STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395265	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion at St Luke Village, The	1000 Stacie Drive Hazleton, PA 18201

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 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** 48276 Based on observation, review of clinical records and the minutes from Residents' Council meetings, and staff and resident interviews, it was determined that the facility failed to afford residents the right to make choices about aspects of their life in the facility that are significant to them for two out of 24 sampled residents (Residents 21 and 72). Findings include: Clinical record review revealed Resident 21 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and heart failure (a condition that develops when the heart doesn't pump enough blood to meet the body's needs). A quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 24, 2024, revealed that Resident 21 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). Resident 21's plan of care, dated September 1, 2020, indicated that the resident's preferred activity was going outside to smoke. An Occupational Therapy Evaluation Form, dated January 23, 2024, indicated that Resident 21 used a wheelchair for mobility with minimal help required from staff. A Smoking Evaluation Form dated May 11, 2024, indicated that Resident 21 is a safe smoker who needs constant supervision while smoking. Clinical record review revealed Resident 72 was admitted to the facility on [DATE], with diagnoses that included hemiplegia (weakness on one side of the body) and hemiparesis (paralysis on one side of the body) following a cerebral infarction (brain damage that results from a lack of blood) affecting the right dominant side. (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	A review of a quarterly Minimum Data Set assessment dated [DATE], revealed that Resident 72 has moderate cognitive impairment with a BIMS score of 09 (a score of 08-12 indicates moderate cognitive impairment). Resident 72's plan of care, dated October 21, 2021, indicated that the resident was a smoker A Smoking Evaluation Form dated February 1, 2024, indicated that Resident 72 is a safe smoker who needs constant supervision while smoking. An Occupational Therapy Evaluation Form, dated May 14, 2024, indicated that Resident 72 used a wheelchair for mobility with substantial help from staff required. A behavior contract titled Smoke-free/Tobacco-Free Violation indicated that the residents met with the facility's administrative staff to discuss changes to the smoking policy and the consequences of not following the new rules effective May 10, 2024. The contract document stated that smoking was no longer allowed on facility grounds. If residents choose to smoke, they are required to sign out of the facility on a leave of absence. All smoking items, including lighters and cigarettes, are to be kept at the facility front desk. Any violations could result in the resident being discharged from the facility. A review of Resident Council meeting minutes dated June 5, 2024, revealed that the smoking policy changes and revisions were discussed and the facility is a non-smoking facility as of May 10, 2024. During an interview on July 17, 2024, at 2:00 PM, Resident 21 stated that about three months ago, the facility changed the resident smoking policy. The Nursing Home Administrator (NHA) informed her that smoking would no longer be allowed at the facility. Resident 21 stated that if she wanted to continue smoking, staff would not provide assistance or supervision, and she would need to sign out and smoke across the street. She stated that she uses a wheelchair for mobility and has tried to reach the designated smoking area, but she is not strong enough to make the trip without help. Resident 21 said she can only smoke when her family visits and assists her to the smoking location. She expressed frustration, saying she is very upset that the facility no longer allows her smoke on facility grounds. During an interview on July 18, 2024, at 10:00 AM, Resident 72 stated that a few months ago, the facility had a meeting during which he was informed that staff would no longer assist residents with smoking. The resident stated that now, if he wants to smoke, he must travel across the street. Resident 72, stated he needs a wheelchair for mobility and cannot cross the street without assistance. He explained that he has smoked all his life and feels terrible that the facility no longer provides him assistance with smoking. Resident 72 explained that his family member has tried to help him get to the smoking area, but she has difficulty pushing him to the location. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on July 18, 2024, at 10:30 AM, the NHA confirmed the location of designated resident smoking area is loacted across the street from the facility. Observation revealed that the road was uneven, with a sloped gradient, multiple cracks, and divots, which potential hazards and obstacles to safe mobility to the location, including wheelchair mobility. The NHA confirmed that a resident in a wheelchair may have difficulty making the trip safely to the smoking location. The NHA confirmed that the facility implemented a smoke and tobacco free policy on May 10, 2024, and ceased to provide Residents 21 and 72 with staff assistance to continue to smoke safely. The NHA stated smoking cessation programs and assistance with transferring to another facility were offered to residents who wished to continue to smoke. The facility failed to allow current residents who smoke to continue smoking in an area that maintains the quality of life and safety of these residents, while taking into account non-smoking residents. The facility failed to provide an accessible outside smoking area that may be safely accessed by the current residents who smoked at the time the facility changed their smoking policy. 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 201.29 (a) Resident Rights

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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** 21738 Based on review of clinical records, select facility incident reports, and select facility grievance reports, and staff interview, it was determined that the facility failed to timely notify the resident representative of an allegation of physical abuse of one resident out of 24 sampled (Resident 35). Findings include: A review of the clinical record revealed that Resident 35 was admitted to the facility on [DATE], with diagnoses which included spinal stenosis (the space around the spinal cord becomes too narrow which puts pressure on the spinal cord and nerves) and hypertension. A review of Resident 87's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses, which included Alzheimer's disease. Review of a facility incident report dated July 9, 2024, at 4:30 PM revealed that Resident 35 reported to a staff member that Resident 87 was in her room uninvited and slapped her in the face, when Resident 35 told Resident 87 to put down her orange. Review of a facility grievance report dated, July 11, 2024, indicated that Resident 35's resident representative (also the resident's medical and financial Power of Attorney) was upset that she was not called regarding the incident on July 9, 2024, during which Resident 87 wandered into Resident 35's room and slapped Resident 35 in the face. A review of Resident 35's clinical record revealed no documented evidence that the facility had notified the resident's representative of the reported physical abuse of Resident 35 perpetrated by Resident 87. An interview with the Nursing Home Administrator on July 18, 2024, at approximately 1:30 PM confirmed the facility failed to timely notify the resident's representative that Resident 35 reported being physically abused by Resident 87. 28 Pa. Code 211.12 (d)(3)(5) Nursing services 28 Pa. Code 201.29 (b) Resident rights

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on observations and resident and staff interviews, it was determined that the facility failed to provide a comfortable environment for one resident out of the 24 sampled (Residents 89). Findings include: Clinical record review revealed Resident 89 was admitted to the facility on [DATE], with diagnoses that included spinal stenosis (a condition where the spaces in the spine narrow and create pressure on the spinal cord and nerve roots that may cause pain or weakness). A review of an admission Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 21, 2024, revealed that Resident 89 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). During an interview on July 16, 2024, at 1:55 PM, Resident 89 stated that he was admitted to the facility over a month ago. He stated that he has complained to facility staff that the temperature in his room (room [ROOM NUMBER]) was too warm and often very uncomfortable for him. Resident 89 stated that the cooling unit in his room has not been working since he was admitted to the facility. He recalled that the hottest days over the past few weeks were awful because it was so warm in his room. He stated that the facility offered him a room change, but he wants to remain in this room, but to able to lower the room temperature and have a working cooling unit. During an observation and interview on July 19, 2024, at 9:45 AM, Employee 5, a maintenance technician, stated that the air cooling unit in resident room [ROOM NUMBER] has not been functioning for over a month. He tested the air temperature, at 75.1 F. Employee 5 stated that he did not know the status of the work orders to repair the air-cooling unit in Resident 89's room. A review of a maintenance request order dated May 24, 2024, at 10:00 AM revealed that the AC in resident room [ROOM NUMBER] was not working but had not yet been repaired at the time of the survey ending July 19, 2024. During an interview on July 19, 2024, at approximately 10:45 AM, the Nursing Home Administrator (NHA) was not able to provide evidence that repairs or replacements were scheduled or in progress for the cooling unit in resident room [ROOM NUMBER]. The NHA confirmed that it is the facility's responsibility to ensure that residents are provided with a comfortable environment, including comfortable and safe temperatures. 28 Pa. Code 201.18 (e)(2.1) Management 28 Pa. Code 201.29 (a) Resident Rights

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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** 21738 Based on review of clinical records, the facility's abuse prohibition policy and select investigative reports, and resident and staff interviews, it was determined that the facility failed to ensure that one resident was free was free from physical abuse and mental anguish out of 11 residents sampled (Resident 35). Findings include: The facility's Abuse, Neglect, Exploitation, and Misappropriation Policy, last reviewed on May 9, 2024, revealed Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Physical abuse includes but is not limited to hitting, slapping, punching, biting, and kicking. Acts of abuse directed against residents are absolutely prohibited. Prevention includes having sufficient numbers of staff to meet the needs of residents, monitoring of residents who may be at risk is the responsibility of all facility staff. The abuse coordinator or designee will investigate all reports of allegation of abuse, neglect, misappropriation and exploitation. The abuse coordinator or director of nursing will take statements from the victim, the suspect, and all possible witnesses including all other employees in the vicinity of the alleged abuse. Upon completion of the investigation, a detailed report shall be prepared. The policy noted that all reported events will be investigated by the Director of Nursing or designee. Patterns or trends will be identified that might constitute abuse. This information will be forwarded to the Executive Director, who will serve as the facility's abuse coordinator, and an abuse investigation will be conducted in the absence of the Executive Director. The DON will serve as the abuse coordinator. Furthermore, the policy indicates that residents will be evaluated for any signs of injury, including a physical exam and/or psychosocial assessment, as appropriate. A review of the clinical record revealed that Resident 35 was admitted to the facility on [DATE], with diagnoses, which included spinal stenosis (the space around the spinal cord becomes too narrow which puts pressure on the spinal cord and nerves) and hypertension. The resident was cognitively intact with a BIMS (Brief Interview for Mental Status - a score of 13-15 equates to intact cognition) score of 13 according to the admission MDS assessment dated [DATE]. A review of Resident 87's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses which included Alzheimer's disease and was severely cognitively impaired. Review of a facility incident report dated July 9, 2024, at 4:30 PM revealed that Resident 35 reported to a staff member that Resident 87 was in her room uninvited and slapped her in the face when she told Resident 87 to put down her orange. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility incident report revealed that Employee 7 (RN Supervisor) was called to Resident 35's room to discuss a complaint received. Resident 35 stated that she went to go bingo with her roommate (Resident 38). Resident 35 placed the stop sign (Velcro door guard placed between door jams of door) on the door before leaving. After bingo, Resident 35 went back to her room and the stop sign was off the door. Resident 35 entered the room with Resident 38 behind her. When Resident 35 passed the bathroom door, it swung open and almost hit Resident 38's wheelchair. Resident 35 stated that Resident 87 came out of the bathroom and proceeded to walk around the room. Resident 87 was touching and grabbing everything. Resident 87 picked up an orange from her table and Resident 35 told her to put it back. Resident 87 put the orange in her pocket. Resident 35 yelled at Resident 87 put it back! It's not yours and you can't have it!. Resident 35 stated that Resident 87 became angry and slapped her in the face. Resident 35 yelled at Resident 87 again and Resident 87 then left the room. The facility incident report Immediate Action Taken section revealed Resident 35 was assessed and no injuries were noted. Resident 35 stated that she was fine. Resident 38 (roommate) was unable to give witness statement due to impaired cognition. Resident 35 was encouraged to close her door when exiting her room and visit with Resident 87 if she wishes in a common area. Resident 87 placed with residential assistant for closer supervision and redirection. Interview with Employee 7 (RN Supervisor) on July 18, 2024, at 1:30 PM revealed that she was initially notified of the incident of physical abuse of Resident 35 by a nurse aide (was unable to recall which aide) who came to her and said that you need to talk to Resident 35 because Resident 35 and Resident 87 got into it. Employee 7 stated that Resident 87 was becoming more agitated lately and had the potential to hit someone if they told her no or tried to take something she wanted. Employee 7 confirmed that Resident 87 would enter other residents' rooms uninvited. During interview with Resident 35 on July 17, 2024, at 11:00 AM the alert and oriented resident confirmed that the incident with Resident 87 did occur on July 9, 2024, and that Resident 87 slapped her in the face and she was upset that the incident occurred. Resident 35 stated that she was not afraid of Resident 87 but did not want Resident 87 entering her room and taking her things due to Resident 87's potential to become angry and hit her again. An interview with the nursing home administrator on July 19, 2024, at approximately 9:30 AM confirmed that the facility failed to ensure that Resident 35 was free from physical abuse and mental anguish perpetrated by Resident 87. Refer F610 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 201.29 (a)(c) Resident Rights 28 Pa. Code 211.12(c)(d)(5) Nursing Services

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records, the facility's abuse prohibition policy, and select facility incident reports, and resident and staff interview, it was determined that the facility failed to investigate an injury of unknown source to rule out abuse, neglect, or mistreatment for one resident (Resident 24) and failed to thoroughly investigate an allegation of physical abuse of one resident (Resident 35) out of 24 residents sampled. Findings include: The facility's Abuse, Neglect, Exploitation, and Misappropriation Policy, last reviewed on May 9, 2024, revealed that it is the facility policy that any employee who has knowledge of an injury of an unknown source is obligated to report such information immediately, but no later than two hours or no later than 24 hours if the events do not result in serious bodily injury to the administrator and to other officials in accordance with state law. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Physical abuse includes but is not limited to hitting, slapping, punching, biting, and kicking. Acts of abuse directed against residents are absolutely prohibited. Prevention includes having sufficient numbers of staff to meet the needs of residents, monitoring of residents who may be at risk is the responsibility of all facility staff. The abuse coordinator or designee will investigate all reports of allegation of abuse, neglect, misappropriation and exploitation. The abuse coordinator or director of nursing will take statements from the victim, the suspect, and all possible witnesses including all other employees in the vicinity of the alleged abuse. Upon completion of the investigation, a detailed report shall be prepared. All reported events will be investigated by the Director of Nursing or designee. Patterns or trends will be identified that might constitute abuse. This information will be forwarded to the Executive Director, who will serve as the facility's abuse coordinator, and an abuse investigation will be conducted in the absence of the Executive Director. The DON will serve as the abuse coordinator. Furthermore, the policy indicates that residents will be evaluated for any signs of injury, including a physical exam and/or psychosocial assessment, as appropriate. A clinical record review revealed Resident 24 was admitted to the facility on [DATE], with diagnoses that include dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities) and atrial fibrillation (a condition that causes the heart to beat irregularly and sometimes much faster than normal). A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated July 6, 2024. revealed that Resident 24 was severely cognitively impaired with a BIMS score of 03 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 01-07 indicates severe cognitive impairment). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's care plan, dated October 21, 2020, revealed that the resident was receiving anticoagulant therapy (a class of medication that prevents blood clots from forming in the bloodstream) related to atrial fibrillation. The care plan, dated January 1, 2021, indicated that Resident 24 had impaired cognition, functioning, or impaired thought processes related to dementia, impaired decision-making, short-term memory loss, and difficulty making decisions. The resident had a physician's order for Pradaxa oral capsule 150 mg (an anti-coagulant medication) with instructions to give 1 capsule by mouth every 12 hours. A nursing progress note dated June 13, 2024, at 9:55 AM revealed that Resident 24 had blood clots in her brief that appeared to be coming from her vagina. The resident denied pain and her vitals were within normal limits. The physician was notified. A nursing progress note dated June 14, 2024, at 4:26 AM indicated that the resident's Pradaxa medication would be held for three days, then restarted. Resident 24's son was notified. A nursing progress note dated June 15, 2024, at 10:24 AM indicated that a small amount of pink blood was found in the resident's brief. The resident denied pain. A nursing progress note dated June 27, 2024, at 10:31 AM indicated that Resident 24 had vaginal bleeding in brief, the physician was notified, and a new order noted to hold Pradaxa Oral capsule 150 mg (anti-coagulant) for three days for moderate amounts of vaginal bleeding. A physician order was noted on July 5, 2024, to hold the resident's Pradaxa for moderate vaginal bleeding. A nursing progress note dated July 5, 2024, at 11:13 PM indicated Resident 24 had moderate vaginal bleeding without complaints or signs or symptoms of pain. A nursing progress note dated July 14, 2024, at 3:34 PM indicated that hematuria was noted in Resident 24's brief. A nursing progress note dated July 15, 2024, at 3:21 PM indicated that the physician was aware of the vaginal bleeding and ordered a consultation with a gynecologist. During an interview on July 16, 2024, at approximately 1:00 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) were unable to provide documented evidence that Resident 24's unexplained vaginal bleeding was investigated as a potential injury of unknown origin and Resident 24 was physically examined to ensure she was free from abuse or mistreatment. The NHA and DON confirmed that Resident 24 was severely cognitively impaired and unable to communicate the possible cause of the bleeding. The NHA and DON confirmed that the facility did conduct an investigation and examination to rule out abuse, neglect or mistreatment as a potential cause of the resident's vaginal bleeding. In response to surveyor inquiry during the survey, a nursing progress note dated July 16, 2024, at 3:31 PM was entered into the clinical record noting that a head-to-toe assessment was conducted of Resident 24 for vaginal bleeding. The resident was examined for signs of abuse, and no suspicious findings were identified. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the clinical record revealed that Resident 35 was admitted to the facility on [DATE], with diagnoses which included spinal stenosis (the space around the spinal cord becomes too narrow which puts pressure on the spinal cord and nerves) and hypertension. The resident's admission MDS assessment dated [DATE], indicated that the resident was cognitively intact. A review of Resident 87's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses which included Alzheimer's disease. A facility incident report dated July 9, 2024, at 4:30 PM revealed that Resident 35 reported to a staff member that Resident 87 was in her room uninvited and slapped her in the face when she told Resident 87 to put down her orange. The facility incident report revealed that Employee 7 (RN Supervisor) was called to Resident 35's room to discuss a complaint received. Resident 35 stated that she went to go bingo with her roommate (Resident 38). Resident 35 placed the stop sign (Velcro door guard placed between door jams of door to deter intrusive wandering) on the door before leaving. After bingo, Resident 35 went back to her room and the stop sign was off the door. Resident 35 entered the room with Resident 38 behind her. When Resident 35 passed the bathroom door, it swung open and almost hit Resident 38's wheelchair. Resident 35 stated that Resident 87 came out of the bathroom and proceeded to walk around the room. Resident 87 was touching and grabbing everything. Resident 87 picked up an orange from her table and Resident 35 told her to put it back. Resident 87 put the orange in her pocket. Resident 35 yelled at Resident 87 put it back! It's not yours and you can't have it!. Resident 35 stated that Resident 87 became angry and slapped her in the face. Resident 35 yelled at Resident 87 again and Resident 87 then left the room. The facility incident report, Immediate Action Taken section, revealed that Resident 35 was assessed and no injuries were noted. Resident 35 stated that she was fine. Resident 38, Resident 35's roommate, was unable to give a witness statement due to cognition. Resident 35 was encouraged to close her door when exiting her room and visit with Resident 87 if she wishes in a common area. Resident 87 was placed with residential assistant for closer supervision and redirection. The investigation concluded that Resident 87 or Resident 38 were unable to give a statement about what occurred due to cognition and that no staff or residents witnessed the incident occurred. Due to the lack of corroborating evidence to support the allegation, the facility is unable to substantiate that physical abuse occurred. However, a review of the witness statements, revealed that the facility failed include a statement from the staff member who initially reported the incident to Employee 7 (RN Supervisor). The investigation noted that Resident 38 was unable to give a statement due to cognition. Interview with Employee 7 (RN Supervisor) on July 18, 2024, at 1:30 PM revealed that she was initially notified of the physical abuse of Resident 35 by a nurse aide (was unable to recall which nurse aide) who came to her and said that you need to talk to Resident 35 because Resident 35 and Resident 87 got into it. Employee 7 stated that Resident 87 was becoming more agitated lately and had the potential to hit someone if they told her no or tried to take something she wanted. Employee 7 confirmed that Resident 87 would enter other residents' rooms uninvited. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with Resident 35 on July 17, 2024, at 11:00 AM the alert and oriented resident confirmed that the incident with Resident 87 did occur on July 9, 2024, and that Resident 87 slapped her in the face and she was upset that the incident occurred. Resident 35 stated that she was not afraid of Resident 87 but did not want Resident 87 entering her room because she takes things and has the potential to become angry and hit her again. Interview with the administrator on July 19, 2024, at approximately 9:30 AM failed to provide documented evidence that a thorough investigation, which included interviewing all potential witnesses, was completed as per the facility abuse policy in response to Resident 35's report that she was physically abused by Resident 87. Refer F600 28 Pa. Code 201.14 (a)(c) Responsibility of licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29 (a)(c) Resident Rights 28 Pa. Code 211.12 (c) Nursing Services

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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** 41581 Based on a review of clinical records and the Resident Assessment Instrument and staff interview, it was determined that the facility failed to ensure that the Minimum Data Set Assessments (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) accurately reflected the status of one resident out of 24 sampled (Residents 96). Findings included: A review of Resident 96's clinical record revealed that the resident was admitted to the facility on [DATE], and discharged from the facility on June 18, 2024. A review of Resident 96's Discharge MDS assessment dated [DATE], revealed in Section A2105 Discharge Status that Resident 96 was discharged to a short term general hospital. A review of the resident's Discharge Plan and Instructions revealed the resident was discharged home, and the June 18, 2024, discharge MDS was inaccurate. Interview with the Nursing Home Administrator on July 19, 2024, at approximately 9:20 AM, confirmed the aforementioned MDS Assessment was inaccurate.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on review of select facility policy and clinical records and staff interviews it was determined that the facility failed to provide nursing services consistent with professional standards of quality to ensure that licensed nurses accurately and fully evaluated and documented the results of those evaluations and assessments to demonstrate that the resident received timely and necessary care to promote the health of one resident (Resident 94) out of 24 residents reviewed. Findings included: According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates that the registered nurse was to collect complete ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health-care team by exercising sound judgement based on preparation, knowledge, skills, understandings and past experiences in nursing situations. The LPN participates in the planning, implementation and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) Document and maintain accurate records. A review of facility policy entitled Non-Pressure Skin Condition Record last reviewed May 9, 2024, revealed a resident will have a Non-Pressure Skin Record completed for each skin impairment that is not related to pressure. The facility staff will document the date, size, drainage, description of the wound area and the peri-wound area. A review of the clinical record of Resident 94 revealed admission to the facility on [DATE], with diagnoses, which included Type 2 diabetes, pressure ulcer to the right heel, non-pressure ulcer to the right lower leg, and non-pressure ulcer to the left lower leg. A review of an Admission assessment dated [DATE], revealed the resident had the following wounds: A 14.5 cm x 16 cm venous ulcer to the front right lower leg which appeared red with exposed fat tissue. A 13 cm x 26 cm venous ulcer to the front left lower leg which appeared red with exposed fat tissue. A 5.5 cm x 2.5 cm venous ulcer to the back lower right leg which appeared red with exposed fat tissue. A 3 cm x 3 cm unstageable pressure wound to the right heel that appeared necrotic (dead black tissue). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Necrotic areas between the right and left toes. No measurements were documented. Nursing staff did not document any any further description or characteristics of these wounds to include any drainage, edges of the wound, condition and appearance of surrounding tissue, or any odor at the time of this admission assessment. A review of a Non-Pressure Skin Condition assessment dated [DATE], revealed that licensed nursing staff did not complete the assessment form for each non-pressure wound. Nursing staff also included the resident's pressure wound, on the non-pressure wound assessment, and recorded the following assessment details: Lower left leg 13 cm x 26 cm. Right heel 3 cm x 3 cm. Right and left toes necrotic. Right lower leg 14.5 cm x 16 cm and Right lower leg 5.5 cm x 2.5 cm. Licensed nursing staff did not identify the type of wound for each measured area noted. The licensed nursing staff also noted the presence of two separate wounds on the resident's right lower leg but failed to identify the specific location of each wound on the right lower leg and their proximity to each other. The assessment failed to identify the presence of any drainage, wound description or appearance, wound bed, appearance of the surrounding tissue, and any odor present for each wound. A review of a Non-Pressure Skin Condition assessment dated as completed July 5, 2024, revealed the licensed professional nursing staff solely documented the measurements of the resident's wounds, and did not complete assessment form for each non-pressure wound. Nursing staff also included the resident's pressure wound on the non-pressure wound assessment. The following was documented as the wound assessment: Left lower extremity 13 cm x 26 cm x 0.2 cm Right heel 3.5 cm x 4 cm x 0.1 cm. Both feet toes necrotic tiny areas scabbed. Right lower extremity front 15 cm x 16 cm x 0.2 cm and Right lower extremity rear 6 cm x 3 cm x 0.2 cm. Licensed nursing staff did not identify the type of wound for each measured area noted. The assessment failed to identify the presence of any drainage, wound description or appearance, wound bed, appearance of the surrounding tissue, and any odor present for each wound. A review of a wound consult note dated July 10, 2024, revealed that the wound consultant indicated that the resident's right heel appeared boggy (soft and spongy) with foul odor and soft eschar (dead tissue). The wound consultant recommended an X-ray of the right heel due to deterioration. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a nursing progress note dated July 11, 2024, at 12:00 PM revealed the contracted x-ray company was in the facility and obtained an x-ray of Resident 94's right heel. A review of a Radiology Result Report dated July 11, 2024, at 2:06 PM revealed the resident had a calcaneus erosion consistent with osteomyelitis (heel bone infection). A review of the resident's clinical record revealed no documentation the resident's attending physician was notified of the results of the resident's x-ray received on July 11, 2024. A review of a Change in condition assessment dated [DATE], five days after the resident was identified with a bone infection, revealed that the resident had increased pain and osteomyelitis. The physician was notified on July 16, 2024 at 3:00 PM and recommended to send the resident out to the hospital for treatment. The facility's licensed and professional nursing staff failed to accurately and thoroughly assess the resident's multiple skin impairments and wounds and document complete assessment results to assure necessary details were noted for continued monitoring the resident's wounds and the timely identification of deterioration and potential need for changes in treatment. A review of hospital records dated July 17, 2024, revealed the resident presented to the hospital with worsening right heel pain and a non-healing worsening wound with osteomyelitis. The resident was noted to have a low grade temperature of 100 degrees Fahrenheit and IV (intravenous) antibiotics were initiated. The hospital documentation noted that the resident's wounds were extensive and with wound debridement and dressing changes they may temporarily improve but the underlying bone infection wound not resolve even with months of IV antibiotics. The wounds will colonize with antibiotic resistant organisms and without debridement of dead bone the chances to cure the osteomyelitis are nil. Interview with the Nursing Home Administrator on July 19, 2024, at approximately 1:40 PM confirmed that the facility's professional nursing staff failed to fully assess a resident's wounds to timely identify and act upon declines in the resident's condition and assure prompt and necessary treatment to prevent further decline. Refer F777 and F686 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing Services

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on select facility policy and clinical records, and staff interviews it was determined that the facility failed to provide necessary care to promote healing, and prevent worsening of a pressure sore, resulting in deterioration and clinical complications with the resident's pressure sore for one resident out of 24 sampled (Resident 94). Findings include: According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, Standardized pressure ulcer risk assessment and care planning and implementation to address areas of risk. ACP (The American College of Physicians is a national organization of internists, who specialize in the diagnosis, treatment, and care of adults. The largest medical-specialty organization and second-largest physician group in the United States) Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i.e. , support surfaces, repositioning and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement and wound cleansing; using adjunctive therapies; and considering possible surgical repair. A review of facility policy entitled Skin and Wound dated as reviewed by the facility May 9, 2024, revealed it is the policy to provide a system for identifying risk and implementing resident centered interventions to promote skin health and the prevention and healing of pressure injuries. The facility policy entitled Pressure Injury Record dated as reviewed by the facility May 9, 2024, revealed that residents will have a pressure injury record competed for each skin impairment that is related to pressure. The staff will mark the pressure area on the body description identifying the site. The staff then will enter the date, stage of the pressure injury, the size of the pressure injury, the tissue type and color, the wound edges, drainage, and peri-wound information. A review of the clinical record of Resident 94 revealed admission to the facility on [DATE], with diagnoses, which included Type 2 diabetes, a pressure ulcer to the right heel, a non-pressure ulcer to the right lower leg, and a non-pressure ulcer to the left lower leg. An Admission Minimum Data Set assessment dated [DATE], (MDS - a federally mandated standardized assessment process completed periodically to plan resident care) revealed that the resident needed partial to moderate assistance in rolling to the left and right, from sitting to lying, lying to sitting, sitting to standing, transferring from the bed to chair, and toileting. The resident was at risk for developing pressure ulcers and had unhealed pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Admission assessment dated [DATE], revealed that the resident had a 3 cm x 3 cm unstageable pressure wound to the right heel that appeared necrotic (dead black tissue). No further assessment was documented upon admission to include any other wound characteristics, to include any drainage, odor, the wound edges, or appearance of surrounding tissue. A review of the resident's baseline plan of care dated June 28, 2024, revealed the resident had a pressure wound to the right heal. The care plan did not include measures to reduce pressure to the unstageable pressure ulcer to the right heel, such as offloading pressure to the heels, turning and repositioning, or floating heels while in bed. A Non-Pressure Skin Condition assessment was conducted June 30, 2024, but this assessment did not include a complete assessment of the resident's pressure wound, the unstageable pressure wound to the resident's right heel. The wound was noted as right heel 3 cm x 3 cm, but no further assesment details were documented, to include stage of the pressure wound and current appearance and wound characteristics (drainage, appearance, wound bed, surrounding tissue, and any odor) of pressure wound to the resident's right heel. A review of a Non-Pressure Skin Condition assessment dated as completed on July 5, 2024, revealed no evidence that nursing staff conducted a thorough assessment of the pressure wound to the right heel. The wound had increased in size, noted as right heel 3.5 cm x 4 cm x 0.1 cm. but no further assesment details were documented, to include stage of the pressure wound and current appearance and wound characteristics (drainage, appearance, wound bed, surrounding tissue, and any odor) of pressure wound to the resident's right heel. A review of a wound consult note dated July 10, 2024, revealed the resident's right heel pressure sore was an unstageable pressure sore measuring 3 cm x 7 cm x 0.5 cm and the wound base was 100 percent eschar (dead tissue). The wound consultant indicated that the facility should implement a repositioning schedule per protocol for pressure prevention and float the resident's heels while in bed with use of prevalon boots (a device applied to the foot to reduce pressure). The wound consultant noted that the resident's right heel appeared boggy (soft and spongy) with foul odor and soft eschar and recommended an x-ray of the right heel due to deterioration. Following this wound consult completed on July 10, 2024, there was no documented evidence that the facility implemented the recommendations for a turning and repositioning schedule or use of prevalon boots. A nursing progress note dated July 11, 2024, at 12:00 PM revealed an x-ray of Resident 94's right heel was completed. A review of a Radiology Result Report dated July 11, 2024, at 2:06 PM revealed the resident had a calcaneus erosion consistent with osteomyelitis (bone infection caused by bacteria or fungi). A review of a change in condition assessment dated [DATE], five days after the resident was identified with a bone infection, revealed the resident has increased pain and osteomyelitis. The physician was notified on July 16, 2024, at 3:00 PM and recommended to send the resident out to the hospital for treatment. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of hospital records dated July 17, 2024, revealed the resident presented to the hospital with worsening right heel pain and a non-healing worsening wound with osteomyelitis. The resident had a low grade temperature of 100 degrees Fahrenheit and IV (intravenous) antibiotics were initiated. The hospital records noted that the resident's wounds were extensive and with wound debridement and dressing changes they may temporarily improve but the underlying bone infection wound not resolve even with months of IV antibiotics. The wounds will colonize with antibiotic resistant organisms and without debridement of dead bone the chances to cure the osteomyelitis are nil. The facility failed to demonstrate timely implementation of recommended measures to promote healing of the pressure sore, including pressure reducing measures and devices, Prevalon boots and repositioning. The facility failed to timely notify the physician of the results of the xray identifying the bone infection to assure prompt treatment. Nursing staff failed to consistently document thorough assessment of the pressure sore to timely identify declines in the wound's condition. An interview with the Nursing Home Administrator on July 18, 2024, at approximately 10:30 AM confirmed the facility was unable to provide evidence of timely development and implementation of measures necessary to promote healing of a pressure ulcer. 28 Pa. Code 211.10 (a)(c)(d) Resident care policies 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.

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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** 21738 Based on review of clinical records and select facility policy, and resident and staff interviews, it was determined that the facility failed to thoroughly assess and evaluate bowel and bladder function, to identify factors for decline, and implement individualized interventions, including timely toileting assistance, to improve bladder and bowel function to the extent possible for one out of 24 sampled residents (Residents 38). Findings include: Review of the facility Bowel and Bladder Evaluation Policy last reviewed May 9, 2024, indicated that residents are evaluated for continence on admission/readmission, quarterly, and with significant change in status. Residents without a documented reversible cause for bowel and bladder incontinence are to have a Bowel and Bladder evaluation completed and Bowel and Bladder Elimination Pattern evaluation completed. Based on data collected from the patterning evaluation residents to be provided an individualized continence management program. Review of Resident 38's clinical record revealed admission to the facility on [DATE], with diagnoses that included diabetes and depression. A review of the resident's admission Minimum Data Set Assessments (MDS - a federally mandated standardized assessment completed at specific intervals to define resident care needs) dated January 16, 2024, Section H Bladder and Bowel indicated the resident was frequently incontinent of bladder and bowel. Review of the resident's quarterly MDS dated , March 15, 2024, Section H Bladder and Bowel indicated the resident was frequently incontinent of bladder and occasionally incontinent of bowel. The assessments indicated the resident was not on a bladder or bowel training program. Resident 38's Quarterly MDSs assessment dated [DATE], Section H Bladder and Bowel, noted that the resident was frequently incontinent of bladder and now frequently incontinent of bowel (a decline of bowel function). Further review of Resident 38's clinical record revealed no documented evidence that a Bowel and Bladder evaluation or Bowel and Bladder Elimination Pattern evaluation was completed upon admission or quarterly as per facility policy for Resident 38 and decline in bowel continence noted on the Quarterly MDS assessment dated [DATE]. During interview with Resident 38 on July 16, 2024, at 12:20 PM the resident stated that nursing staff often take a long time to answer her call bell and provide assistance with toileting when needed. The resident explained that the other day she waited longer than 15 minutes for nursing staff to answer the call bell when she had to have a bowel movement, and as a result of the long wait for staff assistance with toileting, she had an accident (bowel incontinence). (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 with the nursing home administrator on July 19, 2024, at 11:30 AM the NHA confirmed that there was documented evidence that the facility had acted upon the resident's increased bowel incontinence and completed incontinence evaluations and implemented any scheduled toileting programs in response to the resident's decline in bowel function and frequent incontinence of urine. 28 Pa. Code 211.12 (d)(5) Nursing services 28 Pa. Code 211.10 (a)(d) Resident care policies

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on review of clinical records and select facility policy, and staff and resident interviews it was determined that the facility failed to ensure that physician ordered intravenous (IV- medication is administered through needle or tube inserted into a vein) medications, an antibiotic, were administered as prescribed for one resident out of 24 sampled (Resident 148). Findings include: Review of a facility policy titled Administering Medications last reviewed by the facility on May 9, 2024, indicated that medications are administered in a safe and timely manner. It indicated that medications are administered in accordance with prescriber orders, including any required time frame. Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and/or the need for additional staffing. Prescribed medications are to be administered within one hour of their prescribed time, unless otherwise specified. Review of Resident 148's clinical record revealed that the resident was admitted to the facility on [DATE], with a PICC line (peripherally inserted central catheter- thin flexible tube inserted into a vein in the upper arm and guided into a large vein above the right side of the heart and used to administer fluid and medications) and diagnoses to include septic (infected with bacteria) left knee and diabetes. An admission physician order was noted for Daptomycin (an antibiotic used to treat bacterial infections) 750 MG intravenously daily for septic left knee. Review of Resident 148's Medication Administration Record dated July 12, 2024, through July 14, 2024, revealed that the physician ordered intravenous antibiotic medication, Daptomycin, was not administered to the resident on July 12, 2024, July 13, 2024, and July 14, 2024 as prescribed. Interview with the Director of Nursing (DON) on June 13, 2024, at 12:00 PM, confirmed that the facility failed to administer three daily doses of the IV antibiotic therapy prescribed for Resident 86, and failed notify the attending physician of a missed doses. Interview with the nursing home administrator on July 19, 2024, at approximately 10:00 AM, confirmed that the facility failed to administer three doses of Resident 148's prescribed IV antibiotic therapy, and failed to notify the attending physician of three missed doses of the prescribed antibiotic. Refer F755 28 Pa. Code 211.9(a)(1)(k) Pharmacy services 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing Services 28 Pa. Code 211.10 (a)(c)(d) Resident care policies

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on clinical record review and staff interview, it was determined that the facility failed to attempt non-pharmacological interventions to alleviate pain prior to the administration of an opioid pain medication prescribed on an as needed basis and failed to ensure that the physician orders for administration of pain medication were followed for two residents (Resident 8 and 20) of 24 residents reviewed. Findings include: A review of the clinical record revealed that Resident 8 was admitted to the facility on [DATE], with diagnoses to include fibromyalgia. The resident had a current physician order initially dated November 16, 2023, for oxycodone (an opioid pain medication) 5 mg tablet give 2.5 mg by mouth, every 8 hours, as needed, for pain rating 4 to 10 (on a scale of 1-10, with 1 being the least pain and 10 being the most severe pain). A review of the resident's May 2024 Medication Administration Record (MAR) revealed that staff administered the prn opioid pain medication to the resident on May 11, 2024 and May 16, 2024. Of the two doses given, both were administered without attempting non-pharmacological interventions prior to administering the pain medication. A review of the resident's June 2024 MAR revealed that nursing staff administered the as needed opioid pain medication to the resident on June 4, 2024, June 14, 2024, June 17, 2024, June 22, 2024, and June 29, 2024. Of the five doses given, three were administered with no evidence that staff attempted non-pharmacological interventions prior to administering the opioid pain medication prescribed on an as needed basis. A review of the resident's July 2024 MAR revealed that nursing staff administered the as needed opioid pain medication to the resident on July 3, 2024, July 4, 2024, July 5, 2024, and July 12, 2024. Of the four doses given, two were administered without first attempting non-pharmacological interventions prior to administering the as needed opioid pain medication to the resident. A review of Resident 20's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses which included Multiple Sclerosis (A disease in which the immune system eats away at the protective covering of nerves). The resident had a physician order, initially dated September 19, 2023, for Oxycodone HCL 5 mg give one by mouth every 6 hours as needed for a pain level 7 to 10 on the pain scale. A review of Resident 20's May 2024 MAR revealed that on the following dates nursing staff administered the prn opioid pain medication for pain rated below the physician ordered parameters: May 1, 2024 - for a pain level of six May 5, 2024 - for a pain level of six (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	May 11, 2024 - for a pain level of six May 19, 2024 - for a pain level of six May 27, 2024 - for a pain level of five May 29, 2024 - for a pain level of six A review of the resident's June 2024 MAR revealed that on the following dates nursing staff administered the prn opioid pain medication a pain level below the physician ordered parameters: June 5, 2024 - for a pain level of six June 6, 2024 - for a pain level of five June 18, 2024 - for a pain level of six June 25, 2024 - for a pain level of six A review of the resident's July 2024 MAR revealed that on the following dates nursing staff administered the prn opioid pain medication a pain level below the physician ordered parameters: July 4, 2024 - for a pain level of five July 6, 2024 - for a pain level of five July 7, 2024 - for a pain level of five July 10, 2024 - for a pain level of zero July 16, 2024 - for a pain level of six Interview with the Nursing Home Administrator on July 19, 2024, at approximately 1:45 PM confirmed that there was no documented evidence that non-pharmacological interventions were consistently attempted and proved ineffective prior to administration of a as needed pain medication and the facility failed to follow physician's orders for administration of pain medication. 28 Pa. Code 211.10 (a)(c) Resident care policies 28 Pa. Code 211.12 (c)(d)(1)(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** 48276 Based on observation, a review of clinical records, a review of nurse staffing, and grievances filed with the facility, and interviews with staff and residents, it was determined that the facility failed to provide sufficient nursing staff to provide timely and quality care to each resident including eight residents out of 24 sampled (Residents 19, 20, 21, 48, 151, 38, 30 and 85), including concerns expressed in grievances filed with the facility (Resident 85). Findings included: A grievance lodged with the facility dated April 3, 2024, indicated that Resident 48 reported that she was continuously dissatisfied with nursing staff's untimely call bell response time. The facility noted that the grievance is not resolved to the resident's liking, despite facility improvements in staff's call bell response. A grievance filed with the facility dated April 29, 2024, indicated that Resident 85 expressed concerns that staff initially responded to his call bell but left and never came back to get him out of bed as requested. The grievance indicated that he remained in bed all day as a result. The facility noted that the grievance was resolved. A grievance lodged with the facility dated June 1, 2024, indicated that a resident's family member/representative voiced concerns on behalf of the resident, reported that the resident waited over four hours for nursing staff to answer the resident's call bell and that nursing staff does not provide his morning care at the resident's preferred time. The grievance identified the family member but did not include the resident's name. The facility noted that the grievance was resolved. Clinical record review revealed that Resident 21 was admitted to the facility on [DATE], with diagnoses that include chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and heart failure (a condition that develops when the heart doesn't pump enough blood to meet the body's needs). A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 24, 2024 revealed that Resident 21 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). A review of the clinical record revealed that Resident 48 was admitted to the facility on [DATE], with diagnoses to include major depressive disorder (a mental health disorder characterized by a persistently low or depressed mood, decreased interest in pleasurable activities, feelings of worthlessness, lack of energy, poor concentration, appetite changes, sleep disturbances, or suicidal thoughts). A review of a quarterly MDS assessment dated [DATE] revealed that Resident 48 is cognitively intact with a BIMS score of 15. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A clinical record review revealed Resident 20 was admitted to the facility on [DATE], with diagnoses that included coronary artery disease (a type of heart disease where the arteries cannot deliver enough oxygen-rich blood to the heart). A review of a quarterly MDS assessment dated [DATE], revealed that Resident 20 is cognitively intact with a BIMS score of 13. Clinical record review revealed Resident 19 was admitted to the facility on [DATE], with diagnoses that included coronary artery disease (a type of heart disease where the arteries cannot deliver enough oxygen-rich blood to the heart). A review of a quarterly MDS assessment dated [DATE], revealed that Resident 19 is cognitively intact with a BIMS score of 15. During a group interview conducted on July 17, 2024, at 10:00 AM, Resident 48 stated that she waits 30 to 40 minutes for nursing staff to provide her care. She explained that the facility is particularly short staffed on the evening shift. Resident 48 stated that if she has to go to the bathroom after 15 minutes, she will start yelling from her room for staff assistance with a bedpan. Resident 48 stated that if she doesn't yell, then nursing staff don't respond. Resident 48 further explained that during meal times, nursing staff don't respond even when she is yelling for their assistance because they are helping residents in the dining room. She stated that the wait times for nursing staff to provide requested and needed care causes her to feel frustrated and angry. During an interview on July 17, 2024, at 10:45 AM, Resident 21 stated that she experiences long wait times for nursing staff to provide her care, stating that she often waits over 20 minutes for nursing staff to provide her care. Resident 21 stated that she feels frustrated, and after 25 minutes, she starts screaming for help from nursing staff. She explained that there are not a lot of nursing staff, and the wait times are worse when there is less nursing staff working. Resident 21 stated that when there is only one nurse aide assigned to her hallway, it makes her feel rushed when she needs assistance to use the bathroom. She explained that she is upset, because she doesn't want to be dependent on nursing staff for assistance, but she needs their help with activities of daily living. During an interview on July 17, 2024, at 11:15 AM, Resident 20 stated that she rings her call bell and waits between 20 and 40 minutes for nursing staff to respond. She explained that she is independent and can do most things herself, but she is upset when it takes so long for nursing staff to respond when she does need their help. Resident 20 stated that she believes that the issue is because there are not enough nursing staff working at the facility. During an interview on July 18, 2024, at 9:45 AM Resident 19 stated that the facility is often short on nurse staffing and sometimes only assigns one nurse aide to his hallway. He explained that the facility is short on nursing staff at least twice a week, and the weekends are the worst. Resident 19 stated the facility has increased the number of new residents admitted over the past few weeks, but has not increased the amount of nursing staffing. He explained that he waits 20 minutes or longer for nursing care after ringing his call bell for staff assistance. Interview with Resident 38 on July 16, 2024, at 12:20 PM the resident stated that nursing staff often take a long time to answer her call bell and the other day she waited longer than 15 minutes for the call bell to be answered and had an accident (bowel incontinence) because nursing staff did not respond timely to the resident's request for toileting assistance. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on July 18, 2024, at 1:00 PM revealed that Resident 30's bed was not yet made. Interview with Resident 30 at this time revealed that her sheets were due to be changed and were removed that morning but had not yet been replaced. Observation of the Third-floor nursing unit on July 19, 2024, at 9:00 AM revealed that there were 4 nurse aides and 2 LPNs (Employee 7 RN Supervisor was working as an LPN) working on the unit. During interview at this time with Employee 7 (RN Supervisor), Employee 7 stated that 2 nurse aides and 2 LPNs had called off and were not replaced. Review of the facility's deployment sheet for the day shift of July 19, 2024, revealed that the facility's census was 104 residents. There were 4 nurse aides and 2 LPNs working on the Second-floor Nursing Unit, and 4 nurse aides and 2 LPNs working on the Third-floor nursing unit. There was also a restorative nurse aide who covered both nursing units and one RN Charge nurse floating between the nursing units. Interview with Resident 151, a cognitively intact resident, on July 19, 2024, at 9:30 AM revealed that she was unhappy with the nursing care at the facility. Resident 151 stated that due to long call bell waits (longer than 15 minutes) she had soiled herself on three different occasions. Resident 151 stated that it seems the facility does not have enough nursing staff. Resident 151 stated that the facility was aware of her concerns with her call bells not being answered timely and stated that they were to start offering toileting after meals. Resident 151 stated that she finished breakfast around 8:00 AM and, as of 9:30 AM nursing staff still had not offered her toileting. Resident 151 stated that she did have to go to the bathroom presently and the surveyor offered to seek out nursing staff assistance for the resident. Upon entering the hall and nurses station there were no staff available other than Employee 7 who stated that other nursing staff were busy helping other residents. Employee 7 (RN Supervisor) then assisted Resident 151 to the bathroom. Interview with the nursing home administrator (NHA) on July 19, 2024, at 10:30 AM confirmed that nursing staff are to make resident beds timely. The NHA confirmed that nursing staff are to answer call bells timely answered and offer Resident 151 after meals. The NHA confirmed that nursing staff call-offs were a problem, that negatively affected sufficient nurse staffing levels. A review of nurse staffing hours revealed the facility averaged 3.22 direct care hours for each resident with an average census of 98 residents for the week of June 24, 2024, through June 30, 2024. However, with an increase in their census, from June 11, 2024, through June 17, 2024, the facility averaged 3.06 direct care hours for each resident, with an average census of 104 residents. A review of the facility's nurse staffing from June 11, 2024, through July 17, 2024, revealed the facility failed to meet the required minimum state ratio for nurse aides on 18 of the 63 shifts reviewed. The facility failed to meet the required minimum state ratio for licensed practical nurses on 9 of the 63 shifts reviewed. The facility failed to meet the state minimum required nursing staff direct care hours per day for each resident on 10 out of 21 days reviewed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on July 19, 2024, at approximately 11:00 AM, the Nursing Home Administrator (NHA) confirmed that the facility failed to meet the state minimum requirements for nurse aides, licensed practical nurses, and nurse staff direct care hours for residents per day. The NHA was unable to provide evidence that additional direct care staff were provided to ensure residents needs were met with the increase in the resident census from the week of June 11, 2024 (98 residents) to the week of July 11, 2024 (104 residents). The NHA confirmed that it is the facility's responsibility to provide sufficient nursing staff to provide timely and quality care to each resident. 28 Pa. Code 201.18 (b)(1)(3)(e)(1)(2)(3)(6) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12 (c)(d)(4)(5)(f.1)(2)(4)(i)(1)(2) Nursing services.

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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** 21738 Based on a review of clinical records and select incident reports, and resident and staff interview, it was determined that the facility failed to develop and implement individualized plans to manage residents' dementia-related behavioral symptoms to promote resident safety and highest practicable physical and mental well-being residents including one resident out of 24 sampled (Resident 87). Findings include: A review of Resident 87's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses which included Alzheimer's disease and was severely cognitively impaired. Review of a facility incident report dated July 9, 2024, at 4:30 PM revealed that Resident 35 reported to a staff member that Resident 87 was in her room uninvited and slapped her in the face when she told Resident 87 to put down her orange. Interview with Employee 7 (RN Supervisor) on July 18, 2024, at 1:30 PM revealed that a nurse, she cannot recall which aide, initially notified her of the incident of physical abuse of Resident 35. The aide came to her and said that you need to talk to Resident 35 because Resident 35 and Resident 87 got into it. Employee 7 stated that Resident 87 was becoming more agitated lately and had the potential to hit someone if they told her no or tried to take something she wanted. Employee 7 confirmed that Resident 87 would enter other residents' rooms uninvited. Review of Resident 87's care plan. initially dated April 10, 2024, indicated that Resident 87 is an elopement risk/wanderer related to dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and that the resident wanders aimlessly. An intervention dated July 10, 2024, was noted to deter the resident and redirect the resident from entering other residents' rooms, especially Resident 35's room. Resident 87's dementia related care plan failed to identify Resident 87's actual behavior of intrusive wandering and y entering other residents 'room, potential for taking items which do not belong to her, and potential for becoming agitated towards residents who tell her no or attempt to take the item which she wants back from her. Interview with Resident 37, a cognitively intact resident, on July 18, 2024, at 11:00 AM revealed that Resident 87 enters her room uninvited and touches her things. Resident 37 stated that she does not want Resident 87 entering her room. During interview with Resident 35 on July 17, 2024, at 11:00 AM the alert and oriented resident confirmed that the incident with Resident 87 did occur on July 9, 2024, and that Resident 87 slapped her in the face and she was upset that the incident occurred. Resident 35 stated that she was not afraid of Resident 87 but did not want Resident 87 entering her room and taking her things due to Resident 87's potential to become angry and hit her again. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's current care plan, in effect at the time of the survey ending July 19, 2024, did not identify the resident's specific behaviors, incident of physical abuse of Resident 35 on July 9, 2024, and intrusive wandering into other residents' rooms the resident had been exhibiting due to her dementia diagnosis and the development of specific individualized interventions for staff to employ to address this dementia-related behavior. The facility failed to develop and implement an individualized person-centered plan to address, modify and manage, to the extent possible, this resident's dementia-related behavior of intrusive wandering and agitation. The resident's care plan for behavioral symptoms failed to include individualized interventions based on an assessment of the resident in an effort to manage the resident's dementia-related behavioral symptoms. Interview with Nursing Home Administrator on July 19, 2024, at approximately 9:30 AM, confirmed the facility was unable to provide documented evidence of the development and/or implementation of a comprehensive individualized person-centered plan to address dementia-related behaviors for Resident 87. The facility also failed to demonstrate timely and consistent efforts to implement a person-centered individualized dementia-related care plan to address Resident 87's ongoing behavior of intrusive wandering, and potential to become physically agitated and abusive, and minimize, modify, or manage dementia-related behaviors. Refer F600 28 Pa. Code 211.12 (d)(3)(5) Nursing services 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 201.29 (a) Resident rights

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on review of clinical records and staff interview it was determined that the facility failed to provide pharmacy services to assure timely receiving of a prescribed antibiotic medication for one resident out of 24 residents reviewed (Resident 148). Findings include: Review of clinical record revealed that Resident 148, was admitted to the facility on [DATE], with diagnoses to include septic (infected with bacteria) left knee and diabetes. An admission physician order was noted for Daptomycin (an antibiotic medication) 750 mg intravenously (IV-medication is administered through needle or tube inserted into a vein) in the morning daily with end date August 12, 2024, for septic left knee. Review of Resident 148's Medication Administration Record dated July 12, 2024, through July 14, 2024, revealed the physician ordered intravenous antibiotic medication, Daptomycin, was not administered on July 12, 2024 July 13, 2024, and July 14, 2024. Interview with the Nursing Home Administer (NHA) on July 19, 2024, at approximately 10:00 AM confirmed the facility failed to provide Resident 148's intravenous antibiotic medication as prescribed because it was not available in the facility as the facility's pharmacy did not timely deliver the antibiotic drug. Refer F694 28 Pa. Code 211.9 (a)(l)(d)(k) Pharmacy Services. 28 Pa. Code 211.12 (d)(3)(5) Nursing Services.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41581 Based on a review of clinical records and a staff interview, it was determined that the facility failed to demonstrate that the pharmacist identified and reported irregularities in the drug regimen of residents and that the physician acted upon the identified irregularities in the drug regimens of four of the 24 residents sampled (Residents 78, 20, 52, and 17). Findings include: A review of the clinical record revealed that Resident 78 was admitted to the facility on [DATE], and had diagnoses that included type 2 diabetes, depression, and anxiety. A review of a pharmacy consultant note revealed that on February 4, 2024, the pharmacist completed a medication regimen review and noted to see the report for any noted irregularities. A review of a pharmacy consultant note revealed that on May 28, 2024, the pharmacist completed a medication regimen review and noted to see the report for any noted irregularities. A review of the clinical record revealed that Resident 20 was admitted to the facility on [DATE], and had diagnoses that included type 2 diabetes, generalized anxiety disorder, and major depressive disorder. A review of a pharmacy consultant note revealed that on February 5, 2024, the pharmacist completed a medication regimen review and noted to see the report for any noted irregularities. A review of a pharmacy consultant note revealed that on March 5, 2024, the pharmacist completed a medication regimen review and noted to see the report for any noted irregularities. A review of a pharmacy consultant note revealed that on May 28, 2024, the pharmacist completed a medication regimen review and to see the report for any noted irregularities. A review of the clinical record revealed that Resident 52 was admitted to the facility on [DATE], with diagnoses that included type 2 diabetes and viral hepatitis. A pharmacy consultation note dated June 25, 2024, at 3:10 PM indicated that the pharmacist completed a medication regimen review and to see the report for any noted irregularities. A pharmacy consultation note dated May 28, 2024, at 12:10 PM indicated that the pharmacist completed a medication regimen review and to see the report for any noted irregularities. A pharmacy consultation note dated December 4, 2023, at 12:21 PM indicated that the pharmacist completed a medication regimen review and noted to see the report for any noted irregularities. A review of the clinical record revealed that Resident 17 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A pharmacy consultation note dated May 28, 2024, at 9:44 AM indicated that the pharmacist completed a medication regimen review and to see the report for any noted irregularities. A pharmacy consultation note dated March 5, 2024, at 1:31 PM indicated that the pharmacist completed a medication regimen review and to see the report for any noted irregularities. At the time of the survey ending July 19, 2024, the facility was unable to provide the documentation of the results of the above noted pharmacist medication reviews, the irregularities notes, recommendations made and ay physician response to the identified reports. During an interview on July 19, 2024, at approximately 9:20 AM, the Nursing Home Administrator (NHA) verified that the facility was unable to provide documented evidence of the results of these pharmacy drug regimen reviews, and the pharmacist's recommendations or identification of irregularities in the above residents' drug regimens and documented evidence that the physician had acted upon these reports when required. 28 Pa. Code 211.9 (k) Pharmacy services. 28 Pa. Code 211.12 (c) Nursing services. 28 Pa. Code 211.2 (d)(3) Medical Director

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on review of clinical records and staff interviews, it was determined that the facility failed to ensure that the physician was promptly notified of abnormal x-ray results for one of 24 residents reviewed (Resident 94). Findings include: A review of the clinical record of Resident 94 revealed admission to the facility on [DATE], with diagnoses, which included Type 2 diabetes, pressure ulcer to the right heel, non-pressure ulcer to the right lower leg, and non-pressure ulcer to the left lower leg. A review of a wound consult note dated July 10, 2024, revealed the wound consultant noted that the resident's right heel appears boggy (soft and spongy) with foul odor and soft eschar (dead tissue). The wound consultant recommended an X-ray of the right heel be obtained due to its deterioration. A nursing progress note dated July 11, 2024, at 12:00 PM revealed that the facility's contracted mobile x-ray company was in the facility and completed the x-ray of Resident 94's right heel. A review of a Radiology Result Report dated July 11, 2024, at 2:06 PM revealed the resident had a calcaneus erosion consistent with osteomyelitis (heel bone infection). The resident's clinical record revealed no documentation that the resident's attending physician was promptly notified of the results of the resident's x-ray the facility received on July 11, 2024. A review of a change in condition assessment dated [DATE], five days after the x-ray results revealed the resident's bone infection, indicated that the resident had increased pain and osteomyelitis. It was not until this date, that the physician was notified on July 16, 2024 at 3:00 PM and it was recommended to send the resident out to the hospital for treatment at that time. Interview with the Nursing Home Administrator on July 19, 2024, at approximately 1:45 PM confirmed that the facility failed to timely notify the physician of Resident 94's abnormal x-ray results received by the facility on July 11, 2024. Refer F684 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on review of clinical records and select investigative reports and staff interview, it was determined that the facility failed to maintain accurate and complete clinical records, according to professional standards of practice for two of 24 sampled residents (Residents 35 and 87). Findings include: According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient record to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care: Assessments, Clinical problems, Communications with other health care professionals regarding the patient, Communication with and education of the patient, family, and the patient's designated support person and other third parties. According to the Title 49, Professional and Vocational Standards, Department of State, Chapter 21 State Board of Nursing Subsection 21.11 (a) The register nurse assesses human responses and plans, implements and evaluates nursing care for individuals or families for whom the nurse is responsible. In carrying out this responsibility, the nurse performs all of following functions: (4) Carries out nursing care actions which promote, maintain, and restore the well-being of individuals (6)(b) The registered nurse is fully responsible for all actions as a licensed nurse and is accountable to clients for the quality of care delivered and Subsection 21.18. (a)(5) document and maintain accurate records. According to the Title 49, Professional and Vocational Standards, Department of State, Chapter 21 State Board of Nursing Subsection 21.145. (a) The licensed practical nurse (LPN) is prepared to function as a member of a health-care team by exercising sound nursing judgement based on preparation, knowledge, skills, understanding and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. A review of the clinical record revealed that Resident 35 was admitted to the facility on [DATE], with diagnoses which included spinal stenosis (the space around the spinal cord becomes too narrow which puts pressure on the spinal cord and nerves) and hypertension. A review of Resident 87's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses which included Alzheimer's disease. Review of a facility incident report dated July 9, 2024, at 4:30 PM revealed that Resident 35 reported to a staff member that Resident 87 was in her room uninvited and slapped her in the face when she told Resident 87 to put down her orange. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395265	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion at St Luke Village, The	1000 Stacie Drive Hazleton, PA 18201

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the clinical records of both Resident 35's and Resident 87's revealed no documentation in either resident's clinical record regarding Resident 87's intrusive wandering into Resident 35's room and Resident 35's report of physical abuse perpetrated by Resident 87. An interview with the Nursing Home Administrator on July 18, 2024, at approximately 11:00 AM confirmed that there was no documented evidence that Resident 35's report of physical abuse and Resident 87's intrusive wandering were documented in the clinical records of both Resident 35 and Resident 87. 28 Pa. Code 211.5 (f)(iii) Medical records. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on a review of clinical records and staff interviews it was determined the facility failed to ensure coordination of care and services between the facility and the Hospice Agency for one resident out of 24 sampled residents (Resident 84). Findings include: A review of Resident 84's clinical record revealed admission to the facility on [DATE], with a diagnosis of include malignant neoplasm (cancer) of the liver and bile duct. A physician order was noted February 5, 2024, for the resident to be admitted into hospice services at the facility. A review of the resident's care plan conducted during the survey ending July 19, 2024, revealed that the resident's care plan failed to reflect coordination of services between the facility and the Hospice agency in meeting the resident's daily care needs and specific needs related to care and services provided for the resident's terminal diagnosis. An interview with the Nursing Home Administrator on July 19, 2024, at approximately 1:45 PM, confirmed the resident's care plan was not coordinated with hospice services. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services 28 Pa. Code 201.21(c) Use of outside resources

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 48276 Based on a review of select facility policies and the facility's infection monitoring and surveillance system, and staff interviews, it was determined that the facility failed to maintain and implement a comprehensive program to monitor and prevent infections in the facility for two out the eight months reviewed (June 2024 and July 2024). Findings include: A review of the facility policy titled Policies and Practices: Infection Control, reviewed last by the facility on May 9, 2024, revealed that this facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage the transmission of diseases and infections. The objectives of the infection control policies and practices are to prevent, detect, investigate, and control infections in the facility and maintain records of incidents and corrective actions related to infections. The policy also indicates that surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections, monitoring adherence to infection prevention and control practices, and detecting unusual pathogens with infection control implications. Data gathered during surveillance is used to oversee infections and spot trends. The infection preventionist collects data from nursing units, categorizes each infection by body site, and records the number of infections. A review of the facility infection control data revealed that the last recorded data to monitor, investigate, analyze, and manage causes of healthcare associated infections was completed on May 27, 2024. The facility was unable to provide documented evidence that infection control surveillance and data analysis activities were completed from May 27, 2024, through July 19, 2024. During this time period, there was no documented evidence of the implementation of a functional system that enabled the facility to analyze infection clusters, changes in prevalent organisms, or increases in the rate of infection in a timely manner. During an interview on July 19, 2024, at 10:30 AM, Employee 6, Infection Preventionist, indicated that she had coordinated and implemented the facility's infection control program, including surveillance activities, until June 5, 2024, when she transitioned to a different role in the facility. She was unable to provide any evidence of infection control surveillance activities after May 27, 2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on July 19, 2024, at approximately 11:00 AM, the Nursing Home Administrator (NHA) confirmed that Employee 6, Infection Preventionist, was not performing the required duties to implement a comprehensive and effective infection control program. The NHA confirmed that the facility failed to fully implement a comprehensive program to monitor and prevent infections in June 2024 or July 2024. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services. 28 Pa. Code 211.10 (a)(d) Resident care policies