing with cream and a dressing. Review of facility incident documentation revealed a statement by Nurse aide, Employee E22, dated November 11, 2024, which confirmed the course of events given in her interview. Review of Employee E23's, Registered Nurse, statement revealed at 7:30 a.m., on November 11, 2024, she checked Resident R97's skin and found no redness or blisters and noted the coffee was spilled on the resident's bed sheets. Further review of the November 11, 2024, incident report revealed Resident R97 had a blister attributed to the coffee spill, and the measurements of the blister were 5.5 cm x 6.5 cm (centimeter) at left hip/buttock area. Review of the food temperature log for November 11, 2024, revealed the temperature taken of the coffee in the kitchen was 160 degrees Fahrenheit which was within facility's policy. Observation in the main kitchen on November 15, 2024, at 9:50 a.m. revealed coffee carts for all three floors were set up with hot coffee in carafes. The Food Service Director (FSD), Employee E3, took the temperature of the coffee in the carafe's which was 182.8 degrees. She stated that the coffee had been poured about an hour earlier and would cool down to 165 degrees before being delivered at 11:00 a.m. to the floors. The water dispensed from the coffee urn was 190 degrees. Observation of the lunch meal on November 15, 2024, at 11:00 a.m. on the First floor revealed that the coffee cart was delivered and the dietary aide did not know the temperature of the beverages and he went to get a thermometer. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Further observation on November 15, 2024, at 11:15 a.m. revealed nursing aides, Employees E9 and E10, were pouring coffee preparing to serve to residents on the first floor. Surveyor stopped nursing aides until the temperature of the coffee could be taken. The coffee in the carafe was 178 degrees Fahrenheit. Interview conducted at that time with Employees E9 and E10 revealed they were not aware of the facility policy requiring the temperature of the coffee not to exceeded temperature of 165 degrees; they did not know where to find a thermometer to take the temperature. Further interview with Employees E9 and E10 revealed, the nurse aides were not aware of the temperature of the coffee before beginning service to residents on the First floor unit. Interview with the Nursing Home Administrator, on November 15, 2024, at 11:20 a.m. confirmed the coffee was above the facility policy required temperature of 165 degree or less. The Nursing Home Administrator also acknowledged that if the nurse aides were not prevented from serving the coffee, a resident could have received coffee at an unsafe temperature. On November 26, 2024, at 11:35 a.m. an Immediate Jeopardy Template was presented to the Nursing Home Administrator for the facility's failure to ensure that hot beverages were served at safe temperatures by staff who were not aware of the facility policy to ensure hot beverages were served at safe temperatures. The facility submitted a written plan of action on November 26, 2024, at 12:34 p.m. and implemented the plan of action which included: 1. Facility reviewed and updated the hot liquids policy on November 18, 2024. a. Prior to hot liquids leaving Dietary, a temperature will be taken by Dietary staff. b. Before serving to residents a temperature will taken by CNA (nurse aide)/Nurse and be documented. c. If the hot liquid temperature is > 150 degrees, it will not be served and will be cooled down by using ice until the temperature is below 150 degrees. 2. The facility will inservice more than 90% of staff by November 26, 2024 and will be at 100% by November 27, 2024. 3. The facility will do audits to ensure effectiveness of staff in-service using questionnaire and/or on the spot interview and results to be reviewed in QAPI (Quality Assurance Performance Improvement). 4. The facility to audit temperature daily for one week and twice a week for two weeks and weekly for two months and reported and discussed in QAPI. On November 26, 2024, at 3:01 p.m. the action plan was reviewed, observations made on the nursing units to ensure that thermometers were available to take hot beverage temperatures, nursing and dietary staff were interviewed to ensure that in-service training was completed and effective. The Immediate Jeopardy was lifted on November 26, 2024, at 3:01 p.m. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident R9's clinical record revealed the resident was admitted to the facility on [DATE], with a history of respiratory failure, Dysphagia (difficulty swallowing), Bipolar Disorder (condition which a person has periods of depression and periods of being extremely happy), Parkinsonism (nervous system disorder), Schizophrenia (mental disease characterized by loss of reality). Review of Resident R9's quarterly MDS assessment completed May 15, 2024, revealed the resident was assessed with a BIMS (Brief Interview of Mental Status) of 8, which indicates moderate cognitive impairment. The resident was assessed as requiring set up only with eating. Review of Resident R9's July 2024 physician's orders revealed an order for the resident to receive a mechanical soft diet (diet consisting of any foods that can be blended, mashed, pureed, or chopped using a kitchen tool). Review of R9's care plan initiated February 16, 2017, revealed a problem area related to impaired functional mobility and activities of daily living performance. An intervention developed January 7, 2021, included resident needs supervision to assist of one for eating. Continued review of the resident's care plan revealed Resident is a risk for choking/aspiration (when food or liquid goes into your airway instead of the esophagus) due to diagnosis of dysphagia. Interventions include mechanical soft solids, thin liquid/aspirations precautions. Review of Resident R9's nursing notes dated July 15, 2024, at 4:50 p.m. revealed, Resident had an episode of choking while eating a hoagie with another resident in the dining room requiring the Heimlich maneuver . Resident at baseline is oriented to person, situation only, with confusion and poor safety awareness. Unable to understand and follow (his/her) dietary restrictions independently . LLL (left lower lung) with crackles .No SOB (Shortness of Breath) noted/reported. The resident was re-educated on not eating food offered by other residents. The physician was notified, and an immediate x-ray was ordered. Review of a written statement completed by Licensed nurse, Employee E24, confirmed the nurse was called by the nurse aide for statements of the resident was choking. On observation the resident was choking and had breathing difficulty. An assessment was done by a charge nurse. No food substance was observed in the oral cavity. Food substance was found on the floor. The Resident's face was red and fleshy. Heimlich maneuver (first-aid method for choking) was performed 5 times. Minor gasping observed. As per other staff members the resident was eating a sandwich with the fell ow resident in the dining hall. Review of Resident R9's physician's notes dated July 16, 2024, revealed the resident had a choking episode the prior evening. Chest x-ray result showed aspiration pna (pneumonia- infection of the air sacs in one of both lungs) new order for Levaquin 750 milligrams x 5 days. Further review of facility's investigation report revealed staff education was provided after the incident on July 16, 2024, with topic staff to encourage resident to follow with ordered diets and explain the risk of not following appropriate diet. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility failed to ensure that Resident R9 was properly supervised in the dining room during the lunch meal resulting in actual harm to Resident R9 who consumed foods not in accordance with diet orders, experienced a choking episode, required the Heimlich maneuver, and developed aspiration pneumonia. 28 Pa Code 211.12(d)(1) Nursing services 28 Pa Code 211.12(d)(1)(5) Nursing services 28 Pa Code 211.10(d) Resident care policies

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 46993 Based on review of facility provided documentation, and interview with staff, it was determined that facility failed to provide sufficient nursing staff to assure resident safety for one of 22 residents reviewed (Resident R9) Findings include: Review of facility's assessment, updated on September 30, 2024, revealed that 40 residents out of approximately 110 residents residing in the facility require special treatment under Behavioral Health Needs. Review of investigation report, dated July 15, 2024, at 8:24 pm, revealed Resident R9 with medical history of Dysphagia (difficulty swallowing), Bipolar Disorder (condition which a person has periods of depression and periods of being extremely happy), Parkinsonism (nervous system disorder), Schizophrenia (mental disease characterized by loss of reality). Review of Resident R9's July 2024 physician's orders revealed an order for the resident to receive a mechanical soft diet (diet consisting of any foods that can be blended, mashed, pureed, or chopped using a kitchen tool). Review of Resident R9's nursing notes dated July 15, 2024, at 4:50 p.m. revealed, Resident had an episode of choking while eating a hoagie with another resident in the dining room requiring the Heimlich maneuver. Review of the facility investigation report related to Resident R9's choking incident revealed that a chest x-ray was ordered, and it was concluded that Resident R9 was diagnosed with aspiration pneumonia and treated with antibiotic Levaquin 750 milligrams for four days. Further review of investigation report revealed a note from Nurse Supervisor, Employee E17, stating that [Resident R9] at baseline is oriented to person, situation only, with confusion and poor safety awareness. Unable to understand and follow her dietary restrictions independently. Review of R9's care plan revealed [Resident R9] is at risk for choking/aspiration due to dysphagia diagnosis, date initiated March 6, 2023. Intervention to supervise, and/or provide assistance to [Resident R9] during meal times, and to monitor for coughing, shortness of breath, choking, labored respiration and congestion, was initiated after the choking incident on July 15, 2024. Interview with licensed nurse, Employee E8, on November 15, 2024 at 11:30 a.m., confirmed that the facility did not have sufficient amount of nursing staff to supervise residents with behavioral health needs resulting in Resident R9 not being properly supervised during the lunch meal on July 15, 2024. Refer to F 689 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code 211.12(d)(4) Nursing services 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(a)(3) Management

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 46993 Based on observations, review of facility policy and interview with staff, it was determined that the facility did not ensure drugs and biologicals were stored according to professional standards of practice for two out of three medication storage rooms observed (2nd floor and 3rd floor unit medication storage rooms) Findings include: Review of facility's policy 'Medication storage in the facility,' indicates that K. Medications requiring 'refrigeration' or 'temperatures between 2C /36F (Fahrenheit) and 8C/46F are kept in a refrigerator with a thermometer to allow temperature monitoring. During observations of the medication cart on November 11, 2024 at 9:30 am, on 2nd floor unit, revealed that the eye drop medication Latanoprost - 0.005%, with instructions to 'refrigerate before opening.' Finding was confirmed that the eye medication was in the medication cart and not rerigerated with Licensed nurse, Employee E18. Further observations of the medication cart on 3rd floor unit, on November 13, 2024 at 10:46 am, revealed the following expired nutritional supplement: Glucerna with carb steady, expiration date November 1st, 2024. Per interview with licensed nurse, Employee E20, the nutritional supplement was going to be given to a Resident R95 but the resident left the nurses station and has not received it yet. Further observations revealed 19 more expired nutritional supplements in unsealed box in medication storage room on 3rd floor unit. Further review of facility' policy indicates that outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal and reordered from the pharmacy, and medication storage conditions are monitored on a continual basis and corrective action taken if problems are identified. Observations of medication storage room on November 13, 2024 at 10:20 am, on 2nd floor unit, revealed the following expired medications: Vitamin B-6 100mg expiration date 10/2023 Diphenhydramine Hcl antihistamine 25 mg (allergy relief) Reguloid (dietary fiber supplement) expiration date 11/9/2023 Bisacodyl suppository 10mg, expiration date May 31, 2024 (continued on next page)

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	395256	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harborview Rehabilitation and Care Center at Lansd	25 West Fifth Street Lansdale, PA 19446

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Major sore throat spray, expiration date July 2024 Zinc Sulfate 220mg, expiration date 9/8/24 The findings were confirmed with Unit manager, Employee E19. Further observations of medication storage room on 3rd floor unit, on November 13, 2024 at 10:46 am, revealed the following expired medications: Mommy's bliss - baby gas relief - Simethicone drops - 20 mg, expiration date 04/2024. Findings were confirmed with licensed nurse, Employee E20. 28 Pa Code 211.9(a)(1) Pharmacy services 28 Pa Code 211.10(c) Resident care policies 28 Pa Code 211.12(d)(1)(3)(5) Nursing services

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 38735 Based on observation, review of facility documentation and interviews with staff, it was determined that the Nursing Home Administrator and Director of Nursing failed to effectively manage the facility resulting in an Immediate Jeopardy situation related to ensure that a hot beverages was serve at safe temperatures resulting in a burn to the resident (Resident R97). Findings include: Review of the job description of the Nursing Home Administrator (NHA) revealed that he was to ensure that all facility personnel, residents, visitors, etc, follow established safety regulations to include accident prevention. Review of facility policy, Hot Liquid Management, dated March 2017, revealed that prior to delivering beverage carts to designated unit, dietary staff temp (take the temperature) to validate it is not > 165F (Fahrenheit). If temp is > 165F, allow to cool to 165F and record temperature on the log. A review of Resident R97's quarterly Minimum Data Set assessment (MDS - an assessment of care needs) dated October 28, 2024, revealed that the resident had a BIMS (Brief Interview of Mental status) of 15, which indicated that the resident had no cognitive impairments. Continued review of the resident's MDS revealed the resident required set up or clean up for eating (helper sets up or cleans up; resident completes activity). A review of Resident R97's nursing note dated November 11, 2024, at 7:26 p.m. by Licensed nurse, Employee E21, revealed that at 6:30 p.m. the nursing assistant reported resident has a blister at his left hip/buttock area. The nurse aide reported that the resident had coffee spill at the left side of his body at 7:30 a.m. and at that time no blisters were noted. Resident has no complaints of pain or discomfort to the area. The blister measured 5.5 cm x 6.5 cm at left hip/buttock area. A new order from the nurse practitioner was received for Silvadene BID (twice a day) for 5 days. Interview with Nurse aide, Employee E22, on November 14, 2024, at 11:10 a.m. revealed that she was in Resident R97's room at 6:30 a.m. when the coffee spill incident happened. She stated that the resident had his coffee on the over the bed table and was reaching for the cell phone and knocked the coffee over and spilling it onto the bed. She said that she then got the nurse (Employee E23) to check on the resident. Employee E22 stated that it was on her rounds after supper at 6:30 p.m. (she said that she worked a double shift that day) that she noticed the blister on Resident R97's left thigh and she told the nurse (Employee E23) who checked the resident's skin and got the other nurse (Employee E21) to write up the incident report. During a follow up interview with Employee E22 on November 26, 2024, she stated that she did not take the temperature of the coffee before serving it and did not know if anyone took the temperature to see if it was safe to serve. Interview with Resident R97 on November 14, 2024, at 1:45 p.m. confirmed having the coffee spilled on Monday, November 11, 2024, at breakfast which resulted in a blister on the left side of his leg which was being treated by the nurses with cream and a dressing. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the incident report revealed that Resident R97 had a blister from the coffee spill, and that the measurements of the blister were 5.5 cm x 6.5 cm at left hip/buttock area. Observation in the main kitchen on November 15, 2024, at 9:50 a.m. revealed coffee carts for all three floors were set up with hot coffee in carafes. The Food Service Director (FSD), Employee E3, took the temperature of the coffee in the carafe's which was 182.8 degrees. She stated that the coffee had been poured about an hour earlier and would cool down to 165 degrees before being delivered at 11:00 a.m. to the floors. The water dispensed from the coffee urn was 190 degrees. Observation of the lunch meal on November 15, 2024, at 11:00 a.m. on the First floor revealed that the coffee cart was delivered and the dietary aide did not know the temperature of the beverages and he went to get a thermometer. Further observation on November 15, 2024, at 11:15 a.m. revealed that nursing aides Employees E9 and E10 were pouring coffee preparing to serve to residents on the first floor. Surveyor then stopped nursing aides until the temperature of the coffee could be taken. The coffee in the carafe was 178 degrees. Employees E9 and E10 were not aware of the facility policy that required that the temperature of the coffee not exceeded temperature of 165 degrees, did not know where to find a thermometer to take the temperature, and the nurse aides were not aware of what the temperature of the coffee before getting ready to serve it to resident on the first floor. Interview with the Nursing Home Administrator, on November 15, 2024, at 11:20 a.m. confirmed that coffee was above the facility policy which required temperature of 165 degree or less. He also acknowledged that if the nurse aides were not stopped from serving the coffee, a resident could have received coffee at an unsafe temperature above 165 degrees. Based on the deficiencies identified in the report, the NHA failed to fulfill essential duties and responsibilities of his position contributing to the immediate Jeopardy situation. Rrefer to 689. Pa Code 201.14 (a) Responsibility of Licensee Pa. Code 201.18 (a) Management

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29720 Based on observation, interview with staff and review of facility policy, it was determined that the facility did not implement enhanced barrier precautions for four residents (Residents R97, R59, R36, and R17) and no enhaced barrier precaution signage for two of six residents on barrier precautions. (Resident R10 and Resident R103). Findings include: Review of facility policy, Enhanced Barrier Precautions, revised June 2023, revealed, Use Enhanced Barrier Precautions for the management of residents colonized or infected with targeted or epidemiologically important MDRO's (e.g. wounds or indwelling devices present) where contact precautions do not apply, according to the Healthcare Infection ControlPractices Advisory Committee (HICPAC) Consideration for use of Enhanced Barrier Precautions in Skilled Nursing Facilities (2021). Continued review of above policy revealed: Enhanced Barrier Precautions include: Use of gown and gloves during high risk activities including: dressing, bathing, transferring, changing linens, provideing general hygiene assistance, toileting or changing briefs, during care and use of indwelling medical devices (central lines, urinary catheters, feeding tubes, tracheostomy tubes) and during wound care. Gowns and gloves are necessary when there is potential for exposure to body fluids through a splash or spray, or there is a risk of the healthcare provider contaminating their clothing. Observation tour on November 19, 2024 revealed no enhanced barrier precaution signage or personal protective equipment for Resident R97 who was admitted to the facility on [DATE] with a foley catheter for hydronephrosis (condition characterized by excess fluid in a kidney due to backup of urine) and urinary retention. Observation tour on November 19, 2024 revealed no enhanced barrier precaution signage or personal protective equipment for Resident R59 who was admitted to the facility on [DATE] with a feeding tube. Observation tour on November 19, 2024 revealed no enhanced barrier precaution signage or personal protective equipment for Resident R36 who was admitted to the facility on [DATE] with a foot ulcer and osteomyelitis bone infection) of the right hand. Resident R36 has a PICC line (a peripherally inserted central line that is inserted into a vein in the arm and threaded into a large vein near the heart) to receive intravenous antibiotics). Observation tour on November 19, 2024 revealed no enhanced barrier precaution signage or personal protective equipment for Resident R17 who was admitted to the facility on [DATE] with a chronic eye infection (senile ectropion of the eye and eyelid.) Observation tour on November 19, 2024 revealed no enhanced barrirer precaution signage for Resident R10 who was admitted to the facility on [DATE] with carbapenem-resistant enterobacterales (bacteria that can cause urinarytract infections that are resistant to antibiotics). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation tour on November 19, 2024 revealed no enhanced barrier precaution signage for Resident R103 who was admitted to the facility on [DATE] and has a foley cathete, candid aureus and a sacral pressure ulcer. Interview on November 15, 2024 at 1:00 pm. with Employee E27 Registered Nurse Assessment Coordinator and Infection Preventionist and Employee E28 , confirmed that the facility did not implement their policy and provide signage and ppe for above residents. 28 Pa Code 201.14(a) Responsibility of Licensee 28 Pa Code 211.12 (3)(5) Nursing Services

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 36609 Based on interviews with residents and staff and facility documentation, it was determined that the facility did not maintain a safe, and comfortable water temperatures for residents, staff and the public for three of three floors. (1st, 2nd and 3rd floor) Findings include: During a group meeting with 11 residents on November 14, 2024, at 10:00 a.m. Resident R79 and R90 who reside on the second floor complained about the water temperatures. Resident R90 stated when taking a shower this week, suddenly the water temperature changed and felt warmer. Interview with the Nursing Home Administrator on November 14, 2024, at 11: 45 a.m. revealed the facility did not have a policy regarding water temperatures , We go by the state regulations of 110 degrees. Review of the maintenance log for water temperatures revealed temperatures were maintained within the policy. Surveyors recorded water temperatures on all three floors at all three shower rooms, on each floor of residents' rooms, at each end and the middle of each hallway. Two temperatures were recorded at 115.5 degrees on the first floor and 112.4 degrees at 12:30 p.m. in the third-floor shower room. The temperature was the second-floor shower room that registered 106 degrees. When the shower faucet was adjusted very slightly, water became colder. The Maintenance Director determined the faucet was ub need of a new regulator. 28 Pa. Code 201.18(b)(3) Management