STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395270	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Park Nursing and Rehabilitation	700 Walnut Bottom Road Carlisle, PA 17013

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46253 Based on facility policy review, observations, and staff interviews, it was determined that the facility failed to promote care for residents in a manner and environment that enhances each resident's dignity for six of 23 Residents reviewed (Residents 6, 7, 34, 42, 57, and 68). Findings Include: Review of facility policy, titled Dignity, with a last review date of February 3, 2025, revealed, in part, 5. When assisting with care, residents are supported in exercising their rights. For example, residents are e. provided with a dignified dining experience; 10. Staff protect confidential clinical information. Examples include the following: b. Signs indicating the resident's clinical status or care needs are not openly posted in the resident's room unless specifically requested by the resident or family member. Discreet posting of important clinical information for safety reasons is permissible (e.g., taped to the inside of the closet door); and 12. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: a. helping the resident to keep urinary catheter bags covered. Observation of Resident 7 on March 3, 2025, at 11:06 AM, revealed that Resident 7 was seated in her chair and Employee 2 was standing over Resident 7, assisting her with her lunch. Observation of Resident 34 on March 3, 2025, at 11:12 AM, revealed that Resident 34 was laying in his bed, which was in the low position to the floor, and Employee 3 was standing at the bedside, assisting him with his lunch. Observation of Resident 6 on March 4, 2025, at 11:25 AM, revealed that Resident 6 was seated in her chair and Employee 1 was standing over Resident 6, assisting her with her lunch. Observation of Resident 7 on March 4, 2025, at 11:40 AM, revealed that Resident 7 was seated in her chair and Employee 1 was standing over Resident 7, assisting her with her lunch. During a staff interview with Employee 1 on March 4, 2025, at 1:35 PM, Employee 1 indicated that if she is assisting a resident in bed with their meal, she usually brings the bed up to her height to make eye contact with the resident. She further indicated that if she was assisting a resident seated in their chair with their meal, she would sit in a chair if one was available. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a staff interview with the Nursing Home Administrator (NHA) on March 5, 2025, at 10:05 AM, the NHA confirmed that she would expect staff to be at eye-level contact with a resident when assisting them with their meals. Observations of Resident 42's room on March 3, 2025, at 10:29 AM, and on March 4, 2025, at 10:41 AM, revealed a typed sign hanging above the head of her bed that said, Keep head of bed elevated when on tube feeding. Observations of Resident 57's room on March 3, 2025, at 11:00 AM, and March 4, 2025, at 10:39 AM, revealed a typed sign hanging above the head of her bed that said, Please do not leave wipes at bedside. During a staff interview with the NHA on March 5, 2025, at 10:58 AM, the NHA indicated that it was not a good practice to have the signs posted like those observed for public view. Observations of Resident 68 on March 3, 2025, at 10:32 AM, and 12:52 PM, and on March 4, 2025, at 9:18 AM and 11:40 AM, all revealed that Resident 68's urinary catheter drainage bag with urine noted in the bag was visible from the hallway. During an interview with the NHA on March 5, 2025, at 12:20 PM, the NHA indicated that she would expect Resident 68's urinary catheter bag to have a dignity cover in place to hide it from public view. 28 Pa Code 201.29(a) Resident rights 28 Pa Code 211.11(d)(1)(2) Nursing services

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 46253 Based on facility policy review, clinical record reviews, and staff interviews, it was determined that the facility failed to notify the resident/resident representative of a resident's transfer, in writing, to include: the reason for the transfer or discharge, date of transfer, location of transfer, statement of the resident's appeal rights, name, and address (mailing and email) for two of four resident records reviewed for hospitalization (Residents 21 and 80). Findings include: Review of facility policy, titled Bed-Holds and Returns, last reviewed February 3, 2025, revealed, in part, 3. Prior to a transfer, written information will be given to the residents and the resident representative that explain in detail: d. the details of the transfer (per the notice of transfer). Review of Resident 21's clinical record revealed diagnoses that included hypertensive heart disease without heart failure (a long-term condition that develops over many years in people who have high blood pressure), chronic kidney disease (longstanding disease of the kidneys leading to renal failure), and chronic obstructive pulmonary disease (COPD-a type of progressive lung disease characterized by long term respiratory symptoms and airflow limitations). Review of Resident 21's clinical record revealed that the Resident had been transferred and admitted to the hospital on June 3, 2024, and September 5, 2024. Review of Resident 21's transfer notices dated June 4, 2024, and September 6, 2024, revealed that they were not signed by Resident 21 nor their Resident Representative, and there was no documentation on the notice of whom the information may have been reviewed with verbally. Further, they did not contain the mailing address of the Office of the State Long-Term Care Ombudsman; the mailing address for the agency responsible for protection and advocacy of individuals with developmental disabilities; nor, the mailing address for agency responsible for the protection and advocacy of individuals with mental disorders. The facility was unable to provide documentation that Resident 21's transfers to the hospital on June 3, 2024, and September 5, 2024, were reported to the Ombudsman. During a staff interview with the Nursing Home Administrator (NHA) on March 4, 2025, at 1:14 PM, the NHA indicated that when she started at the facility in December 2024, she could not find where there were any reports or emails to show that the Ombudsman reporting was being completed. She confirmed that she would expect the Ombudsman reporting to have been completed. During a staff interview with the NHA on March 5, 2025, at 2:00 PM, the NHA confirmed that the transfer notices were not signed, and she had no documentation to provide of whom received the information contained in the transfer notice. She also confirmed that not all required info was included in transfer notice and should have been. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 80's clinical record revealed diagnoses that included type 2 diabetes mellitus (body's inability to use insulin causing sugar to build up in the blood) and Alzheimer's disease (progress disease that destroys memory and other mental functions). Further review of Resident 80's clinical record revealed he was transferred out of the facility to the hospital on December 29, 2024, and was subsequently admitted to the hospital. Additional review of Resident 80's clinical record failed to reveal a notice of transfer was provided to Resident 80 or his Representative. During an interview on March 6, 2025, at 9:19 AM, with the NHA and Director of Nursing, it was revealed the facility had no additional information to provide. The NHA stated it was the expectation of the facility that notice of transfer be provided to residents and/or representatives. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(2)(3)(5) Nursing services

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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. 46253 Based on facility policy review, clinical record reviews, and staff interviews, it was determined that the facility failed to ensure the resident and/or the resident's representative were provided the bed-hold notice upon transfer for two of four residents reviewed for hospitalization s (Residents 21 and 80). Finding include: Review of the facility policy, titled Bed-Holds and Returns, last reviewed February 3, 2025, revealed, in part, 3. Prior to a transfer, written information will be given to the residents and the residents representatives that explains in detail: a. the rights and limitations of the resident regarding bed-holds; b. the reserve bed payment policy as indicated by the state plan (Medicaid resident); c. the facility per diem rate required to hold a bed (non-Medicaid resident), or to hold a bed beyond the state bed-hold period (Medicaid residents . Review of Resident 21's clinical record revealed diagnoses that included hypertensive heart disease without heart failure (a long-term condition that develops over many years in people who have high blood pressure), chronic kidney disease (longstanding disease of the kidneys leading to renal failure), and chronic obstructive pulmonary disease (COPD-a type of progressive lung disease characterized by long term respiratory symptoms and airflow limitations). Review of Resident 21's clinical record revealed that the Resident had been transferred and admitted to the hospital on June 3, 2024, and September 5, 2024. Review of Resident 21's Bed-Hold Policy and Notification and Authorization notices dated June 3, 2024, and September 5, 2024, failed to include the bed-hold reserve payment rate. During a staff interview with the Nursing Home Administrator (NHA) on March 5, 2025, at 2:00 PM, the NHA confirmed that the facility's Bed-Hold Policy and Notification and Authorization notices should include the bed-hold reserve payment rate. Review of Resident 80's clinical record revealed diagnoses that included type 2 diabetes mellitus (body's inability to use insulin causing sugar to build up in the blood) and Alzheimer's disease (progress disease that destroys memory and other mental functions). Further review of Resident 80's clinical record revealed he was transferred out of the facility to the hospital on December 29, 2024, and was subsequently admitted to the hospital. Additional review of Resident 80's clinical record failed to reveal a bed-hold notification was provided to Resident 80 or his Representative. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on March 6, 2025 at 9:19 AM, with the NHA and Director of Nursing it was revealed the facility had no additional information to provide. The NHA stated it was the expectation of the facility that a bed-hold notification be provided to residents and/or representatives. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(2)(3)(5) 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** 47966 Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for two of 26 residents reviewed (Residents 64 and 72). Findings include: Review of Resident 64's clinical record revealed diagnoses that included contracture of muscle (a condition where muscles, tendons, joints, or other tissues tighten or shorten, causing deformity and loss of movement in the joint), functional quadriplegia (complete immobility due to severe disability or frailty caused by another medical condition, without physical injury or damage to the brain or spinal cord), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest in things). Review of Resident 64's clinical record revealed he has been on a turning and repositioning program since his admission on December 13, 2024; and the intervention has been noted to be a part of his pain management program since December 14, 2024. Review of Resident 64's Admission and 5 Day MDS assessments (Minimum Data Set- assessment tool utilized to identify residents' physical, mental and psychosocial needs) with ARD (assessment reference date- last day of the assessment period) of December 19, 2024, revealed Resident 64 was marked no under section J, Received non-medication intervention for pain?, and was marked no under section M, Turning/repositioning program. During an email correspondence with the Nursing Home Administrator (NHA) on March 5, 2025, at 1:51 PM, she revealed Employee 9 (Licensed Practical Nurse Assessment Coordinator) revised the aforementioned MDS assessments to indicate that Resident 64 received non-medication intervention for pain and was on a turning/repositioning program during the ARD. During a follow-up interview with the NHA on March 6, 2025, at 10:14 AM, she revealed she would expect Resident 64's MDS assessments to be coded accurately. Review of Resident 72's clinical record revealed diagnoses that included hypotension (low blood pressure) and atrial fibrillation (an irregular heartbeat). Review of Resident 72's clinical record revealed the Resident had an un-witnessed fall on September 20, 2024, and fell out of bed, with no injury occurring. Review of Resident 72's Quarterly MDS dated [DATE], revealed that Section J1800, Any Fall Since Admission/Entry/ or Reentry or Prior Assessment (Has the resident had any falls since admission/entry or reentry or the prior assessment) was marked No; as well as Section J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (A. Number of falls since Admission or Prior assessment - No Injury) failed to capture Resident 72's fall on September 20, 2024. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Electronic correspondence received from the NHA on March 5, 2025, at 1:53 PM, revealed Resident 72's Quarterly MDS completed on October 16, 2024, was corrected to reflect Resident 72's fall with no injury, and confirmed a modification was made on Section J1800 and Section J1900. Interview with the NHA on March 6, 2025, at 10:05 AM, revealed she would have expected Resident 72's Quarterly MDS dated [DATE], to have been coded accurately. 28 Pa. Code 211.5(f) Medical records 28 Pa Code 211.12 (d)(3)(5) Nursing Services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 40010 Based on observations, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure the care plan was reviewed and revised for two of 26 residents reviewed (Residents 65 and 88). Findings Include: Review of Resident 65's clinical record revealed diagnoses that included congestive heart failure (a serious condition that occurs when the heart can't pump blood efficiently enough to meet the body's needs) and difficulty walking not elsewhere classified (a medical term used when someone has difficulty walking but the cause cannot be more precise). Observation of Resident 65 on March 3, 2025, at 11:22 AM, revealed Resident 65 lying in bed, and Resident 65's rolling walker was sitting beside the Resident's bed. Interview with Resident 65 at that time revealed that she is able to walk with the rolling walker. Review of Resident 65's care plan revealed a care plan with a focus area of, Requires assistance transferring from one position to anther related to unsteady gait, with a revision date of January 8, 2025. The care plan failed to mention Resident 65's use of a rolling walker. Interview with the Nursing Home Administrator (NHA) on March 5, 2025, at 2:55 PM, revealed that the rolling walker was on the care plan previously, but the care plan was revised and updated, and the previous version cannot be retrieved. Review of Resident 88's clinical record revealed diagnoses that included anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life) and psoriasis (a chronic skin condition characterized by raised, red, scaly patches of skin called plaque). Review of Resident 88's clinical record revealed she had an unwitnessed fall on December 27, 2024, where Resident 88 was found sitting on the floor beside her bed. Review of Resident 88's comprehensive care plan revealed a focus area related to being at risk for falls with an intervention for fall matt(s): Left side of bed, with an initiation date of December 27, 2024. Observations of Resident 88 on March 4, 2025, at 9:25 AM, and March 5, 2025, at 9:57 AM, revealed Resident 88 was in their room laying in bed, with no fall mat present on the left side. Electronic correspondence received from the NHA on March 5, 2025, at 3:40 PM, revealed the fall mat was being removed from Resident 88's care plan as Resident 88 transfers independently in and out of bed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the NHA on March 6, 2025, at 10:04 AM, revealed she would have expected Resident 88's fall mat to have been removed from their care plan if it was not in use. 28 Pa. Code 211.12(d)(5) Nursing services

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 46253 Based on facility policy reviews, product information review, observations, clinical record reviews, and staff interviews, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards for two of six residents observed during medication preparation and administration for (Residents 25 and 65) and for one of one resident observed for treatment administration (Resident 68). Findings include: Review of facility policy, titled Administering Medications, with a last review date of February 3, 2025, revealed,in part, 25. Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. Review of facility policy, titled Insulin Administration, with a last review date of February 3, 2025, revealed, in part, 5. The nursing staff will have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery system(s) prior to their use. Review of facility policy, titled Pharmacy Services Policy and Procedure, with a last review date of February 3, 2025, revealed, in part, Facility staff shall not borrow medication from another resident's supply. The practice of borrowing medication is not consistent with professional standards and contributes to medication errors. Review of the instruction leaflet for Lantus-Solostar Insulin Pen, with a last revised date of February 23, 2016, revealed the following, in part: Always use a new sterile needle for each injection. A. Wipe the rubber seal with alcohol. B. Remove the protective seal from a new needle. C. Line up the needle with the pen and keep it straight as you attach it (screw or push on, depending on the needle type). Review of Resident 25's clinical record revealed diagnoses that included hypertension (high blood pressure), chronic diastolic congestive heart failure (heart failure that occurs when the heart does not relax properly between beats, causing the heart to be unable to pump an adequate amount of blood to the body), and diabetes mellitus (disease that occurs when your blood glucose, also called blood sugar, is too high). Review of Resident 25's current physician orders revealed an order for Lantus SoloStar Subcutaneous Solution Pen-injector 100 units/ml (Insulin Glargine) Inject 20 unit subcutaneously in the morning for DM [Diabetes Mellitus], Give 1/2 dose if sugar less than 120, dated May 24, 2024. During a medication pass observation on March 5, 2025, at approximately 8:41 AM, Employee 4 (Licensed Practical Nurse) was observed removing Resident 25's Lantus Solostar insulin pen from the medication cart, removing the cap on the insulin pen, and applying a new sterile needle to the pen. Employee 25 failed to cleanse the rubber seal prior to applying the new sterile needle. In addition, at approximately 8:55 AM, Employee 4 was observed administering Resident 25's Lantus insulin to her abdomen without wearing gloves. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 65's clinical record revealed diagnoses that included chronic systolic congestive heart failure (a specific type of heart failure that occurs in the left ventricle and the ventricle cannot contract normally when the heart beats) and diabetes. Review of Resident 65's current physician orders revealed orders for Insulin Glargine Subcutaneous Solution 100 UNIT/ML (Insulin Glargine-Lantus) Inject 15 unit subcutaneously two times a day related to diabetes, dated February 20, 2025; and Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro) Inject 8 unit subcutaneously with meals related to diabetes, dated February 20, 2025. During a medication pass observation on March 5, 2025, at approximately 9:02 AM, Employee 4 was observed removing Resident 65's Lantus SoloStar insulin pen and her Lispro insulin pen from the medication cart, removing the caps on the insulin pens, and applying a new sterile needle to the pens. Employee 4 failed to cleanse the rubber seals prior to applying the new sterile needle. During a staff interview with Employee 4 on March 5, 2025, at 9:32 AM, he confirmed that he did not clean the insulin pens for Residents 25 and 65 prior to attaching the new sterile needle. He said that the pens were a closed system and did not need to be cleaned since he did not touch the end of the pens. He said that he had never been instructed that the end of an insulin pen should be cleansed with alcohol before applying the needle. Employee 4 further confirmed that he did not wear gloves while administering Resident 25's insulin. He said that if a person administers their own insulin, they do not have to wear gloves and, therefore, he did not wear gloves. During a staff interview with the Nursing Home Administrator (NHA) on March 6, 2025, at 09:36 AM, the NHA confirmed that she would expect insulin pens to be cleaned before the needles are applied and that Employee 4 should have worn gloves when administering the insulin injection to Resident 25. Review of Resident 68's clinical record revealed diagnoses that included cerebral infarction (a stroke-damage to the brain from interruption of its blood supply), diabetes mellitus, and liver transplant. Further review of Resident 68's clinical record revealed that he had a stage 2 pressure ulcer (a partial thickness tissue loss wound that does not go deeper than the dermis or middle layer of skin) on his right buttock; a stage 3 pressure ulcer (a full-thickness tissue loss wound where the tissue just under the skin may be visible, but no bone, tendon, or muscle is exposed) on his left buttock; and an unstageable pressure ulcer (full-thickness skin and muscle loss, with slough or eschar obstructing the wound bed making it impossible to determine the depth of the wound) on his sacrum (the part of the spinal column that is directly connected to the pelvis). Review of Resident 68's current physician orders revealed orders to apply zinc oxide ointment to left and right buttock every shift for wound care, dated February 26, 2025; and cleanse sacrum with NSS (normal saline solution), apply Santyl (a medication used to remove debris or dead tissue from a burn, ulcer, or wound, which helps promote healing and decrease the risk of infection), and cover with a dry sterile dressing every day shift, dated February 20, 2025. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident 68's dressing change on March 5, 2025, at 12:52 PM, performed by Employee 5 (Licensed Practical Nurse) revealed that Employee 5 had prepared all treatment items prior to surveyor arrival. After the treatment observation was completed, at approximately 1:30 PM, Employee 5 was asked to provide the tube of Santyl she utilized to perform the treatment. Observation of this tube at approximately 1:30 PM, revealed that it was labeled with another resident's name. During an immediate interview with Employee 5, she acknowledged the tube of Santyl had another resident's name on it. In addition, the name on the tube was also verified by Employee 6 (Licensed Practical Nurse) and the Director of Nursing (DON) at 1:35 PM. During a staff interview with the NHA and DON on March 6, 2025, at 10:09 AM, the DON confirmed that Employee 5 should have used Resident 68's tube of Santyl for his treatment. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services

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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. 46253 Based on clinical record reviews, observation, facility document review, and resident and staff interviews, it was determined that the facility failed to provide care and services in accordance with professional standards for four of 23 residents reviewed (Resident 5, 64, 68, and 88). Findings include: Review of Resident 5's clinical record revealed diagnoses that included vascular dementia (disease process in which damage to the blood vessels of the brain causes decreased contact with reality and decreased ability to perform activities of daily living) and congestive heart failure (decreased ability of the heart to pump blood through the body). Review of Resident 5's clinical record revealed that on April 30, 2024, Resident 5 had a consultative gastrointestinal appointment for signs of dysphagia (difficulty swallowing). Review of the consultation report revealed the recommendations stated, Call with update in [two] weeks if [swallowing] no better Barium swallow next. Continue soft diet, thin liquids. Recommends dentures - see dentist. Review of the consultation sheet revealed it was signed by facility staff and the attending physician. After Resident 5's April 30, 2024, appointment, facility staff documented that Resident 5 had coughing during meal consumption (sign and/or symptom of dysphagia) on May 9, 10, 11, 12, 13, and 14, 2024. As of March 5, 2025, Resident 5 did not have a dental consult scheduled for the evaluation of dentures, did not have any further gastrointestinal appointments, nor any further speech therapy to address Resident 5's dysphagia despite the coughing episodes persisting. Review of Resident 5's February, 2025 interdisciplinary progress notes revealed that staff documented that Resident 5 continued to have coughing episodes during or directly after meal consumption. During a staff interview on March 6, 2025, the Nursing Home Administrator (NHA) revealed it was the facility's expectation that staff would have followed the recommendations provided by Resident 5's consultant gastrointestinal physician. Review of Resident 64's clinical record revealed diagnoses that included contracture of muscle (a condition where muscles, tendons, joints, or other tissues tighten or shorten, causing deformity and loss of movement in the joint), functional quadriplegia (complete immobility due to severe disability or frailty caused by another medical condition, without physical injury or damage to the brain or spinal cord), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest in things). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 64's January 2025 TAR (Treatment Administration Record- documentation for medication/treatment administered or monitored) revealed three wound treatments on January 27, 2025, all of which were marked with a 9 rather than being checked to indicate they were administered. Further review of the TAR revealed 9 is a chart code for other/see progress notes. Review of Resident 64's progress notes on January 27, 2025, failed to reveal notation as to why the wound treatments were not completed on that date. Review of Resident 64's February 2025 TAR revealed a daily wound treatment to his right medial shin, with a start date of December 21, 2024. Further review of his TAR revealed it was left blank on February 17, 2025, failing to indicate the treatment was completed. During an interview with the Director of Nursing (DON) on March 6, 2025, at 10:14 AM, she revealed she was unable to provide information as to why the wound treatments were not documented as completed on January 27, 2025, and February 17, 2025; and she would expect wound treatments to be documented as completed, or notation in the clinical record why they were not completed. Review of Resident 68's clinical record revealed diagnoses that included cerebral infarction (a stroke-damage to the brain from interruption of its blood supply), type 2 diabetes mellitus (disease that occurs when your blood glucose, also called blood sugar, is too high, but does not require the use of insulin), and liver transplant. Review of Resident 68's January physician orders revealed an order for Humulin 70/30 Insulin Suspension 100 units per ml (milliliters) inject 16 units subcutaneously every 8 hours for diabetes, dated January 5, 2025. The order did not indicate any parameters as to when insulin should not be administered. Review of Resident 68's January 2025 Medication Administration Record (MAR) revealed the following: 1) January 16th 8:00 AM: dose was not administered, blood sugar was recorded as 68, and the insulin was coded as 14 (insulin not needed); 2) January 21st 8:00 AM: dose was not administered, no blood sugar was recorded, and the insulin was coded as 5 (Hold see progress note); and 3) January 23rd 8:00 AM: dose was not administered, no blood sugar was recorded, and the insulin was coded as 5 (Hold see progress note). Review of Resident 68's January 2025 progress notes revealed the following: 1) there was no documentation on January 16, at 8:00 AM, indicating why the insulin was not administered or that Resident 68's physician was made aware that the insulin was not administered; 2) a progress note dated January 21, at 8:21 AM, that indicated AM BS [blood sugar] low, resident refused breakfast, but failed to indicate if Resident 68's physician was made aware of the low blood sugar, Resident refusing breakfast, and insulin not being administered; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) a progress note dated January 23, at 8:25 AM, that indicated the insulin was not administered Due to low BS, but failed to indicate if Resident 68's physician was made aware of the low blood sugar and insulin not being administered. Review of Resident 68's February 2025 physician orders revealed an order for Humulin 70/30 Insulin Suspension 100 units/ml (milliliters) inject 16 units subcutaneously every 8 hours for diabetes, dated February 20, 2025. This order did not indicate any parameters as to when insulin should not be administered. Review of Resident 68's February 2025 MAR revealed the following: 1) February 20th 12:00 PM: dose was not administered, blood sugar was recorded as 89, and the insulin was coded as 5 (Hold see progress note); 2) February 21st 8:00 AM: dose was not administered, blood sugar was recorded as 112, and the insulin was coded as 5 (Hold see progress note); 3) February 21st 12:00 PM: dose was not administered, blood sugar was recorded as 112, and the insulin was coded as 5 (Hold see progress note); 4) February 24th 8:00 AM: dose was not administered, blood sugar was recorded as 122, and the insulin was coded as 5 (Hold see progress note); and 5) February 24th 12:00 PM: dose was not administered, blood sugar was recorded as 112, and the insulin was coded as 5 (Hold see progress note). Review of Resident 68's February 2025 progress notes revealed the following: 1) a progress note dated February 20, at 2:05 PM, indicated that the insulin was not administered due to low BS, but failed to indicate if Resident 68's physician was made aware of the low blood sugar and insulin not being administered; 2) a progress note dated February 21, at 9:49 AM, that indicated the insulin was not administered due to low BS, but failed to indicate if Resident 68's physician was made aware of the low blood sugar and insulin not being administered; 3) a progress note dated February 21, at 1:27 PM, that indicated the insulin was not administered due to low BS, but failed to indicate if Resident 68's physician was made aware of the low blood sugar and insulin not being administered; 4) a progress note dated February 24, at 9:24 AM, that indicated the insulin was not administered Resident refused breakfast, but failed to indicate if Resident 68's physician was made aware that he had refused breakfast and insulin was not administered; and 5) a progress note dated February 24, at 1:08 PM, that indicated the insulin was not administered Resident refused lunch, but failed to indicate if Resident 68's physician was made aware that he had refused lunch and insulin was not administered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a staff interview with the NHA and DON on March 6, 2025, at 10:12 AM, the DON confirmed that she would expect residents to receive their ordered insulin doses or physician notification to occur if a nurse felt the need to hold the insulin based on their nursing judgement. Review of Resident 88's clinical record revealed diagnoses that included anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life) and psoriasis (a chronic skin condition characterized by raised, red, scaly patches of skin called plaque). Review of Resident 88's clinical record revealed an active physician's order for: compression stockings, apply in the morning and remove at bedtime. Check every day and evening shift for Prevent DVT (Deep vein thrombosis - a blood clot that forms in a deep vein). Apply in the morning, with a start date of November 30, 2024. Observation of Resident 88 on March 3, 2025, at 9:25 AM, and March 4, 2025, at 9:59 AM, revealed the Resident was laying in bed without compression stockings on. Interview with Resident 88 on March 4, 2025, at 9:27 AM, revealed staff told her that she only needs to wear compression stockings if she is going to be out of bed for a few hours at a time. Review of Resident 88's March 2025 MAR revealed that the order for compression stockings, apply in the morning and remove at bedtime. Check everyday and evening shift for prevent DVT, was marked off as being administered to Resident 88 on March 3, 2025, and March 4, 2025, during day shift. Electronic correspondence received from the DON on March 5, 2025, at 3:40 PM, revealed that Resident 88 has been refusing compression stockings, but it has not been documented in progress notes. Interview with the NHA on March 6, 2025, at 10:05 AM, revealed she would have expected staff to be marking if Resident 88 is refusing compression stockings on the MAR instead of marking that it is being completed. 28 Pa Code 201.18(b)(1) Management 28 Pa Code 211.12(d)(1)(3)(5) Nursing services

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 46253 Based on facility policy review, clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that residents receive necessary treatment and services, consistent with professional standards of practice, to identify pressure ulcers and to promote healing and prevent infection of a pressure ulcer for one of three residents reviewed for pressure ulcers (Resident 68). Findings include: Review of facility policy, titled Dressings, Dry/Clean, with a last review date of February 3, 2025, revealed, in part, 15. Cleanse the wound with ordered cleanser. If using gauze, use clean gauze for each cleansing stroke. Clean from the least contaminated area to the most contaminated area (usually, from the center outward); 16. Use dry gauze to pat the wound dry; and 17. Apply the ordered dressing and secure with tape or bordered dressing per order. Review of Resident 68's clinical record revealed diagnoses that included cerebral infarction (a stroke-damage to the brain from interruption of its blood supply), type 2 diabetes mellitus (disease that occurs when your blood glucose, also called blood sugar, is too high, but does not require the use of insulin), and liver transplant. Further review of Resident 68's clinical record revealed that he had a stage 2 pressure ulcer (a partial thickness tissue loss wound that does not go deeper than the dermis or middle layer of skin) on his right buttock; a stage 3 pressure ulcer (a full-thickness tissue loss wound where the tissue just under the skin may be visible, but no bone, tendon, or muscle is exposed) on his left buttock; and an unstageable pressure ulcer (full-thickness skin and muscle loss, with slough or eschar obstructing the wound bed making it impossible to determine the depth of the wound) on his sacrum (the part of the spinal column that is directly connected to the pelvis). Review of Resident 68's current physician orders revealed orders to apply zinc oxide ointment to left and right buttock every shift for wound care, dated February 26, 2025; and cleanse sacrum with NSS (normal saline solution), apply Santyl (a medication used to remove debris or dead tissue from a burn, ulcer, or wound, which helps promote healing and decrease the risk of infection), and cover with a dry sterile dressing every day shift, dated February 20, 2025. Observation of Resident 68's dressing change on March 5, 2025, at 12:52 PM, performed by Employee 5 (Licensed Practical Nurse), revealed that Employee 5 cleansed all wounds with normal saline solution and a gauze pad, Employee 5 then applied the Santyl to the sacral wound utilizing a tongue depressor, applied the zinc oxide ointment to the buttock wounds, applied a foam bordered dressing to the sacrum, removed her gloves, washed her hands, and applied clean gloves to assist in repositioning Resident 68. During a staff interview with the Nursing Home Administrator and Director of Nursing (DON) on March 6, 2025, at 10:09 AM, the DON confirmed that Employee 5 should have changed gloves, washed her hands, and applied clean gloves between cleansing Resident 68's wound and applying ordered treatment. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. 47966 Based on clinical record review and staff interviews, it was determined that the facility failed to monitor the resident's nutritional status for one of seven residents reviewed for nutrition (Resident 72). Findings include: Review of Resident 72's clinical record revealed diagnoses that included hypotension (low blood pressure) and atrial fibrillation (an irregular heartbeat). Review of Resident 72's clinical record revealed a full nutrition assessment/weight change completed by the dietitian on September 13, 2024, at 10:16 PM, which read, in part, that Resident 72 triggers for significant undesired weight loss of 25% in one month and will order weekly weights for four weeks for weight monitoring. Will monitor weight trends. Review of Resident 72's September 2024 MAR (Medication Administration Record) revealed an order for Weights; weekly weights for 4 weeks, for weight monitoring for four administrations, with a start date of September 14, 2024. Further review of Resident 72's September 2024 MAR revealed that no weights were obtained per the order above on September 14 and 28, 2024, or October 5, 2024. Review of Resident 72's comprehensive care plan revealed a nutrition focus area with an intervention for weights as ordered, with an initiation date of July 9, 2024. Electronic correspondence received from the Director of Nursing on March 5, 2025, at 2:44 PM, revealed she is unsure as to why weights were not obtained for Resident 72 as she was not at the facility. Interview with the Nursing Home Administrator on March 6, 2025, at 10:07 AM, revealed she would have expected weights to have been obtained as ordered by the physician. 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. 46253 Based on facility policy review, clinical record review, observations, and staff interview, it was determined that the facility failed to provide respiratory care/oxygen services consistent with professional standards of practice for one of one resident reviewed for oxygen use (Resident 57). Findings include: Review of the facility policy, titled Oxygen Administration, with a last review date of February 3, 2025, revealed, in part, Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review of Resident 57's clinical record revealed diagnoses that included hypertension (high blood pressure), atrial fibrillation (abnormal heart rhythm characterized by rapid and irregular beating of the upper chamber of the heart), and cerebral infarction (a stroke-damage to the brain from interruption of its blood supply). Observations of Resident 57 on March 3, 2025, at 11:01 AM, and March 4, 2025, at 11:00 AM, revealed that the Resident was receiving oxygen at 1 liter per minute via a nasal cannula. Review of Resident 57's clinical record physician orders failed to reveal an order for oxygen administration. During a staff interview with the Nursing Home Administrator on March 5, 2025, at 9:58 AM, she confirmed that Resident 57 was currently utilizing oxygen and that an order should have been in place for her oxygen use. 28 Pa code 211.12(d)(1)(2) Nursing services

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48484 Based on facility policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure that pain management is provided to residents who require such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one of three residents reviewed for pain management (Resident 64). Findings include: Review of facility policy, titled Pain Assessment and Management, last reviewed February 3, 2025, read, in part, The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. Pain management is a multidisciplinary care process that includes the following: Developing and implementing approaches to pain management; identifying and using specific strategies for different levels and sources of pain; monitoring for the effectiveness of interventions; and modifying approaches as necessary. Non-pharmacological interventions may be appropriate alone or in conjunction with medications. Some non-pharmacological interventions include: a. Environmental - adjusting the room temperature, smoothing the linens, providing a pressure-reducing mattress, repositioning, etc.; b. Physical - ice packs, cool or warm compresses, baths, transcutaneous electrical nerve stimulation (TENS), massage, acupuncture, etc.; c. Exercise - range of motion exercises to prevent muscle stiffness and contractures; and d. Cognitive or Behavioral - relaxation, music, diversions, activities, etc. If pain has not been adequately controlled, the multidisciplinary team, including the physician, shall reconsider approaches and make adjustments as indicated. Report the following information to the physician or practitioner: significant changes in the level of the resident's pain; and prolonged, unrelieved pain despite care plan interventions. Review of Resident 64's clinical record revealed he was admitted to the facility on [DATE], with diagnoses that included contracture of muscle (a condition where muscles, tendons, joints, or other tissues tighten or shorten, causing deformity and loss of movement in the joint), functional quadriplegia (complete immobility due to severe disability or frailty caused by another medical condition, without physical injury or damage to the brain or spinal cord), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest in things). Interview with Resident 64 on March 3, 2025, at 10:26 AM, revealed his pain level is consistently an 8 (out of 10), but when he receives his medicine, sometimes it goes down to a 5 or 6. Review of Resident 64's physician orders revealed he had orders for both routine and PRN (as needed) pain medications. Review of Resident 64's care plan revealed a focus area At risk for pain with an intervention for Notify physician if pain frequency/intensity is worsening or if current analgesia regimen has become ineffective, with a start date of December 30, 2024. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 64's MAR (Medication Administration Record - documentation for medication/treatment administered or monitored) revealed he was administered a dose of as needed oxycodone (narcotic pain medication) on December 17, 2024, at 1:59 PM, and that his pain level was an 8. Review of Resident 64's nursing progress notes revealed a note on December 17, 2024, at 1:59 PM, that stated complained of general discomfort-rest/reposition ineffective. Further review of Resident 64's nursing progress notes revealed a follow-up note linked to the aforementioned notes on December 17, 2024, at 4:47 PM, that stated PRN administration was: ineffective. Follow-up pain scale was 7. No further as needed pain medication was administered that evening, no non-pharmacological interventions were noted to be effective, and no physician notification was noted in response to the prolonged, unrelieved pain. Review of Resident 64's clinical record revealed from January 12, 2025, at 11:10 PM, until January 13, 2025, at 9:45 AM, his pain level was assessed four times during that period; all four times his pain level was noted to be at an 8. Review of Resident 64's nursing progress notes revealed a note on January 13, 2025, at 3:50 AM, that stated, Resident verbalized pain, requesting pain medication, Administered [at] 3:50 AM. Review of Resident 64's nursing progress notes revealed a follow-up note linked to the aforementioned note on January 13, 2025, at 6:34 AM, that stated PRN administration was: ineffective. Follow-up pain scale was 8. Review of Resident 64's clinical record revealed he was administered as needed oxycodone on January 13, 2025, at 9:45 AM, and it was noted that rest and repositioning was ineffective for pain relief. No physician notification was noted in response to the prolonged, unrelieved pain. Further review of Resident 64's nursing progress notes revealed a follow-up note linked to the aforementioned note on January 13, 2025, at 4:35 PM, that stated PRN administration was: unknown [for effectiveness]. Review of Resident 64's clinical record revealed he was administered as needed oxycodone on January 21, 2025, at 2:01 AM; a nursing progress note was linked to the medication administration that stated, requested for complaint of lower back pain, repositioning not effective. Further review of Resident 64's nursing progress notes revealed a follow-up note linked to the aforementioned note on January 21, 2025, at 5:33 AM, that stated PRN administration was: ineffective. Follow-up pain scale was 6. No further as needed pain medication was administered that day, no non-pharmacological interventions were noted to be effective, and no physician notification was noted in response to the prolonged, unrelieved pain. Review of Resident 64's clinical record revealed from February 21, 2025, at 11:56 AM, until February 21, 2025, at 10:03 PM, his pain level was assessed eight times during that period; all four times his pain level was noted to be at an 8. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 64's nursing progress notes revealed a progress note on February 21, 2025, at 11:30 AM, that he was given an as needed oxycodone medication that stated, Complaints of general discomfort-rest/reposition ineffective. Further review of Resident 64's TAR revealed he was given his as needed oxycodone every four hours as requested for pain, but that the as needed administrations were ineffective at relieving his pain, with a follow up pain scale of 8 at 11:56 AM, and 6:14 PM. No further as needed pain medication was administered that day, no non-pharmacological interventions were noted to be effective, and no physician notification was noted in response to the prolonged, unrelieved pain. Review of Resident 64's clinical record on March 4, 2025, revealed the following physician orders for as needed pain medications: Oxycodone HCl Oral Tablet 15 MG, Give one tablet by mouth every 4 hours as needed for moderate pain, max daily amount 90 mg, with a start date of December 13, 2024. Hydromorphone (opioid pain medication) HCl Oral Tablet 2 MG, Give one tablet by mouth every 4 hours as needed for breakthrough pain, max daily Amount 12 mg, with a start date of December 13, 2024. Ibuprofen (pain medication) Oral Tablet 400 MG, Give one tablet by mouth every 6 hours as needed for headaches, with a start date of December 13, 2024. During an interview with Employee 7 (Licensed Practical Nurse) on March 4, 2025, at 1:06 PM, the surveyor questioned the process for administering the as needed pain medications. She revealed if Resident 64 continued with unrelieved pain after his routine pain medications are given, she administers the as needed oxycodone. If Resident 64 is still experiencing pain after he has received his as needed oxycodone, she will administer the as needed ibuprofen. She further revealed that she does not administer the as needed hydromorphone, because it hasn't been available in the medicine cart for quite some time. During an email correspondence with the Director of Nursing (DON) on March 4, 2025, at 1:25 PM, the surveyor inquired if there should be numerical pain scales attached to the as needed oxycodone and hydromorphone so staff knows which medication to administer first, why the hydromorphone hasn't been available, and if the resident would benefit from having other non-pharmacological pain interventions that are being measured in their effectiveness of pain relief, other than rest/repositioning that is frequently noted to be ineffective. Return email from the DON on March 4, 2025, at 5:27 PM, revealed they had added pain scales to the hydromorphone and oxycodone orders so staff knows which medication to administer first based on the residents pain level, and that the hydromorphone needs a new written prescription which is why it is not in the medication cart. She further revealed that she would follow-up with the physician for a new prescription for the medication, and that she has requested that Employee 9 (Licensed Practical Nurse Assessment Coordinator) review if Resident 64 would benefit from additional non-pharmacological pain interventions. During an interview with Resident 64 on March 5, 2025, at 12:49 PM, he revealed he gets headaches and has a lot of pain, and sometimes it helps him to hold a cup of ice to his forehead and listen to music. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 64's physician orders on March 5, 2025, revealed pain scales of 5-7 for oxycodone administration, 8-10 for hydromorphone administration, and the following non-pharmacological pain interventions had been added to his as needed oxycodone and hydromorphone medication orders: 1. Reposition 2. Back rub 3. Music 4. Warm/cool compress 5. Diversional activity 6. Other (progress note). Interview with the DON on March 6, 2025, at 10:18 AM, revealed she would expect the pain medications to have pain scales for guidelines to administer the medications, and the facility should have notified the physician in response to days of prolonged unrelieved pain per his care plan intervention and facility policy. She further revealed that they should have reviewed the Resident for the potential of additional, measurable, non-pharmacological pain interventions, including the possibility to be seen by a pain clinic, and the interventions that have now been added to his physician orders. During a follow-up interview with the DON on March 6, 2025, at 12:00 PM, the surveyor revealed the overall concern with Resident 64's regimen for pain management, lack of facility implemented effective non-pharmacological interventions to manage his pain, consistent use of as needed pain medications versus effective routine pain management, and lack of availability of one of his as needed pain medications for a severe pain level of 8-10. The DON verbalized her understanding, revealed the facility will be reaching out to the physician to inquire the ability to revise his pain management regimen, and stated that the only written prescription for hydromorphone that the facility had since his admission was from December 17, 2024, and there were only 28 tablets, so when the medication was no longer available, that is when the facility should have looked into other options for pain management. 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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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. 49123 Based on policy review, observation, record review, and staff interviews, it was determined that the facility failed to complete a risk benefit analysis and obtain consent for enabler bar use for one of 23 residents reviewed (Resident 56). Findings include: Review of the facility policy, titled Bed Safety last reviewed February 3, 2025, revealed, 5. If side rails are used, there shall be an interdisciplinary assessment of the resident, consultation with the attending physician, and input form the resident and/or legal representative. 6. The staff shall obtain consent for the use of side rails from the resident or the resident's legal representative prior to their use. Review of Resident 56's clinical record revealed the diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders, personality changes, and impaired reasoning) and acquired absence of the right and left leg above the knee (absence of a limb that has been removed due to trauma, medical condition, or surgery). Observation of Resident 56's room on March 3, 2025, at 12:29 PM, revealed bilateral (on both sides) enabler bars. Additional review of Resident 56's clinical record failed to reveal a consent for enabler bar use. An email correspondence with the Director of Nursing (DON) on March 6, 2025, at 9:17 AM, revealed the facility was not able to provide a signed consent for Resident 56's enabler bar use. During an interview with the Nursing Home Administrator and DON on March 6, 2025 at 9:51 AM, the DON stated it was the expectation of the facility that consent for enabler bar usage be obtained. 28 PA code 201.18(b)(1) Management 28 PA code 211.12(d)(1)(2)(3)(5) Nursing services

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 47966 Based on clinical record review, policy review, and staff interviews, it was determined that the facility failed to act upon the licensed pharmacist's report of a medication recommendation, and failed to provide a monthly medication regimen review for one of five residents reviewed for unnecessary medications, psychotropic medications, and medication regimen review (Resident 23). Findings include: Review of the facility policy, titled Consultant Pharmacist Reports: Medication Regimen Review (Monthly Report), with a last review date of February 3, 2025, revealed, The consultant pharmacist reviews the medication regimen of each resident at least monthly; and Physician accepts and acts upon suggestion or rejects and provides and explanation for disagreeing. Review of Resident 23's clinical record revealed diagnoses that included anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life) and hypertension (high blood pressure). Review of Resident 23's pharmacy recommendation dated July 12, 2024, revealed the consultant pharmacist's recommendation stated, This resident is receiving lisinopril. Please ensure that a periodic cmp (comprehensive metabolic panel) is conducted to monitor this medication. Document of results should be accessible for review. Further review of the recommendation dated July 12, 2024, revealed the physician failed to provide a response. Review of Resident 23's pharmacy recommendation dated September 16, 2024, revealed the consultant pharmacist's recommendation stated, Orders for PRN (as needed) psychotropic drugs are limited to 14 days. Please evaluate if the PRN Lorazepam can be discontinued or add a stop/reassess date; as well as the recommendation, This resident has been receiving Lexapro 20 milligram (mg) daily, Remeron 15 mg at bedtime, Seroquel 25 mg AM and 75 mg 2 times a day, Ativan 1 mg every 8 hours as needed and 0.5 mg 2 times a day - please consider GDR (gradual dose reduction) - if GDR is clinically contraindicated at this time, please document that clinical rationale below. Further review of the recommendation dated September 16, 2024, revealed the physician failed to provide a response. Review of Resident 23's pharmacy recommendation dated November 15, 2024, revealed the consultant pharmacist's recommendation stated, Please add 'mix into 4 to 8 ounces of fluid to the polyethylene glycol order as well as, In addition to the over the counter pain management options, this resident has been receiving the following medication for long-term pain management: morphine 10 mg every 1 hour as needed. In an effort to eliminate unnecessary medications and prevent possible side effects associated with them, please evaluate the risk verse benefit of each medication, then discontinue all unnecessary medications, as you deem appropriate. Further review of the recommendation dated November 15, 2024, revealed the physician failed to provide a response. Further review of Resident 23's monthly pharmacy recommendations revealed the facility was unable to provide evidence that Resident 23 had a pharmacy recommendation completed in December 2024. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Electronic correspondence received from the Director of Nursing on March 5, 2025, at 3:40 PM, revealed she was not able to provide a pharmacy recommendation for December 2024 for Resident 23, or any physician's responses to the recommendations made by the pharmacist in July 2024, September 2024, or November 2024. Interview with the Nursing Home Administrator on March 6, 2025, at 10:06 AM, revealed she would have expected Resident 23 to have had a pharmacy recommendation completed in December 2024, and would have expected the physician to have responded to the recommendations for Resident 23 in July 2024, September 2024, and November 2024. 42 CFR 483.45 Drug Regimen Review 28 Pa. Code 211.9 (a)(1) Pharmacy services 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 46253 Based on clinical record reviews and staff interviews, it was determined that the facility failed to adequately monitor possible side effects and target behaviors for two of five residents reviewed for unnecessary psychotropic medications (Residents 68 and 80). Findings include: Review of Resident 68's clinical record revealed diagnoses that included depression, anxiety, and cerebral infarction (a stroke-damage to the brain from interruption of its blood supply). Review of Resident 68's physician orders revealed an order for lorazepam tablet 0.5 milligrams give one tablet via PEG (percutaneous endoscopic gastrostomy-a flexible feeding tube placed through the abdominal wall and into the stomach which allows nutrition to be placed directly into the stomach) tube every 6 hours as needed for anxiety for 14 days, dated February 20, 2025. Review of Resident 68's Medication Administration Records (MARs) for February 2025 and March 2025 revealed that he had received four doses of his lorazepam: February 21, 2025, at 10:54 PM; March 3, 2025, at 11:53 AM and 9:21 PM; and March 6, 2025, at 1:14 AM. Further review of Resident 68's MARs for February 2025 and March 2025, as well as his clinical record progress notes, revealed that there were no non-pharmacological interventions documented as being attempted prior to the lorazepam administration February 21, at 10:54 PM; March 3, at 11:53 AM; or March 6, at 1:14 AM. Further review failed to reveal any identified targeted behaviors, behavior monitoring, or side effect monitoring for the use of the lorazepam. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on March 6, 2025, at 12:02 PM, the DON confirmed that staff should have been documenting non-pharmacological interventions that were attempted prior to the administration of the lorazepam to Resident 68. She indicated that the order was entered incorrectly and did not allow supplemental documentation of non-pharmacological interventions to be documented on the MAR. The DON also confirmed that behaviors and medication side effects should have been monitored and documented. Review of Resident 80's clinical record revealed diagnoses that include major depressive disorder (persistent low mood that significantly interferes with daily life) and dementia (a chronic disorder of the mental processes caused by brain disease and marked by memory disorders, personality changes, and impaired reasoning). Review of Resident 80's physician orders revealed orders for Seroquel (antipsychotic medication) for dementia, buspirone for anxiety disorder, and mirtazapine for depression. Resident 80 also had orders for side effect monitoring every shift for antipsychotic use, antidepressant use, antianxiety medication use, and behavior monitoring every shift. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 80's medication administration record revealed no side effect monitoring documentation and no behavior monitoring documentation for the following dates and shifts: day shift - January 28, 2025; February 2, 14, 15, and 28, 2025; and March 1 and 2, 2025; evening shift - January 27, 28, 30, and 31, 2025, February 1, 2, 8, 14, 15, 22, 24, and 28, 2025; and March 1, 2, and 3, 2025; night shift - January 28 and 29, 2025; and February 2, 6, 8, 14, 16, 19, and 26, 2025. During an interview with the NHA and DON on March 5, 2025 at 12:13 PM, it was revealed the facility had no addition information regarding the missing documentation. The DON stated it was the expectation of the facility that side effect and behavior monitoring be done as ordered. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46253 Based on facility policy review, observation, and staff interview, it was determined that the facility failed to properly label and store prescribed medication or preventative creams in one of two treatment carts observed (Evergreen Way/Stepping Stones). Findings include: Review of facility policy, titled Storage of Medications, with a last review date of February 3, 2025, revealed, in part, 2. Drugs and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers; 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Review of facility policy, titled Pharmacy Services Policy and Procedure, with a last review dated of February 3, 2025, revealed, in part, Drugs and biologicals used in the facility shall be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Observation of the Evergreen Way/Stepping Stones treatment cart on March 5, 2025, at 1:33 PM, with the Director of Nursing (DON) revealed that there were seven tubes of medication or preventative creams that were laying in the top drawer of the cart, outside of a box or bag labeled with a resident's name. Four of the tubes were noted to have a resident's name on them. During an immediate staff interview with the DON, she indicated that the treatment creams/medications should have been stored in their proper packaging or individual bags with a resident's name clearly indicated. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(a)(1) Pharmacy services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48484 Based on facility policy review, observations, and staff interviews, it was determined that the facility failed to store food items in accordance with professional standards for food service safety in the main kitchen and three of three nourishment areas. Findings include: Review of facility policy, titled Food Receiving and Storage, last revised October 2023, read, in part, Food shall be received and stored in a manner that complies with safe food handling practices. Dry foods that are stored in bins will be removed from original packaging, labeled and dated ('use by' date). All food items to be kept at 41 degrees Fahrenheit must be placed in the refrigerator located at the nurses station and labeled with a 'use by' date. Observation of the dry storage area on March 3, 2025, at 9:38 AM, revealed one bag of egg noodles open without an open date or use by date once opened; one bag of spiral pasta open without an open date or use by date once opened; 10 boxes of fudge round cookies not dated; and one box of potatoes that were all covered with sprouts and appeared to be old. Interview with Employee 8 (Foodservice Director) on March 3, 2025, at 9:40 AM, revealed she preferred to store potatoes in the walk-in refrigerator to preserve their freshness, and that box of potatoes should be thrown out. Observation in the Laurel Lane pantry area refrigerator on March 3, 2025, at 9:50 AM, revealed one honey thickened cranberry juice and one nectar thickened cranberry juice open without an open date. Further observation of the Laurel Lane pantry area on March 3, 2025, at 9:52 AM, revealed a bin containing individually labeled snacks without dates, to indicate when the snacks expire. Interview with Employee 8 on March 3, 2025, at 9:54 AM, revealed the snack bins should be labeled when they are replenished to indicate when the snacks will expire; and that juices should be labeled when opened, as they have guidelines on the containers to be discarded at either 7 or 10 days once opened. Observation in the Chapel [NAME] pantry area refrigerator on March 3, 2025, at 9:55 AM, revealed one honey thickened orange juice; one honey thickened apple juice; and one carton of fortified nutritional drink, all open without an open date. Further observation of the Chapel [NAME] pantry area on March 3, 2025, at 9:56 AM, revealed a bin containing individually labeled snacks without dates. Observation in the Evergreen/Stepping Stone pantry area refrigerator on March 3, 2025, at 9:58 AM, revealed one honey thickened apple juice and two cartons of fortified nutritional drinks, all open without an open date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further observation of the Chapel [NAME] pantry area on March 3, 2025, at 9:59 AM, revealed a bin containing individually labeled snacks without dates. Interview with Employee 8 on March 3, 2025, at 10:04 AM, the surveyor revealed the concern with the dry storage area of the kitchen as well as the three pantries. Employee 8 revealed she is working with the staff on proper food storage, including labeling and dating. Interview with the Nursing Home Administrator on March 4, 2025, at 1:07 PM, revealed it was the facility's expectation that food and beverages are labeled and dated per facility policy and in accordance with professional standards. 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 33879 Based on facility policy review and staff interview, it was determined that the facility failed to establish and implement an antibiotic stewardship program to monitor the use of antibiotics. Findings include: Review of the facility's policy, titled Antibiotic Stewardship, last revised December 2016, revealed the policy statement was, Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The policy's interpretation and implementation included, The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in [the] residents. As of March 6, 2025, at 11:45 AM, the facility was unable to provide evidence that antibiotic stewardship was implemented via providing documentation including, but not limited to, tracking antibiotics used, duration of use, and monitoring culture and sensitivity of identified organisms to ensure prescribed antibiotic effectiveness. During a staff interview on March 6, 2025, at approximately 11:45 AM, Nursing Home Administrator revealed it was the facility's expectation that monitoring antibiotic use via an antibiotic stewardship program should be in place. 28 Pa code 211.12(d)(1)(3)(5) Nursing services