STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395266	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Valley Healthcare and Rehabilitation Center	257 Georgetown Road Beaver Falls, PA 15010

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469 Based on observations, resident, and staff interviews, it was determined that the facility failed to determine the ability to self-administer medications for one of three residents (Residents R96). Findings include: Review of the facility policy Self-Administration of Medication dated 8/1/24, indicated residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Self-administered medications must be stored in a safe and secure place. Review of the admission record indicated Resident R96 was admitted to the facility on [DATE], with diagnosis that include acute kidney failure (kidneys suddenly can't filter waste), anemia (low iron in the blood), and hypertension (high blood pressure). Observation on 9/3/24, at 10:26 a.m. Resident R96 was sitting on the edge of bed. A box of Ivizia eye drops (used for dry eyes) were noted to her bedside stand. During an interview on 9/3/24 at 10:43 a.m. Licensed Practical Nurse (LPN) E4 stated those should not be in here removed the Ivizia eye drops and confirmed Resident R96 did not have orders for medication self-administration. 28. Pa. Code 211.12(d)(1)(2) Nursing services.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of facility policies, resident records and staff interview, the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for two out of two residents sampled with facility-initiated transfers (Resident R21 and R60). Finding include: Review of the facility policy Transfer or Discharge Documentation dated 8/1/24, indicated when a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provided. When a resident is transferred or discharged from the facility, the following information will be documented in the medical record: The basis for transfer or discharge Disposition of medication Summary of the resident's overall medical, physical, and mental condition That an appropriate notice was provided to the resident and /or legal representative All special instructions or precautions for ongoing care, as appropriate Comprehensive care plan goals All other necessary information including a copy of the resident's discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care. Review of Resident R21's admission record indicated she was admitted [DATE], with diagnosis that included anxiety, weakness, and high blood pressure. Review of Resident R21's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/20/23, indicated that the resident was sent to the hospital and admitted . Review of Resident R21's progress note dated 3/10/24, indicated the resident complained of shortness of breath, feeling tired, and weakness. The resident was sent to the hospital and admitted . Review of Resident R21's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record indicated Resident R60 was admitted to the facility on [DATE]. Review of Resident R60's MDS dated [DATE], indicated diagnoses of high blood pressure, Alzheimer ' s disease (a type of brain disorder that causes problems with memory, thinking and behavior), and dependence on wheelchair. Review of Resident R60's clinical record revealed that the resident was transferred to the hospital on 6/2/24, and returned to the facility on [DATE]. Review of Resident R60's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. During an interview on 9/5/24, at 1:14 p.m. the Nursing Home Administrator confirmed that there was no evidence that the necessary information was communicated to the receiving health care institution or provider upon transfer for two out of two residents sampled with facility-initiated transfers (Residents R21 and R60). 28 Pa. Code 201.29 (a)(c.3)(2) Resident rights.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of facility policy, clinical records, and staff interviews it was determined that the facility failed to provide the resident and/or resident representative with a written notice of the facility bed-hold policy (explanation of how long a bed can be held during a leave of absence and the cost per day) upon or within twenty-four hours of transfer for two of two residents (Residents R21 and R60). Findings include: Review of the facility policy Bed Hold, dated 8/1/24, indicated that the facility is required to notify responsible party of the Bed Hold options and associated financial liability: 1) At the time of admission to ensure that the Resident/Responsible Party is aware of the procedure to be followed to guarantee a bed upon returning from a future leave. 2) Each time a resident will be absent from the facility for hospitalization or other medical or therapeutic leave so that the Resident and/or Responsible Party may make a choice to either hold the bed or discharge from the facility for the current leave days. Proper documentation of the leave/bed hold days must be maintained in compliance with current Federal; and/or State specific regulation. Review of Resident R21's admission record indicated she was admitted [DATE], with diagnosis that included anxiety, weakness, and high blood pressure. Review of Resident R21's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/20/23, indicated that the resident was sent to the hospital and admitted . Review of Resident R21's clinical physician progress note dated 3/10/24, indicated the resident was admitted to the hospital. Review of Resident R21's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 3/10/24. Review of the clinical record indicated Resident R60 was admitted to the facility on [DATE]. Review of Resident R60's MDS dated [DATE], indicated diagnoses of high blood pressure, Alzheimer ' s disease (a type of brain disorder that causes problems with memory, thinking and behavior), and dependence on wheelchair. Review of Resident R60's clinical record revealed that the resident was transferred to the hospital on 6/2/24. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R60's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 6/2/24. During an interview on 9/5/24, at 1:14 p.m. the Nursing Home Administrator stated the facility was not completing bed hold notifications, and confirmed that there was no evidence that a written notification of the facility bed hold policy was provided to the resident/agent upon transfer to the hospital for Resident R21, and R60 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(f) Resident rights

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49469 Based on review of facility policy, resident observations, clinical record review and staff interviews, it was determined that the facility failed to develop a plan of care to include a focus and interventions to maintain a resident's highest practicable physical well-being as required for one of three residents. (Resident R28) Findings include: Review of the facility Care Plans, Comprehensive Person Centered policy dated 8/1/24, indicates a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Review of Resident R28's Minimum Data Set (MDS-periodic assessment of care needs) dated 7/23/24, indicated a re-entry to facility on 10/17/22, with diagnoses of heart failure (heart doesn't pump as well as it should), hypertension (high blood pressure), and diabetes (high sugar in the blood). Observation 9/3/24, at 10:40 a.m. resident R28 was sitting next to his bed and was noted to have bilateral skin sleeves on. A review of Resident R28's care plan did not include interventions for skin sleeves. During an interview on 9/5/24, at 12:10 p.m. the Director of Nursing (DON) confirmed the facility failed to develop a care plan to include goals and interventions for Resident R28's skin sleeves. 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: S211.10(c) Resident care policies

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of facility policy, clinical record review, observations, and staff interviews, it was determined that the facility failed to ensure a resident had a physician order for treatment residents were receiving for two of five residents (Resident R28 and 260). Findings include: Review of facility policy Therapeutic Diets dated 8/1/24, indicated therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with the resident's goals and preferences. Diet order should match the terminology used by the food and nutrition services department. Review of the facility policy Medication and Treatment Orders dated 8/1/24, indicates orders for medications and treatments will be consistent with principles of safe and effective order writing. Drugs and biologicals orders must be recorded on the Physicians orders sheet. Review of Resident R28's Minimum Data Set (MDS-periodic assessment of care needs) dated 7/23/24, indicated a re-entry to facility on 10/17/22, with diagnoses of heart failure (heart doesn't pump as well as it should), hypertension (high blood pressure), and diabetes (high sugar in the blood). Observation 9/3/24, at 10:40 a.m. Resident R28 was sitting next to his bed and was noted to have bilateral skin sleeves on. A review of Resident R28's physician orders on 9/3/24, at 10:42 a.m. failed to contain current orders for bilateral skin sleeves. During an interview on 9/5/24, at 12:10 p.m. the Director of Nursing (DON) confirmed the facility failed to obtain physician orders for Resident R28's skin sleeves. Review of the clinical record indicated Resident R260 was admitted to the facility on [DATE], with diagnoses of dementia (a group of symptoms affecting memory, thinking and social abilities), heart failure (occurs when the heart muscle doesn't pump blood as well as it should), and dysphagia (difficulty swallowing). Review of Resident R260's Nutrition Evaluation dated 8/30/24, indicated the resident's diet order was NPO-Nothing by mouth. It was indicated the resident was observed choking on water while in the emergency room and failed multiple swallow studies. Review of Resident R260's physician order on 9/3/24, at 10:52 a.m. failed to include an order for nothing by mouth. During an interview on 9/3/24, at 1:00 p.m. Nurse Aide, Employee E8 confirmed Resident R260 does not take anything by mouth. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/3/24, at 1:03 p.m. Licensed Practical Nurse, Employee E5 confirmed Resident R260 does not take anything by mouth. During an interview on 9/3/24, at 1:04 p.m. the Director of Nursing confirmed Resident R260 failed to have a physician order for nothing by mouth. The DON confirmed the facility failed to provide care and services needed for a resident to maintain the highest practicable physical well-being for one of five residents (Resident R260). 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.29(d) Resident Rights 28 Pa. Code 211.10 (c)(d) Resident Care policies 28 Pa. Code 211.12 (d)(1)(2)(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** 46337 Based on review of clinical records, and staff interviews, it was determined that the facility failed to make certain that appropriate treatment and services were ordered and/or provided for two of three residents with a urinary catheter (Resident R37 and R260). Findings include: Review of the facility policy Medication and Treatment Orders dated 8/1/24, indicates orders for medications and treatments will be consistent with principles of safe and effective order writing. Review of the facility policy Catheter Care, Urinary last reviewed 8/1/24, indicate check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter tubing free of kinks, the drainage bag must be held or positioned lower that the bladder at all times. Review of the facility policy Resident Rights last reviewed 8/1/24, these rights include the residents right to a dignified existence, to be treated with respect, kindness, and dignity. Review of Resident R37's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/29/24, indicated re-admitted [DATE], with diagnoses of hypertension (high blood pressure), neurogenic bladder (lack of bladder control) and orthostatic hypotension (a person's blood pressure drops when standing up). Review of Resident R37's physician orders dated 6/8/24, indicate foley catheter size eighteen french with 10cc balloon to straight bag gravity drainage. Observation 9/3/24, at 10:21 a.m. Resident R37 was sitting in his bed his foley catheter bag was observed hanging from the bedframe the bag failed to have a dignity/privacy cover. Interview 9/3/24, at 10:24 a.m. Licensed Practical Nurse (LPN) Employee E4 confirmed the foley catheter bag failed to have a dignity/privacy cover. Review of the clinical record indicated Resident R260 was admitted to the facility on [DATE], with diagnoses of dementia (a group of symptoms affecting memory, thinking and social abilities), heart failure (occurs when the heart muscle doesn't pump blood as well as it should), and dysphagia (difficulty swallowing). Review of Resident R260's progress note dated 8/30/24, indicated a foley catheter was inserted. During an observation on 9/3/24, at 12:14 p.m. Resident R260 was observed with a foley catheter. Review of Resident R260's physician order on 9/4/24, at 12:02 p.m. failed to include an order for Resident R260's catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/4/24, at 12:14 p.m. Licensed Practical Nurse, Employee E5 confirmed Resident R260 failed to have a physician order for a foley catheter. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa code: 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469 Based on facility policy review, observations, and staff interviews, it was determined that the facility failed to maintain sanitary conditions of respiratory equipment for one of three residents reviewed (Resident R51). Findings include: Review of the facility policy Oxygen Administration dated 8/1/24, indicates the purpose of this procedure is to provide guidelines for safe oxygen administration. Steps in procedure include but not limited to: -Be sure there is water in the humidifying jar and the water level is high enough that the water bubbles as oxygen flows. -Periodically re-check water in humidifying jar. Review of the facility policy Administering Medications through a Small Volume (handheld) Nebulizer dated 8/1/24, indicates the purpose of the procedure is to administer particles of medication safely and aseptically into the resident's airway. Steps in procedure include but not limited to: -When treatment is completed, turn off nebulizer and disconnect T-piece, mouthpiece, and medication cup. -Rinse and disinfect the nebulizer equipment according to facility protocol. -When equipment is completely dry, store in a plastic bag with the resident's name and date on it. Review of the admission record indicated Resident R51 was admitted to the facility on [DATE]. Review of Resident R51's Minimum Data Set (MDS- a periodic assessment of care needs) dated 5/16/24, indicated the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), hypertension (high blood pressure), and chronic bronchitis (long term inflammation of the breathing tubes) Review of Resident R51's physician order on 10/31/21, indicated Ipratropium-Albuterol Solution Nebulization Solution (a medication that is inhaled like a mist to assist in breathing) every four hours as needed for wheezing. Review of Resident R51's physician order dated 10/31/21, indicated oxygen at two liters per minute (lpm) via nasal canula. Review of Resident R51's physician order dated 11/02/21, indicated change oxygen tubing and canister every Tuesday night shift. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident R51 on 9/3/24, at 9:13 a.m. resident was in bed, a nebulization machine was sitting on the bedside stand not in a bag, not labeled with the date. The humidifying jar on the oxygen concentrator was void of water. Interview on 9/3/24, at 10:42 a.m. Licensed Practical Nurse (LPN) Employee E4 confirmed the nebulizer was not in a bag, not labeled with date and time and the humidifying jar on the oxygen concentrator was void of water for Resident R51. 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing Services. 28 Pa. Code: 201.14(a) Responsibility of licensee.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on review of facility policy, resident record review, and staff interviews, it was determined that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for two of two residents (Resident R36, and R84). Findings include: Review of facility policy Trauma Informed Care dated 8/1/24, indicated that trauma-informed care is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization. Review of the clinical record indicated Resident R36 was admitted to the facility on [DATE]. Review of Resident R36's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/26/24, indicated diagnoses of Post Traumatic Stress Disorder (PTSD- a disorder that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event), high blood pressure, and chronic pain. Review of Resident R36's care plan indicated that resident had PTSD but failed to identify what the triggers were and how to avoid them. Review of the clinical record indicated Resident R84 was admitted to the facility on [DATE]. Review of Resident R84's MDS dated [DATE], indicated diagnoses of PTSD, muscle weakness, and difficulty in walking. Review of Resident R84's care plan indicated that resident had PTSD but failed to identify what the triggers were and how to avoid them. During an interview on 9/5/24, at 11:09 a.m. Social Service Director Employee E3 confirmed that the facility failed to identify PTSD triggers for Resident 36, and R84 in order to eliminate or mitigate any triggers that may cause re-traumatization for these residents. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1) Management.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469 Based on observations, review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to conduct ongoing assessments to ensure that bed rails were used to meet residents' needs and the risks associated with bed rail usage for two of five residents (Residents R51 and R79). Findings include: Review of Title 42 Code of Federal Regulations (CFR) S483.25(n) - Bed Rails states that the facility must assess the resident for risk of entrapment from bed rails prior to installation. Additionally, there should be evidence in the resident's records that the facility performed ongoing assessments to assure that the bed rail is used to meet the resident's needs and that there is an ongoing evaluation of risks associated with bed rail usage. Review of the facility policy Proper Use of Side Rails dated 8/1/24, indicated the resident will be checked re-evaluated relative to side rail use quarterly, annually and with a change in condition. Review of the admission record indicated Resident R51 was admitted to the facility on [DATE]. Review of Resident R51's Minimum Data Set (MDS- a periodic assessment of care needs) dated 5/16/24, indicated the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), hypertension (high blood pressure), and chronic bronchitis (long term inflammation of the breathing tubes) Review of Resident R51's physician order dated 8/6/22, indicate bilateral grab bars to promote bed mobility. Review of Resident R51's care plan dated 8/18/22, indicate bilateral grab (enabler) bars for positioning and transferring. Review of Resident R51's clinical record revealed the most current Enabler/Assist Rail/Device Evaluation dated 3/12/24, indicated assist rails were in use. Interview on 9/4/24, at 2:00 p.m. the Director of Nursing (DON) confirmed the facility failed to conduct ongoing assessments to ensure that bed rails were used to meet residents' needs and the risks associated with bed rail usage for Resident R51. Review of the clinical record indicated that Resident R79 was admitted to the facility on [DATE], with the diagnosis of parkinsonism (a brain condition that causes slowed movements, rigidity, and tremors), diabetes (high sugar in the blood) and overactive bladder. Review of Resident R79's physician order dated 8/7/23, indicate enabler bars to both sides of bed for positioning and participation in care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395266	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Valley Healthcare and Rehabilitation Center	257 Georgetown Road Beaver Falls, PA 15010

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R79's care plan dated 8/7/23, indicate enabler bars to both sides of bed for positioning and participation in care. Review of Resident R79's clinical record revealed the most current Enabler/Assist Rail/Device Evaluation dated 3/12/24, indicated assist rails were in use. Interview on 9/5/24, at 1:30 p.m. the Nursing Home Administrator (NHA) confirmed the facility failed to conduct ongoing assessments to ensure that bed rails were used to meet residents' needs and the risks associated with bed rail usage for Resident R79. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49469 Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to store medications and biologicals properly and securely in one of three medications carts (one [NAME] medication cart). Findings include: Review of the facility policy Medication Storage in the Facility last reviewed 8/1/24, indicated medications and biologicals are stored safely, securely, and properly, following manufactures recommendations or those of the supplier. During an observation on 9/4/24, at 9:18 a.m. it was revealed that the one [NAME] medication cart contained: . One vial of artificial tears, that failed to have name or date opened. . One vial fluticasone nasal spray that failed to have date opened. . One bottle lactulose solution that failed to have date opened. . One anora ellipta inhaler that failed to have date opened. . One bottle of opened pure leaf tea. . Two cans of Arizona herbal tonic energy drink. . One medicine cup labeled with the initial H that contained: . One brown capsule . Four white tablets . One beige tablet . One tan gel filled tablet. . One purple tablet During an interview on 9/4/24, at 10:12 a.m. Registered Nurse (RN) Employee E7 confirmed the above observations and stated, the medicine cup belongs to a resident who was sleeping, I didn't want to wake up to give them and the drinks are my personal drinks. 28 Pa. Code: 211.9(a)(1)(h)(k)(l)(1) Pharmacy services. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code:211.12(d)(1)(2)(3)(5) Nursing services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of facility policy, resident clinical records, observation, and staff interviews, it was determined that the facility failed to implement infection control monitoring and management during a COVID-19 outbreak for one out of two residents (Resident R6) and failed to prevent cross contamination during a dressing change for one of three residents (Resident R13). Finding include: Review of facility policy SARS-CoV-2 Management dated 8/1/24, indicated the facility follows current guidelines and recommendations for managing COVID-19 in the facility. Anyone with even mild symptoms of COVID-19 (fatigue, headache, sore throat, fever, chills, etc.), regardless of vaccination status, should receive a viral test as soon as possible. It was indicated as part of the broad-based approach during an outbreak, testing should continue on affected units or facility-wide every 3-7 days until there are no new cases for 14 days. Testing should be performed for all residents and staff identified as close contacts or on the affected units if using a broad-based approach. The duration of isolation precautions for residents with COVID with mild to moderate illness who are not moderately to severely immunocompromised at least 10 days have passed since symptoms first appeared, at least 24 hours have passed since last fever without the use of fever-reducing medications, and symptoms have improved. Review of facility policy Wound Care dated 8/1/24 indicated the purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Steps including but not limited to: 1. Use disposable cloth to establish clean field on residents overbed table. Place all items to be used during procedure on the clean field. 2. Wash and dry hands thoroughly. 3. Position the resident. Place disposable cloth next to resident (under the wound) to serve as a barrier to protect the bed linen and other body sites. 4. Use no touch technique. Use sterile tongue blades and applicators to remove ointments and creams from their containers. 5. Discard disposable items into the designated container. Discard all soiled laundry, linen, towels, and wash clothes into the soiled laundry container. 6. Take only the disposable supplies that are necessary for the treatment into the room. Disposable supplies cannot be returned to cart. Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's physician order dated 7/5/24, indicated to test for COVID as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R6's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/20/23, indicated diagnoses of arthritis (the swelling and tenderness of one or more joints), atrial fibrillation (an irregular and often very rapid heart rhythm) and muscle weakness. Review of Resident R6's follow-up visit dated 8/19/24, entered by Certified Registered Nurse Practitioner (CRNP), Employee E1 indicated over the weekend the resident was complaining of a frontal headache and a sore throat. It was stated Resident R6 started having symptoms after a leave of absence with her family and concerned she may have picked up an illness. Review of Resident R6's follow-up visit dated 8/26/24, entered by Certified Registered Nurse Practitioner (CRNP), Employee E1 indicated the resident was out with family on a leave of absence and developed a sore throat and right earache. It was indicated the resident had some coughing and sputum. A rapid COVID test was ordered. Review of Resident R6's progress note dated 8/26/24, indicated the resident had a positive rapid covid test after reporting cold like symptoms to the provider. It was indicated isolation precaution was initiated per policy. Review of Resident R6's physician order dated 8/26/24, indicated to implement contact and droplet precautions: Masks (N95), gloves, gowns, and eye shields, every shift. Seven days after Resident R6 displayed symptoms. Review of Resident R6's progress note dated 9/1/24, indicated the Resident's isolation precautions were discontinued due to negative covid test. During an observation on 9/3/24, at 9:08 a.m. no signage was posted at the entrance that indicated the facility was in an active COVID outbreak. During an interview on 9/3/24, at 9:31 a.m. the Nursing Home Administrator stated the facility is not in an active COVID outbreak. During an interview on 9/5/24, at 11:14 a.m. Infection Preventionist, Employee E9 stated residents are tested immediately for COVID if symptomatic. It was indicated all residents have a standing order to test for covid as needed. During an outbreak test are completed on Day 1, 3, and 5. IP, Employee E9 confirmed Resident R6 should have been tested on [DATE], when she displayed symptoms. IP, Employee E9 indicated as a response to the outbreak, the facility was monitoring for symptoms, and anyone that develops symptoms was tested . IP, Employee E9 stated the duration of isolation precautions for a resident with COVID depends on their test results. It was indicated if a resident has two negative tests within 48 hours or after 10 days, the isolation precautions are discontinued. IP, Employee E9 indicated after 10 days of the last positive test, the facility is no longer considered in an outbreak. During an interview on 9/5/24, at 11:39 a.m. the Nursing Home Administrator confirmed the facility failed to implement infection prevention, monitoring, and management for COVID-19 during an outbreak for one of two residents (Resident R6). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of Resident R13's dressing change on 9/5/24, at 11:11 a.m. Licensed Practical Nurse (LPN) Employee E5 made the following cross contamination and hand hygiene opportunities. LPN Employee E5 placed a washable lift pad onto Resident R13's bed next to her right leg and proceeded to place dressing supplies onto the lift pad that included a box of gloves 4x4's, calcium alginate and bordered gauze. LPN Employee E5 opened supplies and placed onto washable lift pad. Resident R13 requested to turn towards the right, LPN Employee E5 slid the lift pad over the resident to the left side of the bed. LPN employee E5 failed to place a clean barrier under the resident prior to completing dressing change. After cleansing the wound LPN Employee E5 removed gloves and applied new gloves. LPN Employee E5 used gloved finger and dipped into jar of Silvadene, continued to apply the Silvadene to the wound with gloved finger, covered with the alginate and dry dressing, placed lid onto Silvadene container. LPN Employee E5 placed all used supplies into a bag for disposable except the lift pad and box of gloves and jar of Silvadene which were placed in said order onto the floor. Resident R13 requested to be repositioned. LPN Employee E5 picked up the lift pad and gloves from the floor and placed to another area onto floor. The Silvadene was given to LPN Employee E6 who was assisting with the treatment and stated she would put it back. After repositioning the resident, LPN Employee E5 picked up the lift pad and gloves from the floor, placed the gloves onto Resident 13's overside bed table and placed the washable lift pad into a bag. Removed gown and gloves and washed hands. He then picked up the gloves from the table and placed under his left arm, picked up the bag containing the lift pad and the bag of soiled supplies and placed into proper receptacles. Walked down the hallway and placed the box of gloves into left the compartment of medication cart. During an interview on 09/05/24, 11:37 a.m. LPN Employee E5 confirmed he failed to implement infection control practices to prevent cross contamination during a dressing change, failed to set up a clean barrier field and treat the wound without contaminating the wound bed and returned used supplies to the medication cart for Resident R13. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services 28 Pa. Code: 211.12(d)(3) Nursing services.