STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395262	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Healthcare and Rehabilitation Center	1521 West 54th Street Erie, PA 16509

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42655 Based on a review of facility and clinical records, resident and staff interviews, and observations, it was determined that the facility failed to provide a bath/shower as resident preference for two of 21 residents reviewed (Residents R2 and R68). Findings include: A facility policy, Resident Showers, dated 11/01/24, revealed it is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice. Residents will be provided showers as resident preference. Resident's R2's clinical record revealed an admitted [DATE], with diagnoses that included lupus (a disease when the immune system attacks your own tissue and organs), chronic obstructive pulmonary disease (a group of diseases that affects the lungs and breathing), heart disease, and rheumatoid arthritis (a chronic inflammatory disorder that typically affects the hands and feet). During an interview with Resident R2 on 1/28/25, at 2:25 p.m., he/she indicated their bath/shower was scheduled for Wednesday and Saturday evenings, but he/she has not received scheduled bath/shower in the past several weeks. Resident R2 verbalized, I am really easy. All they have to do is get me in the shower room and up over a hump, and I can do the rest. I end up washing my hair and washing up in the sink here in my room cause I stink. Review of Resident R2's bath/shower documentation for 12/28/24, through 1/28/25, revealed he/she was scheduled for a bath/shower on Wednesday/Saturday 3-11 p.m., however, no bath/shower was provided on 12/29/24, 1/01/25, and 1/15/25. Resident's R68's clinical record revealed an admitted [DATE], with diagnoses that included hemiplegia and hemiparesis following cerebral infarction (neurological conditions that cause weakness or paralysis on one side of the body after a stroke), aphasia (a language disorder that affects a person's ability to communicate), muscle weakness, and unsteadiness on feet. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident R68 on 1/28/25, at 2:30 p.m., he/she indicated their bath/shower was scheduled for Wednesday and Saturday evenings, but he/she has not received a shower since 1/14/25. Resident R68 verbalized, We are told also that the staff does not give showers on Sunday, so we never know when we will be getting an actual shower. But the last time I had water running over me was the 14th. Resident R68 was observed looking at his/her phone where he/she had the shower documented. Resident R68 was observed with greasy hair. Review of Resident 68's bath/shower documentation for 12/28/24, through 1/28/25, revealed he/she was scheduled for a bath/shower on Wednesday/Saturday 3-11 p.m., however, no bath/shower was provided on 12/29/24, 1/01/25, 1/12/25, 1/19/25, and 1/26/25. An interview with the Regional Clinical Consultant on 1/31/25, at 12:55 p.m. revealed frequency of Baths/Showers are based on resident preference and confirmed that baths/showers were not provided according to residents' scheduled days and preference for the period of 12/28/24, through 1/28/25, for above noted residents. 28 Pa. Code 211.10 (d) Resident care policies 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42655 Based on review of facility policy and clinical records, review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual 2019 (RAI-assessment guide used to plan the provision of care for residents), and staff interviews, it was determined that the facility failed to notify the resident's representative of a change in condition timely for one of 21 residents reviewed (Resident R51). Findings include: The facility policy entitled The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Resident's R51's clinical record revealed an admitted [DATE], with diagnoses that included multiple sclerosis (a disease in which the immune system destroys the protective covering of nerves resulting in nerve damage disrupting communication between body and brain), Alzheimer's disease (a disease of the brain resulting in mood and behavioral changes and poor decision making), neuromuscular dysfunction of the bladder (a condition where the nerves controlling bladder function are damaged), and muscle weakness. Review of the RAI manual for Section C0500 Brief Interview for Mental Status (BIMS) revealed that a score of 13-15 identified a resident as cognitively intact and a score of 8-12 identified a resident as moderately impaired, and a score of 0-7 as severely impaired. Resident R51's BIMS score was a 9/15. Resident R51's clinical record revealed progress notes dated 12/08/24, PCP [physician] notified of residents suprapubic cath [catheter-a thin tube inserted through abdominal wall into bladder to drain urine] leaking and no output into Foley Bag [urine collection bag]. Abdominal pain noted at insertion site. PCP ordered to send the resident to ER [emergency room] for evaluation, EMS [Emergency Medical Services] contacted and dispatched to the facility, Resident will be sent to UPMC [University of Pittsburgh Medical Center] Resident R51's clinical record revealed a physician's order dated 12/20/24, Citalopram Hydrobromide (a drug that can treat depression and/or regulates mood and behavior) 10 milligram (mg) Give 0.5 tablet by mouth daily. Resident R51's clinical record lacked evidence that Resident R51's resident representative was notified of transfer to hospital on 12/08/24, or a new physician's order on 12/20/24, for Citalopram Hydrobromide. During an interview on 1/30/25, at 1:25 p.m. the Regional Clinical Consultant confirmed the facility lacked evidence that Resident R51's resident representative was notified for the above noted change in condition/transfer to hospital or new physician's order and that Resident R51's resident representative should have been timely notified. (continued on next page)

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F 0580 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(b)(1) Management 28 Pa. Code 211.12 (d)(1)(5) Nursing services

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832 Based on review of facility policy and clinical record, and staff interview, it was determined that the facility failed to include the recapitulation of stay (summary of resident's stay and course of treatment in the facility) that included a reconciliation of all pre-discharge medications with the resident's post-discharge medications for one of four closed record residents reviewed (Closed Record Resident CR82). Findings include: A facility policy entitled Discharge Summary dated 11/01/24, indicated that upon discharge of a resident a discharge summary will be provided to the receiving care provider at the time the resident leaves the facility. Resident CR82's clinical record revealed and admitted [DATE], with diagnoses that included osteoarthritis of left knee (type of arthritis that occurs when flexible tissue at ends of bones in knee that wears down), pancytopenia (a blood disorder that occurs when the bone marrow does not form all three types of blood cells - red, white, and platelets), history of falling, and aortic valve stenosis (narrowing of the valve in the large blood vessel branching off the heart). Resident CR82's admission record indicated that Resident CR82 was discharged on [DATE], at 2:30 p.m. to home. Resident CR82's clinical record lacked documentation that the discharge summary included a reconciliation of all pre-discharge medications with the resident's post-discharge medications when Resident CR82 was discharged to home on 10/31/24. During an interview on 1/31/25, at 12:53 p.m. the Regional Clinical Consultant confirmed CR82's clincial record lacked documentation that the discharge summary included a reconciliation of all pre-discharge medications with the resident's post-discharge medications. 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 211.12(d)(1)(5) Nursing Services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832 Based on review of clinical records and facility policy, and resident and staff interviews, it was determined that the facility failed to assess and ensure safe smoking practices for one of 21 residents reviewed (Resident R50). Findings include: A facility policy entitled, Resident Smoking/Nonsmoking Facility dated 11/01/24, indicated that the facility will provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking; smoking is prohibited; all residents and family members will be notified of this policy during the admission process, and as needed; and included electronic cigarettes. Resident R50's clinical record revealed an initial admitted [DATE], with diagnoses that included nicotine dependence, respiratory failure, chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), end-stage renal disease and dependence on dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly), and dependence on supplemental oxygen. Resident R50's clinical record included a care plan entitled Resident is a smoker initiated 10/24/23, with interventions including instruct resident about smoking risks, hazards, and about smoking cessation aids that ae available; monitor oral hygiene; nicotine gum as scheduled while awake (added 2/28/24), notify charge nurse immediately if it is suspected resident has violated facility smoking policy. Resident R50's clinical record included a care plan entitled Resident had possession of nicotine substance not allowed on premises, history of smoking in resident bathroom initiated 10/26/22, with interventions including: continue to attempt to transfer to facilities that allow smoking, per resident request (added 11/20/22), discuss coping strategies (added 10/26/22), instruct patient/visitors that nicotine products may not be brought onto the premises, resident will be checked upon return of leave of absence (added 10/26/22), offer Nicorette gum per physician's order (added 11/03/22), provide information on support groups or addiction treatment (added 10/26/22), psychological/psychiatric services as indicated/ordered (added 10/26/22), and routinely check on resident to ensure he/she is not smoking inside of facility (added 11/03/22). Further review of Resident R50's clinical record revealed a departmental progress note dated 12/23/24, that indicated Resident R50 was caught by staff smoking in his/her bathroom, staff educated Resident R50 about the facility policies and not smoking in the building and that the supervisor was informed of the incident. Resident R50's clinical record lacked evidence of documentation of confiscation of cigarettes and lighters, a smoking assessment, signed smoking policy agreement, and signed admission agreement. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 1/29/25, at 12:55 p.m. of two light blue empty packs and three light blue opened partial packs of cigarettes and two lighters in Nursing Home Administrator's (NHA) office. During an interview at that time, the NHA confirmed the products belonged to Resident R50 and he/she has taken several packs of cigarettes and lighters from Resident R50 and told him/her that he/she can't smoke at the facility. During an interview on 1/29/25, at 1:09 p.m. Licensed Practical Nurse (LPN) Employee E1 confirmed that he/she had not witnessed Resident R50 smoking but had heard that he/she had been caught smoking. During an interview on 1/29/25, at 1:13 p.m. LPN Employee E2 confirmed that he/she had smelled the cigarette smoke and notified the supervisor, but never actually caught Resident R50 in the act of smoking. During an interview on 1/29/25, at 1:20 p.m. the Social Worker confirmed that on two occasions (prior to 12/23/24) he/she was asked to accompany the NHA to confiscate cigarettes and lighters from Resident R50 due to staff reported smelling smoke in the bathroom and that when Resident R50 was asked he/she volunteered cigarettes and lighters from under his/her wheelchair cushion. During an interview on 1/30/25, at 8:22 a.m. the NHA confirmed that there was no evidence of a signed admission agreement by Resident R50. During an interview on 1/30/25, at 8:36 a.m. the Social Worker confirmed that there was a no smoking policy in the Resident Handbook that is provided to residents/families on admission and believes the policy is provided on a case-by-case basis. During an interview on 1/30/25, at 9:30 a.m. Resident R50 confirmed that he/she didn't have any cigarettes/lighters at that time and has been offered alternatives but didn't like the way they made him/her feel. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(1)(d) Management 28 Pa. Code 211.10(a)(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** 40832 Based on review of facility policies and clinical records, observations, and resident and staff interviews, it was determined that the facility failed to maintain proper care of respiratory equipment for two of 21 residents reviewed (Residents R27 and R50). Findings include: A facility policy entitled Oxygen Concentrator dated 11/01/24, indicated that the concentrator filters are cleaned weekly and that the main body cabinet should be dusted when needed and can be wiped down clean with a damp cloth and mild cleanser. A facility policy entitled CPAP/BiPAP [continuous positive airway pressure/bilevel positive airway pressure] Support dated 11/01/24, revealed the following: -Only a qualified and properly trained nurse or respiratory therapist should administer oxygen through a CPAP mask. -Review the resident's medical record to determine his/her baseline oxygen saturation or arterial blood gases (ABGs- measures the balance of oxygen and carbon dioxide in your blood to see how well your lungs are working), respiratory(organs that are involved in breathing), circulatory (delivers nutrients and oxygen to all cells in the body) and gastrointestinal (group of organs that work together to digest and absorb nutrients from the food you eat) status. -Review the physician's order to determine the oxygen concentration and flow for the machine. -General guidelines included: wipe machine with warm water at last once a week; clean humidifier chamber weekly; masks, nasal pillows, and tubing are cleaned daily and allowed to air dry; and wash headgear as needed and allow to dry. -Documentation includes general assessment before procedure, time machine was started and duration of therapy, mode and settings of the machine, oxygen concentration and flow, resident tolerance, and oxygen saturation during procedure. -Notify the physician if the resident refuses the procedure. Resident R27's clinical record revealed an admitted [DATE], with diagnoses including obstructive sleep apnea (sleep disorder characterized by repeated episodes of complete or partial blockage of the upper airway during sleep), respiratory failure, heart failure, and obesity. The clinical record lacked a physician's order and/or care plan to apply a CPAP. An Inventory of Personal Effects revealed that Resident 27 brought a CPAP machine with him into the facility upon admission. Departmental progress notes revealed the following: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/05/24, at 2:04 p.m. that the facility notified the physician of abnormal carbon dioxide levels in Resident R27's lab results, and the physician responded to encourage Resident R27 to use the CPAP machine as ordered. On 12/08/24, at 1:38 a.m. that Resident R27 had fallen and that his/her oxygen saturation levels dropped into the 60%'s, and that staff applied the CPAP machine and Resident R27's oxygen saturation level rose into the 80%'s. On 12/18/24, at 9:09 a.m. that Resident R27 experienced a mental decline and that he/she was removing his/her supplemental oxygen and CPAP. On 12/18/24, at 2:24 p.m. Resident R27 was transferred to the hospital in respiratory distress due to staff not able to improve his/her oxygen saturations by using supplemental oxygen and the CPAP machine. On 1/02/25, at 5:50 p.m. Resident R27 reported chest pain, upon staff assessment he/she was offered the CPAP and Resident R27 responded the . CPAP don't work, and that the Supervisor and Director of Nursing were both informed. Observations 1/28/25, at 2:02 p.m. revealed Resident R27's CPAP mask and tubing laying on the floor between the bed and nightstand, the humidifier chamber was empty, and the machine was not attached to the oxygen concentrator. During an interview at that time, Resident R27 confirmed that the mask and tubing have been laying on the floor, that no one has cleaned the machine because he/she can't use it because it doesn't attach to the oxygen concentrator he/she has now. Observation 1/29/25, at 11:05 a.m. revealed Resident R27's CPAP mask and tubing laying on the floor between the bed and nightstand, the humidifier chamber was empty, and the machine was not attached to the oxygen concentrator. During an interview on 1/30/25, at 2:40 p.m. Licensed Practical Nurse Employee E3 confirmed the CPAP mask and tubing were on the floor, that the CPAP machine was Resident R27's personal machine from home, and that he/she didn't believe that it can be hooked up to the concentrator. During an interview on 1/30/25, at 4:03 p.m. the Nursing Home Administrator confirmed there was no physician's order, care plan, or documentation of the necessary CPAP machine settings in Resident R27's clinical record. Resident R50's clinical record revealed an initial admitted [DATE], with diagnoses that included nicotine dependence, respiratory failure, chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), end-stage renal disease and dependence on dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly), and dependence on supplemental oxygen. Resident R50's clinical record revealed a physician's order dated 1/24/25, to clean oxygen concentrator filter, change all oxygen tubing, change nebulizer tubing if in use every Friday. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 1/28/25, at 3:00 p.m. and 1/29/25, at 11:30 a.m. revealed Resident R50's oxygen concentrator filter was covered in a thick layer of greyish white, fluffy substance. During an interview on 1/30/25, at 1:35 p.m. the Assistant Director of Nursing confirmed the oxygen concentrator filter was covered in a thick layer of greyish white, fluffy substance. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832 Based on review of the facility documents and clinical records, and resident and staff interview, it was determined that the facility failed to maintain complete and accurate records relating to dialysis communication for one of 21 residents reviewed (Resident R50). Findings include: The Nursing Home Dialysis Transfer Agreement signed on 1/02/25, revealed that the facility shall ensure that all appropriate medical, social, administrative, and other information accompany all Designated Residents at the time of transfer to the center, and that the facility will provide for the interchange of information useful or necessary for the care of the Designated Resident and will inform the Center of a contact person at the Facility whose responsibilities include oversight of provision of dialysis services by Center to the Designated Residents of Facility. Resident R50's clinical record revealed an initial admitted [DATE], with diagnoses that included nicotine dependence, respiratory failure, chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), end-stage renal disease and dependence on dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly), and dependence on supplemental oxygen. The clinical record also revealed a current physician's order dated 1/24/25, to send Resident R50 to dialysis center on Monday, Wednesday, and Friday for an 11:00 a.m. chair time. Review on 1/30/25, at 5:00 p.m. of Resident R50's designated dialysis book (kept in his/her room) revealed that it contained Dialysis Communication Forms dated 1/15/25, 12/24/24, 12/22/24, 11/18/24, 11/15/24, 11/13/24, 11/11/24, 1/04/24, 10/28/24, 10/11/24, 10/09/24, 10/07/24, 10/04/24, and 9/27/24. During an interview at that time, Resident R50 confirmed that staff from the facility don't ask to see it and it depends on who's working at the dialysis center. During an interview on 1/30/25, at 6:30 p.m. the Nursing Home Administrator confirmed that Resident R50's dialysis book was missing several Dialysis Communication Forms and the forms in the book were not current. 28 Pa. Code 211.5(f)(viii) Medical Records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41309 Based on resident interviews and observations, it was determined that the facility failed to provide sufficient nursing staff to promote the physical and mental well-being and meet the needs of seven of 21 residents interviewed (Residents R2, R55, R34, R6, R186, R68, R36, R2, R41, and R19). Findings include: Interviews during the Resident Council meeting on 1/29/25, between 1:00 p.m. and 1:45 p.m., revealed seven out of seven alert and oriented residents in attendance had concerns related to staff not responding to their call bells timely. Resident R68 indicated that it could take 45 minutes or more for his/her call bell to be answered and staff are observed on their phones and occasionally have earbuds in and talking on the phone when performing care. Resident R68 stated that he/she is left wet for long periods of time waiting for assistance. Resident R68 also disclosed that on weekends there is no use asking to get out of bed, because you will wait all day for assistance to get back in bed. Resident R6 indicated that he/she will wait for 30 minutes to an hour to recieve care or assistance with the call bell once turning it on. Resident R2 agreed that he/she observes and witnesses long call bell waits and employees constantly on their phones and talking to significant others on the phone or performing care with ear buds in. Residents R55, R34, R186, and R36 indicated they wait 30 minutes or longer when their call bell is turned on to be responded to by staff. During an interview on 1/28/25, at 2:25 p.m. Resident R2 revealed he/she was frustrated that it takes over an hour for his/her call bell to be responded to by staff. Resident R2 further indicated that staff are always sitting at the desk on their phones or in the hallways with their phones; sometimes, the staff will even be on their phones when they are in the residents' rooms. During an interview on 1/28/25, at 2:30 p.m. Resident R68 revealed that his/her call bell can be on for an hour easily and even more on the weekends. Resident R68 verbalized, I will not get out of bed on the weekends due to being left in my chair then for way too long. One weekend, I was left in my wheelchair for nine hours. I was in so much pain and I was totally soaked. An observation on 1/29/25, at 10:25 a.m. revealed a call light on for room [ROOM NUMBER]. The call light continued on for a period of 30 minutes and during that time, the Director of Nursing (DON) was requested to address the call light at 10:55 a.m. Resident R41 indicated that it was his/her call bell on for past 30 minutes and that he/she was incontinent and needed changed. The DON confirmed that 30 minutes was too long for a resident to have to wait for their call bell to be answered, being left incontinent and at risk for skin breakdown. During observation of a dressing change of Resident R19 on 1/30/2025, at about 10:30 a.m. it was observed upon preparing the resident for the dressing change that Resident R19 was lying in bed dressed with an adult undergarment on wet with urine and soaked through to the bed pad and bed sheets. Licensed Practical Nurse (LPN) Employee E4 was observed and cleaned and changed the resident prior to performing the dressing change. LPN Employee E4 confirmed that Resident R19 was lying in bed in urine for an extended period of time. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Healthcare and Rehabilitation Center	1521 West 54th Street Erie, PA 16509

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(4)(5) Nursing services

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 41309 Based on observations and staff interview, it was determined that the facility failed to ensure that the required nursing staffing information was posted on a daily basis. Findings include: Observations on 1/28/25, at 1:00 p.m., 1/29/25, at 9:00 a.m., and 1/30/25, at 1:00 p.m. revealed that the daily staffing posting was not posted in the facility. During an interview on 1/30/25, at 1:10 p.m. the Nursing Home Administrator, confirmed that the staffing was not posted as required. 28 Pa. Code 211.12 (c) Nursing services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42655 Based on review of clinical and facility records, and resident and staff interviews, it was determined that the facility failed to ensure medications were administered, whether prescribed on a routine, emergency, or as needed basis, to not impede timely administration and adversely affect a resident's condition for one of 21 residents reviewed (Resident R234). Findings include: Facility pharmacy policy, Specialty Rx, Inc. PA ADS [Automated Dispensing System] Station Medication Policies and Procedures, dated 11/01/24, revealed Nursing and Pharmacy will use the ADS Station as an inventory, charging and information system for the control and distribution of medications for Emergency, First-Dose use and other situations where medications are not available from pharmacy. (NOT TO BE USED FOR CONTINUOUS DOSING). Emergency doses for narcotic medications removed from the ADS system will require a written order from a prescriber (order should include that medication can be taken from the ADS) and would require signature within 48 hours per regulations. The facility must contact the pharmacy and obtain an authorization code for removal of any controlled substance. An authorization code can only be given if the pharmacy has a script on file with quantity remaining matching the controlled substance the facility wishes to remove. If there is no script on file, the pharmacist will page the prescriber for an electronic prescription or an emergency supply. Facility provided report on 1/31/25, by the Nursing Home Administrator (NHA) entitled Inventory on Hand, C11 revealed Hydroco/APAP Tab 5-325 mg as medication available in the emergency ADS Station supply within the facility for resident emergency, first dose, and other situations where medications are not available from the pharmacy. Resident R234's Admission Record revealed an admitted [DATE], with diagnoses that included Parkinson's disease (a disorder of the central nervous system that affects movement), cardiac arrythmias (improper beating of the heart, whether irregular, too fast or too slow), bipolar disorder (a mental health condition that affects mood swings ranging from depressive lows to maniac highs), and dysphagia (difficulty swallowing foods or liquids). Resident R234's clinical record revealed progress notes dated 1/25/25, at 5:01 p.m. that Resident complained of pain this shift. Resident family (brother) called facility asked for pain medication for Resident R234. Facility nurse looked in resident orders to find resident has only prn (as needed) Tylenol ordered at this time for pain. Facility nurse called Nurse Practitioner (NP). New order for Norco 5 milligrams (mg) Q (every) 12 Hrs P.O. (by mouth) E-script (electronic medication prescription). NP sent E-scripts to pharmacy. This author called pharmacy and asked to be given a pull code for E-kit (emergency medication kit). Pharmacist stated no because I have already packed up the medication and it will be leaving here in about 20 minutes. Facility nurse stated to pharmacist I believe you maybe 5-6 hours away, and resident already have had to wait this long. Pharmacist stated, well I cannot unwrap medication from delivery stock. Facility nurse stated ok. Facility nurse notified nursing supervisor, RN. This author then called DON (Director of Nursing), because he/she was here in his/her office to see if he/she could talk with pharmacy about Resident R234's medication. Awaiting outcome. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident R234's clinical record revealed his/her Medication Administration Record (MAR) dated 1/25/25, for a physician order Hydrocodone-Acetaminophen oral tablet 5-325 mg (Hydrocodone-Acetaminophen) Give one tablet by mouth every 12 hours as needed for Pain-Moderate with a start date 1/25/25, 3:00 p.m. and discontinue date date 1/27/25, at 12:01 p.m Resident R234's MAR further revealed that Resident R234 was administered the first dose of Hydrocodone-Acetaminophen 5-325 mg oral tablet at 11:09 p.m. on 1/25/25. During an interview with Resident R234 on 1/28/25, at 1:30 p.m. he/she indicated the facility did not ensure he/she was medicated for pain. Resident R234 further indicated he/she had to wait a long time for pain medication, even when it was finally ordered by the physician on 1/25/25, it took several hours to actually get it. Resident R234 indicated that he/she had discomfort with leg and back cramps related to Parkinson's disease. During an interview on 1/31/25, at 8:55 a.m. the NHA confirmed that the Hydrocodone-Acetaminophen 5-325 mg medication was available in the emergency medication stock in the facility and Resident R234 should have been administered the medication at 5:01 p.m. on 1/25/25, per the physician's order. The NHA further confirmed that the pharmacist failed to further communicate with the physician the need for a further script for a one-time dose, since he/she would not provide the facility nurse an authorization code from the initial script for the Hydrocodone Acetaminophen 5-325 mg medication at 5:01 p.m. 1/25/25, delaying the acquisition of a medication and impeding the timely administration to help with Resident R234's pain. 28 Pa. Code 211.9(a)(1)(d)(l)(4) Pharmacy services 28 Pa. Code 211.12(d)(1)(3)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832 Based on review of Centers for Disease Control (CDC) vaccine guidance, facility policy, observation, and staff interview, it was determined that the facility failed to safely store medications in one of two medication rooms observed (East Wing). Findings include: A facility policy entitled Multi-Dose Vials (contain more than one dose of medication) dated [DATE], indicated that when a multiple dose vial is opened it shall be labeled with date open, medications will be discarded as per manufacturer guidelines for vaccines. Observation on [DATE], at 11:44 a.m. of the East Wing medication room revealed a multi-dose vial of Flucelvax (vaccine that protects against the flu) was opened, lacked an opened date, and lacked guidance related to discarding opened vials. During an interview at that time the Assistant Director of Nursing confirmed that the multi-dose vial lacked an open date, and that staff cannot tell when the vaccine should be discarded. Review of the CDC web site revealed that the guidance for opened multi-dose vials is to discard 28 days after opening. On [DATE], at 12:07 p.m. information obtained by the facility from the dispensing pharmacy confirmed pharmacy indicated the multi-dose vial would be expired 28 days after opening. 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1)(5) Nursing Services

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42655 Based on review of clinical and facility records, observation, and resident and staff interviews, it was determined that the facility failed to ensure the use of dentures for two of 21 residents reviewed (Residents R51 and R187). Findings include: Review of a facility policy entitled, Care of Dentures with an annual review date of 11/01/2024, revealed Dentures that are missing, damaged, or lost and the facility or facility are at fault, a referral will be made promptly within three days. Facility responsibilities include dropped, stolen, and/or broken by our employees. facility is not responsible for the resident discarding themselves or ill fitting dentures or partials at admission. Facility will assist resident/responsible party with non-facility related denture issues. Resident's R51's clinical record revealed an admitted [DATE] with diagnoses that included multiple sclerosis (a disease in which the immune system destroys the protective covering of nerves resulting in nerve damage disrupting communication between body and brain), Alzheimer's disease (a disease of the brain resulting in mood and behavioral changes and poor decision making), neuromuscular dysfunction of the bladder (a condition where the nerves controlling bladder function are damaged), and muscle weakness. Resident R51's Inventory of Personal Effects dated 3/23/22, indicated the resident had upper and lower dentures. Resident R51's 360 Care of Pennsylvania Dental provider log revealed on 12/18/24, he/she was evaluated by the dentist. A description of the dental visit dated 12/18/24, revealed Exam Medical History - reviewed, Patient presents for periodic exam. Patient is edentulous has upper and lower denture. Denture(s) fit well and patient is satisfied. Resident R51's dental care plan dated 11/06/24, indicated Resident 51 required assistance with oral hygiene and to wear his/her dentures, and nursing staff are to report changes in oral cavity, chewing ability, signs and symptoms or oral pain, etc. An interview with Resident R51 on 1/29/25, at 1:00 p.m. revealed that he/she was missing his/her upper dentures. Resident R18 verbalized, Oh I would like to have my dentures. I need them. An interview with the Nursing Home Administrator (NHA) on 1/30/25, at 11:00 a.m. confirmed that Resident R51 did not have his/her upper and lower dentures, and no investigation or follow-up process had been initiated by the facility to replace the dentures. Resident's R187's clinical record revealed an admitted [DATE] with diagnoses that included cerebral infarction (a condition in which blood flow to the brain is interrupted, causing brain tissue to die), [NAME] syndrome (an immune system illness that mainly causes dry eyes and mouth), vascular dementia with mood disturbance (experiencing mood changes such as depression, anxiety, depression, or apathy related to having dementia), and brief psychotic disorder. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident R187's Inventory of Personal Effects dated 7/7/23, indicated the resident had one upper partial upon admission. An evaluation of speech sound production and language assessment on 7/10/23, revealed that upon a general, facial, and mandibular assessment: Oral Motor Function = WFL (for mechanical soft chopped food items. Resident has upper partial that she removes from oral cavity and does not always wear during oral intake). A social services progress note dated 7/11/23, at 8:57 a.m. revealed, Concern that upper partial is missing since Sunday 7/9, last seen Sat 7/8 in denture cup. Discussed dietary preferences No coffee/tea/milk, No eggs, enjoys orange juice, ice water and ginger ale. Resident does not like sandwiches nut enjoys fish, chicken, noodles, rice, vegetables and bananas. A progress note from 7/12/23, at 9:31 a.m. revealed observed a denture cup in the garbage can in res room. Looked through garbage can, in nightstand, dresser, in pockets of clothing items, in bathroom medicine cabinet; did not see partial. Res does not recall wearing partial. Partial not in residents mouth. Notified nursing of the above. LPN reported that clothing items were removed from res garbage can in the previous days. Nursing, Social services, DON [Director of Nursing], ADON [Assistant Director of Nursing] and Administrator notified. An interview with the Nursing Home Administrator (NHA) on 1/30/25, at about 3:00 p.m., confirmed that Resident R187 did have an upper partial upon being admitted to the facility on [DATE], according to the inventory sheet. They did go missing according to documentation record, and no evidence of an investigation or follow-up process had been initiated by the facility to replace the dentures. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a) Resident rights

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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** 42655 Based on review of facility and clinical records, observations, and staff and resident representative interviews, it was determined the facility failed to ensure that residents with an indwelling catheter (a tube inserted into the bladder to facilitate urine drainage) receive essential care for one of 21 residents reviewed with indwelling catheters (Resident R14). Findings include: Facility policy entitiled, Catheter Care dated 11/01/24, revealed it is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. Privacy bags will be available and catheter drainage bags will be covered at all times while in use. Ensure drainage bag is located below the level of the bladder to discourage backflow of urine and not to be located on the floor. Resident R14's clinical record revealed an admitted [DATE], with diagnoses that included osteomyelitis of vertebra, sacral, and sacrococcygeal region (inflammation of bones of lower spine caused by infection), paraplegia (impairment or loss of motor and sensory functions of both legs), absence of left leg above knee, and protein-calorie malnutrition (a condition when the body does not receive enough protein through diet). Observation on 1/28/25, at 1:55 p.m., revealed Resident R14's catheter tubing stretched out with the drainage bag laying in the center of the floor beside the left of bed. Resident R14 indicated at this time, that he/she did not place the bag on the floor, but staff would be in to empty the catheter bag. Observation on 1/29/25, at 1:00 p.m., revealed Resident R14's catheter drainage bag laying on the floor beside the left of bed. Observation on 1/30/25, at 3:05 p.m., revealed Resident R14's catheter drainage bag uncovered and laying on the floor beside the left of bed. An interview with Licensed Practical Nurse (LPN) Employee E1 on 1/30/25, at 3:05 p.m. confirmed that Resident R14's foley catheter bag was observed laying on the floor. LPN Employee E1 further confirmed the foley catheter should be covered and maintained off the floor for dignity and infection control measures to prevent an infection. An interview with the Nursing Home Administrator on 1/30/25, at 5:00 p.m. confirmed that Resident R14's foley catheter bag should be covered to ensure dignity and be maintained off the floor and/or not touch an unclean surface due to risk for infection. 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 41309 Based on review of facility employee in-service training records and staff interview, it was determined that the facility failed to assure that staff completed all the required mandatory trainings for the yearly Nurse Aide (NA) 12-hour mandatory trainings. Findings include: Review of requested records or evidence of in-service mandatory training for all NA's from 1/2024 through 1/2025 was incomplete upon review. The facility was unable to provide complete evidence of completed competencies the the past year. During an interview on 1/31/25, at 2:30 p.m. the Nursing Home Administrator confirmed that no evidence could be provided of NA's 12-hour mandatory in-service trainings as required. 28 Pa. Code 211.12(d)(3)(5) Nursing services 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.19(7) Personnel policies and procedures