| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395273 | A. Building<br>B. Wing | 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Embassy of Scranton | 824 Adams Avenue<br>Scranton, PA 18510 |

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|---|---|
| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to organize and participate in resident/family groups in the facility.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of select facility policy, facility grievance forms, resident interviews, staff interviews, and observations it was determined the facility failed to make ongoing efforts to resolve grievances and provide timely follow up with residents regarding the status update on the resolution process of call bell response times for 8 of 22 residents interviewed (Resident 5, 9,13 ,21 , 30, 45 ,65,78).Findings include: A review facility policy entitled Resident and Family Concerns last reviewed by the facility on October 21, 2024, indicated that it is the grievance official's responsibility to receive and track all grievances through to their conclusion. The policy further indicated the grievance official is responsible to provide a copy of the grievance policy to the resident. The policy further revealed it is the grievance officer's responsibility to issue written grievance decisions to the residents. A Resident Council meeting was conducted on July 23, 2025, at 10:00AM with six alert and oriented residents. The interview revealed six out of six residents (Residents 21,30, 5, 65, 9, 78) have experienced call bell wait times exceeding 1 hour. A review of a grievance filed on February 13, 2025, revealed a complaint from resident 30 indicating the resident waited over an hour for a response to her call bell. The grievance form further revealed the staff was educated and disciplined. A review of a grievance filed on May 29, 2025, revealed Resident 13 and Resident 45 filed a grievance indicating the residents were not changed at any time during day and evening shift. The grievance indicated the residents reported they were left to sit in their own urine-soaked beds for an extensive amount of time. Further review of the grievance indicated the staff was unaware of the resident's incontinent status and the residents were not changed during these shifts. Interview with Resident 30 on July 23, 2025, at approximately 11:00AM revealed Resident 30 has not received a response from the grievance official confirming a resolution to her call bell wait times as of July 24, 2025. Residents 13 and 45 were unavailable for interview. Interview with Employee 1 (Social services) on July 24, 2025, at 12:32PM confirmed Employee 1 sometimes meets with residents to review the resolution of grievances filed, but it is not a consistent pattern she follows. Employee 1 was unable to provide any information the resolution was provided to Residents 13, 30, and 45. The interview further confirmed Employee 1 does not have a system in place to track filed and resolved grievances as indicated in the policy. Observations on July 23, 2025, at approximately 1:00PM located on the third floor, revealed a call bell tracking system with a call bell going unresolved for 47 minutes from room [ROOM NUMBER]C. Observation of the area revealed no staff present, responding to the call bell. Further observation of room [ROOM NUMBER]C revealed a foul odor of feces emanating from the room. Interview with the Nursing Home Administrator on July 24, 2025, revealed the facility was unable to provide any documentation that a resolution to the call bell response time was provided to residents regardless of the filed grievances about the ongoing response time issue. 28 Pa. Code 201.14(a) Responsibility of licensee. |

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 |
|---|---|---|

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| F 0582<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>Based on clinical record review, facility provided documentation and staff interviews, it was determined the facility failed to timely provide the required Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF-ABN) to notify one of three residents reviewed (Resident CR-1) that Medicare Part A coverage for skilled nursing services was ending.Findings Include: A review of Resident CR-1's clinical record revealed admission to the facility on February 12, 2025, with diagnoses to include weakness and need for personal assistance. Review of the resident's Medicare coverage documentation revealed the last day of covered Medicare Part A services was February 18, 2025. Further review revealed the facility did not issue the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF-ABN) form to Resident CR-1 until February 18, 2025, on the date of Medicare Part A coverage ending. An interview conducted with the director of nursing on July 23, 2025, at approximately 11:00 a.m., confirmed the resident had exhausted Medicare Part A benefits as of February 18, 2025, and acknowledged that the SNF-ABN form had not been provided until the day of coverage ending. The facility's failed to issue the required notice prior to the end of coverage. 28 Pa. Code 201.14 (a) Responsibility of licensee. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>Based on observations and staff interview, it was determined the facility failed to provide housekeeping services necessary to maintain a clean and sanitary environment and resident care equipment for one of two residents receiving enteral tube feeding. (Resident101)Findings include: Observations conducted in Resident 101's room on July 22, 2025, at 11:00 A.M. and 1:30 P.M., and again on July 23, 2025, at 8:30 A.M. and 1:00 P.M., revealed dried tube feeding residue in multiple locations within the resident's room. Specifically, dried nutritional formula was observed on the base of the resident's tube feeding pole, on the fall mat placed on the floor to the right side of the bed, and on the surface of the resident's bedside table. During an interview July 24, 2025, at 10 A.M., the Nursing Home Administrator confirmed the resident's tube feeding pole and surrounding areas in his room should be free from liquid tube feed.28 Pa code 201.18 (b)(1) Management |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, facility policy review, and staff interview, it was determined the facility failed to protect one of 23 sampled residents (Resident 9) from neglect. Findings include: A review of the facility policy titled Abuse Policy last reviewed by the facility on October 21, 2024, revealed it is the facility's policy that a resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The policy defines neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.A clinical record review revealed that Resident 9 was admitted to the facility on [DATE]. 2025, with diagnoses that included below-the-knee right and left leg amputations, generalized weakness, and need for personal assistance. A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 30, 2025, revealed Resident 9 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). The resident's Kardex (a nursing tool used to communicate individualized care instructions) initiated on March 5, 2025, indicated Resident 9 required the assistance of two staff members for all transfers. The resident's care plan, initiated on February 14, 2025, specified that transfers were to be performed with two staff members using a sliding board. A sliding board is a smooth, rigid board used as a transfer aid to bridge the gap between two surfaces, allowing a resident to slide from one location to another (e.g., bed to wheelchair), typically used for residents with limited mobility or amputations. A review of the facility's internal incident documentation revealed that Resident 9 experienced falls on February 26, 2025, and March 5, 2025. There was no documented evidence that new interventions were implemented following these incidents to prevent recurrence. A review of a progress note dated March 17, 2025, at 2:48PM revealed on March 15, 2025, at 6:50PM, a nurse aide (facility unable to identify which employee) was transferring Resident 9 from the bed to the wheelchair using a sliding board when the resident fell. The facility's fall investigation revealed that only one staff member was present during the transfer, contrary to the resident's documented need for a two-person assist. In addition, the investigation revealed that the staff member failed to lock the wheelchair prior to initiating the transfer. This failure to follow the established transfer protocol including the use of two-person assistance and securing mobility equipment, resulted in the resident falling and landing on the site of his right leg amputation. Although the facility initiated an internal investigation, the documentation lacked witness statements, staff interviews, and a complete written account of the event. The facility failed to identify or hold accountable the staff member who had performed the unauthorized solo transfer. As a result, the investigation was incomplete and did not demonstrate appropriate follow-up or corrective action. Additionally, a review of the clinical record and accident logs revealed that Resident 9 experienced three additional falls after the incident on March 15, 2025. During an interview on July 24, 2025, at approximately 09:30AM the Director of Nursing revealed the facility was unable to provide any further documentation or details related to the March 15, 2025, incident. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident Rights. 28 Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(5) Nursing Services. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, the facility's abuse neglect and exploitation policy, information provided by the facility, and staff interviews, it was determined that the facility failed to promptly conduct a thorough investigation to rule out abuse and implement corrective action for one of 22 residents reviewed (Resident 9). Findings include: A facility policy entitled Abuse, Neglect and Exploitation, last reviewed by the facility on October 21, 2024, indicated an immediate investigation is warranted when suspicion of abuse, neglect or exploitation occurs. The policy further indicated the investigation is to include identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. The policy further indicated the result of the investigation should include analyzing the occurrence to determine why neglect occurred and what changes are needed to prevent further occurrences. The facility is to define how care provisions will be changed or improved to protect resident receiving services, identify staff responsible for implementing corrective actions, and the expected date for implementation. A clinical record review revealed that Resident 9 was admitted to the facility on [DATE]. 2025, with diagnoses that included below-the-knee right and left leg amputation, weakness, and need for personal assistance. A quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 30, 2025, revealed Resident 9 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). The resident's Kardex (a nursing tool used to communicate individualized care instructions) initiated on March 5, 2025, indicated Resident 9 required the assistance of two staff members for all transfers. The resident's care plan, initiated on February 14, 2025, specified that transfers were to be performed with two staff members using a sliding board. A sliding board is a smooth, rigid board used as a transfer aid to bridge the gap between two surfaces, allowing a resident to slide from one location to another (e.g., bed to wheelchair), typically used for residents with limited mobility or amputations. A review of clinical records and accident logs revealed the resident had experienced falls on February 26 and March 5, 2025. No new interventions were implemented following those events. A progress note dated March 17, 2025, documented that on March 15, 2025, at 6:50 PM, Resident 9 was transferred from bed to wheelchair using a sliding board by a single staff member, contrary to the resident's documented need for two-person assistance. The resident fell during the transfer and landed on his right amputated leg. The facility's investigative report dated March 15, 2025, confirmed that the resident was transferred by one staff member and that the wheelchair had not been locked prior to the transfer. Despite this, the facility's documentation did not include witness statements, staff interviews, or any documentation indicating that the alleged neglect was fully investigated. The identity of the staff member involved was not determined. On July 24, 2025, at approximately 9:30 AM, when the surveyor asked to review documentation of the completed investigation related to the March 15, 2025, incident, the Director of Nursing (DON) was unable to provide any evidence that a thorough investigation was completed. The DON confirmed that the staff working on the evening of March 15, 2025, were not interviewed, that no documentation existed to demonstrate who had performed the transfer, and that no interviews were conducted with the resident or any potential witnesses. The DON also confirmed the facility did not implement any new corrective actions following the fall and did not complete an analysis to determine the root cause or prevent future occurrences. During a follow-up interview on July 24, 2025, at approximately 12:00 PM, the DON reiterated that no documentation existed to show the facility had conducted an investigation consistent with facility policy. The facility failed to promptly investigate a potential incident of neglect involving improper transfer technique and lack of staff adherence to care plan instructions. The investigation was not initiated in a timely manner, was incomplete, and lacked required elements including staff identification, interviews, and corrective planning. As a result, the facility failed to ensure that the circumstances surrounding the neglectful event were appropriately examined and addressed. 28 Pa. Code 201.14 (c) Responsibility of licensee. 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.10(d) Resident care policies. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that a discharge summary, including a recapitulation of the resident's stay, were completed for two of three discharged residents reviewed (Residents 96, and 98). A review of Resident 96's clinical record revealed that he was admitted to the facility on [DATE], with diagnoses that included metabolic encephalopathy (ME) are brain dysfunctions due to problems with metabolism, or the body's chemical processes that turn food into energy and filter out harmful toxins), transient cerebral ischemic attacks (TIA - is a short period of symptoms similar to those of a stroke and caused by a brief blockage of blood flow to the brain), and weakness. A nursing note for Resident 96, dated June 10, 2025, at 5:45 PM, revealed that the resident was slumped over in his wheelchair drooling, responded to painful stimuli but when speaking words were garbled and not making sense. Nurse Practitioner (NP) updated and order to send to the emergency room (ER) for evaluation due to history of TIA. Family aware and agree with plan to transfer to ER. Emergency Medical Services (EMS) called and arrived at facility. Additionally, Resident 96's clinical record revealed a nurses' progress note dated June 10, 2025, at 6:11 AM, revealed that the resident was admitted to the hospital with altered mental status. A nurse's progress note dated June 19, 2025, at 11:16 AM, indicated the Director of Nursing contacted Area Agency on Aging (AAA) was called and informed of patient being send to the hospital on 6/10/2025 and will not be returning to embassy of [NAME]. Uncertain of discharge plan. As of June 25, 2025, there was no documented evidence that a discharge summary that included a recapitulation of the resident's stay was completed for Resident 96. A review of Resident 98's clinical record revealed that he was admitted to the facility on [DATE], with diagnoses that spinal stenosis (happens when the space inside the backbone is too small and places pressure on spinal cord and nerves that travel through the spine and happens most often in the lower back and the neck) and anxiety disorder (frequently have intense, excessive and persistent worry and fear about everyday situations and involve repeated episodes of sudden feelings of intense anxiety and fear or terror that reach a peak within minutes (panic attacks). A review of Resident 98's nursing progress notes dated June 7, 2025, at 5:12 PM, indicated the resident and spouse requested to be discharged home the Director of Nursing (DON) and MD was notified and orders were obtained for discharge. The resident and spouse gathered all belongings and was discharged to home at that time. As of June 25, 2025, there was no documented evidence a discharge summary that included a recapitulation of the resident's stay was completed for Resident 98. During an interview conducted with the Director of Nursing, in the presence of the Nursing Home Administrator on July 25, 2025, at 12:30 PM, the above findings were reviewed. At that time, no additional documented evidence was provided to demonstrate the attending physician had completed a discharge summary that included a recap of stays for Resident 96 or Resident 98 during their admissions to the facility. 28 Pa. Code 211.5(d) Clinical Records. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, a review of clinical records, review of facility policies, and facility provided investigative documentation, and staff interviews, it was determined the facility failed to provide adequate staff supervision to a resident identified at risk of elopement to prevent unsupervised exits from the facility for one resident (Resident 74) and failed to provide supervision to prevent a fall for one resident ( Resident 35) out of 22 residents sampled.Findings included: A review of a facility policy entitled Elopement and Wandering Residents last reviewed by the facility on October 21, 2025, indicated the facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering and elopement risk. The facility is equipped with door locks/alarms to help avoid elopements but are not a replacement for necessary supervision. Additionally, monitoring and managing residents at risk for elopement or unsafe wandering include residents will be assessed upon admission and throughout their stay by the interdisciplinary care plan team for elopement or unsafe wandering and identify unique factors contributing to risk in order to develop a person-centered plan of care. Interventions to increase staff awareness of the resident's risk, modified behavior, or to minimize risk associated with hazards will be added to the resident's care plan and communicated to appropriate staff. Adequate supervision will be provided to help prevent accidents or elopements. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff. A review of Resident 74's clinical record revealed he was admitted to the facility on [DATE], with diagnoses that included hemiplegia ( a symptom that involves one-sided paralysis and affects either the right or left side of the body) and hemiparesis (one-sided muscle weakness because of disruptions in the brain, spinal cord or the nerves that connect to the affected muscles) following cerebral infarction (also known as stroke, is the process that results in an area of dead tissue in the brain) affecting right dominant side, aphasia (disorder that affects how one communicates and can impact speech and written language), alcohol use, and cognitive communication deficit (a common consequence of brain injuries that affects a person's ability to communicate effectively and these deficits arise when the brain's cognitive functions, such as attention, memory, reasoning, and problem-solving, are impaired, impacting communication). A review of the resident's quarterly MDS (Minimum Data Set - a federally mandated standardized assessment process conducted periodically to plan resident care) assessment dated [DATE], section C Cognitive Patterns revealed the resident had a BIMS score (Brief Interview for Mental Status is a tool used to evaluate cognitive impairment and assist with dementia diagnosis) of 15, which indicated that the resident was cognitively intact. Additionally, the resident independently walked with the use of cane or used a wheelchair to ambulate. A clinical record review revealed an assessment completed by the facility's Director of Nursing (DON) entitled Elopement Evaluation dated January 18, 2025, indicated the resident had a history of elopement while at home and exhibited wandering behaviors and identified the resident was at risk of wandering/elopement. A review of a nursing behavior note completed by Employee 1, a Registered Nurse (RN), dated March 31, 2025, at 9:20 PM, revealed Resident 74 was exit seeking and staff were unable to redirect. Resident was educated on the safety protocols of the facility and refused to comply. Further review of Resident 74's clinical record progress completed by the DON dated May 8, 2025, at 5:18 PM, documented that the resident exited the back of the building and as observed by the Nursing Supervisor, who was outside smoking, when asked what he was doing, the resident stated, I'm coming to smoke. The DON was notified immediately, and the door code was changed. The resident was reminded of the facility's nonsmoking policy but was allowed to smoke as requested. The resident then requested to stay outside and get some fresh air.Staff were alternating observations of the resident until 7:30 PM, when the DON asked the resident what he wanted, and he requested a pizza in order to return inside. The DON ordered a pizza and delivered it to the resident's room At the time of survey ending July 25, 2025, the facility could not provide documented evidence that facility completed an investigation related to the above incident, elopement, and develop and implement person-centered interventions to address Resident 74's wandering/exit seeking behaviors. A review of a facility provided investigation for an elopement completed by Employee 2, RN, dated June 21, 2025, at 10:00 AM, indicated the writer (Employee 2) was informed that resident was not in his room or the common area. Thorough search of the premises and surrounding area were done, and |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and select facility policy, staff interview, and review of facility documentation, it was determined the facility failed to ensure that a resident who is unable to maintain adequate nutrition and hydration status received appropriate nutritional support, physician notification, and timely interdisciplinary assessment to prevent further nutritional decline for one of 21 residents reviewed (Resident 76). Findings include: A review of the clinical record revealed that Resident 76 was admitted on [DATE], with diagnoses that included multiple sclerosis (MS), a chronic, progressive disease of the central nervous system, and dysphagia (difficulty swallowing), related to MS. A physician's order dated January 31, 2025, directed that the resident receive a regular diet with pureed texture and honey/moderately thick consistency liquids, fortified foods with all meals, and a frozen nutritional treat (120 ml) twice daily with lunch and dinner, with intake percentages to be recorded. These interventions were intended to support nutritional intake. The resident's care plan, initiated October 14, 2022, identified him as being at risk for nutritional and hydration imbalances due to a history of significant weight loss. Interventions included honoring food preferences, providing the prescribed diet, offering fortified foods, and monitoring weight per facility policy. Per that policy, significant weight changes are to be reported to the physician and the resident's responsible party (RP). A review of the facility's policy titled Weight Monitoring, revised October 1, 2024, indicated that, based on each resident's comprehensive assessment, the facility is to ensure residents maintain acceptable parameters of nutritional status such as usual body weight or desirable weight range, unless the resident's clinical condition or preferences dictate otherwise. The policy defines significant weight loss as:5% in one month (30 days),7. 5% in three months (90 days), or10% in six months (180 days). The policy also states that the physician should be informed of significant weight changes and may order nutritional interventions. Additionally, meal consumption should be documented and may be used by the interdisciplinary team in care planning. The registered dietitian or dietary manager should be consulted to assist with interventions, and all actions are to be recorded in the nutritional progress notes. A review of the resident's weight record showed the following:May 12, 2025: 122.0 lbs.May 20, 2025: 118.8 lbs.June 2, 2025: 115.4 lbs. (a 6.6 lb. loss; 5.41% in three weeks meeting the facility's definition of significant weight loss)June 4, 2025: 115.8 lbs. (reweigh)July 3, 2025: 113.6 lbs.Total weight loss between May 12 and July 3, 2025: 8.4 lbs. (6.89% over seven weeks) A review of meal intake records from May and June 2025 showed the resident typically consumed between 50% and 75% of meals, without documented use of additional oral nutritional supplements beyond the twice-daily frozen nutritional treat, which was reportedly consumed in full. Despite the observed weight loss on June 2, 2025, the clinical record did not contain documentation the physician or responsible party were notified. Additionally, there was no documentation of a nutritional assessment, no new interventions implemented, and no care plan revisions to address the weight loss at that time or following the continued decline noted on July 3, 2025. The first documented response to the weight loss occurred on July 8, 2025, when a dietary note identified the weight of 113.6 lbs., acknowledged the weight loss as significant, and indicated that the resident had existing pressure areas. At that time, an assessment was completed, and dietary interventions were implemented for weight stabilization and wound healing. During an interview on July 24, 2025, at approximately 2:00 PM, the facility's registered dietitian (RD) stated that she is present in the facility only once per week. She was unable to recall whether she was present on the dates when the resident was weighed, confirmed that she had not evaluated the resident following the weight loss on June 2 or July 3, 2025, and acknowledged that the nutritional regimen was not reviewed or revised until July 8, 2025. There was no documented evidence that the resident's nutritional status was reassessed by the interdisciplinary team or that the weight loss was addressed in a timely manner 28 Pa Code 211.12 (d)(3)(5) Nursing services. 28 Pa Code 211.10 (d) Resident care policies. |

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| | 395273 | A. Building<br>B. Wing | 07/25/2025 |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care or services that was trauma informed and/or culturally competent.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and staff interview, it was determined the facility failed to develop and implement an individualized person-centered care plan to render trauma informed care to a resident with a diagnosis of Post-Traumatic Stress Disorder (PTSD) for one out of 22 residents reviewed. (Resident 90)A review of Resident 90's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included metabolic encephalopathy (ME brain dysfunctions due to problems with metabolism, or the body's chemical processes that turn food into energy and filter out harmful toxins), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest, and it affects how one feels, thinks and behaves and can lead to a variety of emotional and physical problems), and post-traumatic stress disorder (PTSD a mental health condition that's caused by an extremely stressful or terrifying event, either being part of it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the event). The resident's current care plan, in effect at the time of review on July 22, 2025, did not identify the resident's PTSD triggers related to this diagnosis and resident specific interventions to meet the resident's needs for minimizing triggers and/or re-traumatization. The facility failed to develop and implement an individualized person-centered plan to address, this resident's diagnosis of PTSD according to standards of practice to promote the resident's emotional well-being and safety. During an interview with the Nursing Home Administrator (NHA) on July 24, 2025, at 1:52 PM, reviewed the above information and was unable to demonstrate the facility provided culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for resident's experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident.28 Pa Code 211. 12 (d)(3)(5) Nursing services. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and staff interview, it was determined the physician failed to act upon pharmacist identified irregularities in the medication regimen for one of twenty-two residents sampled (Resident 30). Findings include: A review of a facility policy Consulting Pharmacist Monthly Drug Review last reviewed by the facility on October1, 2024, revealed the resident's attending physician must document in the medical record that the identified pharmacist recommendation has been reviewed, and what, if any action has been taken to address it. The policy further stated if there is to be no change in the medication, the attending physician must document his or her rationale in the resident's medical record. A review of the clinical record revealed that Resident 30 was admitted to the facility on [DATE], and had diagnoses that included depressive disorder (condition characterized by persistent low mood, loss of interest, and other symptoms that significantly interfere with daily life), and weakness. A review of an April 2025 Medication Regimen Review revealed the consultant pharmacist indicated the resident's order for Sertraline 25mg (antidepressant medication) was to be reviewed for a gradual dose reduction. The resident's attending physician failed to document in the resident's clinical record the rational and justification for the continued use of Sertraline and a reason for the rejection of the gradual dose reduction. In an interview with the Director of Nursing (DON) conducted July 24, 2025, at approximately 09:00 AM, the DON revealed the facility has identified an ongoing issue with obtaining documentation from the attending physician. The DON stated that the attending physician has been previously notified via fax of the gradual dose recommendation but as of survey date July 24, 2025, the physician has not responded. 28 Pa. Code 211.9 (k) Pharmacy services. 28 Pa. Code 211.12 (c) Nursing services. 28 Pa. Code 211.2 (d)(3) Medical Director |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, and staff interviews, it was determined the facility failed to ensure that a resident's drug regimen was free of unnecessary antibiotics for one out of 22 residents sampled (Resident 8).Findings include:A review of a facility policy Antibiotic Stewardship Program last reviewed by the facility on October 1, 2024, revealed it is the facility's responsibility to utilize McGeer criteria (a standardized set of definitions for identifying infections in long term care facilities) to define infections. The policy further revealed the Loeb Minimum criteria (a set of minimum clinical criteria designed to help clinicians in long-term care facilities determine when to initiate antibiotic therapy for suspected infections, particularly urinary tract infections, even before diagnostic test results are available) may be used to determine where to treat an infection with antibiotics. A review of Resident 8's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including atrial fibrillation (a heart condition characterized by an irregular and often rapid heart rate) and generalized weakness. A nursing progress note dated May 6, 2025, at 4:51 PM, documented that Resident 8 complained of discomfort in the penis and had slightly cloudy urine. A subsequent note dated May 8, 2025, at 11:17 AM, revealed the resident had no urinary complaints, and the urine was described as clear and yellow. Despite the absence of consistent clinical signs or symptoms meeting McGeer or Loeb criteria, a physician's order dated May 8, 2025, directed administration of ceftriaxone sodium (an antibiotic) intramuscularly (injection into a muscle) in the evening for a diagnosis of UTI (urinary tract infection), to be continued for 7 days.Review of the resident's clinical record failed to show documentation that either McGeer or Loeb criteria had been met to justify initiating antibiotic therapy on May 8, 2025. Further review of a laboratory report dated May 11, 2025, indicated that the urine culture grew Klebsiella pneumoniae (a bacterium commonly associated with healthcare-related infections, particularly in individuals with compromised immune systems). The culture showed bacterial growth exceeding 100,000 colonies/mL. However, the report also confirmed the prescribed antibiotic, ceftriaxone, was resistant to the identified bacteria, rendering the medication ineffective. A review of the May 2025 Medication Administration Record (MAR) revealed Resident 8 received one dose of ceftriaxone prior to receiving the culture and sensitivity (C & S culture and sensitivity- A urine culture is a method to grow and identify bacteria that may be in the urine. The sensitivity test helps select the best medicine to treat the infection) report. Therefore, the antibiotic was administered without justification and did not align with evidence-based practice standards. During an interview with the Director of Nursing (DON) on July 24, 2025, at approximately 1:15 PM, the DON acknowledged that the facility was unable to provide any additional documentation or justification supporting the clinical decision to initiate antibiotic therapy for Resident 8. 28 Pa. Code 211.2(d)(3)(5) Medical Director 28 Pa. Code 211.12(d)(3)(5) Nursing services |

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| F 0807<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of select facility policy and resident and staff interviews, it was determined the facility failed to ensure that fresh drinking water was consistently readily accessible to residents to promote adequate hydration, meet resident preferences, and maintain their comfort for six of 22 residents reviewed (Residents 78, 21, 30, 5, 65, and 9).Findings include: A review of the facility policy titled Hydration/Fresh Water and Fluids last reviewed by the facility on May 1, 2025, indicated the facility will provide a fresh supply of drinking water. Residents will be provided fresh water to residents each shift and repeat [NAME] delivery as needed throughout the shift and upon request for fresh water. During an environmental tour of the Third-Floor Pantry conducted on July 23, 2025, at approximately 10:00 AM, observations of the unit's ice chest contained approximately 5 inches of stagnant water with visible strands of hair and dead insects inside and the resident's freezer had a tray with six 6 oz plastic cups each containing frozen water and labeled with resident names and two filled ice cube trays. The above observations were confirmed by Employee 8, NA (nurse aide), who stated during the observation that she was unaware residents had been filling plastic cups with water and storing them in the freezer. She stated the facility's ice machine had been broken for the past two weeks and confirmed the residents did not receive fresh water that shift due to the lack of ice. During a resident group interview on July 23, 2025, at 10:30 AM, six of six alert and oriented residents in attendance (Residents 78, 21, 30, 5, 65, and 9) voiced concerns that fresh ice water was not consistently provided during all shift due to the facility's ice machine being out of service. All residents in attendance reported the facility was purchasing bags of ice, but staff were not consistently re-filling the units ice chest. Also, residents reported that they purchased extra ice and made their own ice with plastic cups filled with water and placing in the resident freezers.Residents reported that they enjoy ice water especially on a hot day and asked staff but were told that they didn't have any ice and were told the ice machine was broken. Resident 5 stated that she enjoys drinking fresh ice water but was not provided with fresh water during the day or evening unless she asks staff to provide it. Resident 78 reported that the facility was purchasing bags of ice and storing it inside the ice machine in dietary, but staff don't always refill the unit's ice chest because they have to leave the unit. All residents in attendance confirmed Resident 78's report. On July 23, 2025, at 12:05 PM, a tour of the Second-Floor Resident Pantry revealed an ice chest that contained approximately 0.25 inches of standing water, with small flies floating in it. During an interview with the Nursing Home Administrator (NHA) on July 24, 2025, at 10:45 AM, confirmed that the facility ice machine wasn't working and provided receipts that ice was being purchased for residents. However, could not explain why ice water wasn't consistently being provided to the residents upon their requests. 28 Pa. Code 211.12 (d)(3)(5) Nursing services. 28 Pa. Code 211.10 (a)(d) Resident care policies. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Based on observation and staff interview, it was determined the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in the dietary department and in two out of two resident pantry areas located on second and third floor.Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). A review a facility policy entitled Use and Storage of Food Brought in by Family or Visitors last reviewed by the facility on October 21, 2024, indicated it was the right of the residents to have food brought in by family or other visitors, and must be handled in a way to ensure the safety of the residents. All food items already prepared by family or visitors must be labeled with content and date. The facility may refrigerate labeled and dated prepared items in the nourishment refrigerator; the food must be consumed by the resident within three days. If not consumed within three days, food will be thrown away by facility staff. The facility staff will assist residents in accessing and consuming food that is brought in by residents and family or visitors if the resident is not able to do so on their own. An initial tour of the dietary department was conducted on June 28, 2025, at 10:41 AM, and confirmed with the facility's Certified Dietary Manager (CDM). Observations revealed unsanitary conditions in the dishwashing area, including brown and white-colored splatter on the ceiling tiles and light fixtures above the dish machine. Inside the janitor's closet, a dirty mop was left soaking in a mop bucket, and a broom was stored alongside it, contributing to an environment not conducive to sanitation. In the kitchen, a large plastic bulk container of flour was observed with an unsecured and visibly soiled lid, which contained debris particles, creating a risk for food contamination. On July 23, 2025, at 12:05 PM, a tour of the Second-Floor Resident Pantry revealed a utility cart holding the unit's ice chest and two dirty breakfast trays. The inside of the ice chest contained approximately 0.25 inches of standing water, which had small flies floating in it. The pantry floor was sticky and coated in a black substance along the perimeter and corners. During an environmental tour of the Third-Floor Pantry conducted on July 23, 2025, at approximately 10:00 AM, additional unsanitary conditions were observed. The floor contained visible dirt, dried food, paper, and plastic debris. It was also sticky and stained with dried liquid. The baseboards and lower walls were smeared with dried food and liquids. The metal threshold between the pantry and hallway was missing and the gap had a buildup of dirt and dried food particles. Cabinets inside the pantry were visibly soiled with food crumbs, dirt, and trash. The ceiling air vent was covered in dust and dirt, and a red, unidentified substance was adhered to a ceiling tile above the refrigerator. Multiple dead insects were seen in the ceiling light. The unit's ice chest contained approximately 5 inches of stagnant water with visible strands of hair and dead insects inside. The freezer had a tray with six 6 oz plastic cups each containing frozen water and labeled with resident names, along with six zip-lock bags of cooked meat, five labeled July 2025 and one labeled August 2025. Additionally, there was a package of 12 ice cream sandwiches and 12 single-serving ice cream cups with no identifying information, name or date. There was an opened, unlabeled bag of raw green beans (from a grocery store) stored on the freezer door. The freezer interior had visible dirt and liquid residue. Two filled ice cube trays were located beneath the aforementioned items. The refrigerator contained unclean surfaces with visible dirt and stains. Two pitchers of juice and a jar of potato salad were present without labels or discard dates. Three open containers of thickened juice were not dated. There were three bags with takeout food items present, with no resident names or dates of receipt on it. A plastic bag containing cold cuts and cheese bore a discard date of July 17, 2025. An opened container of mayonnaise had no open date. These items emitted a strong offensive odor. The above observations were confirmed by Employee 8, NA (nurse aide), who stated during the observation that she was unaware residents had been filling plastic cups with water and storing them in the freezer. She stated the facility's ice machine had been broken for the past two weeks. She confirmed the residents did not receive fresh water that shift due to the lack of ice. During an interview with the Nursing Home Administrator (NHA) on July 23, 2025, at 1:45 PM, the above observations were reviewed. The NHA acknowledged the dietary department and resident pantry areas should be maintained in a clean and sanitary manner. 28 Pa |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Keep all essential equipment working safely.<br><br>Based on observations, and staff and resident interviews, it was determined the facility failed to ensure that essential equipment, it was determined that essential equipment for the mechanical preparation of ice was not being maintained in a safe operating condition.Findings include: During a resident group interview on July 23, 2025, at 10:30 AM, six of six alert and oriented residents in attendance (Residents 78, 21, 30, 5, 65, and 9) voiced concerns that fresh ice water was only consistently provided during all shift due to the facility's ice machine being broken. The residents in attendance reported that they were purchasing their own bags of ice through an online website and had them delivered to the facility. An interview with Employee 8, a Nurse Aide (NA), stated the facility's ice machine had been broken for the past two weeks and confirmed the residents did not consistently receive fresh water that shift due to the lack of ice. Interview with the Nursing Home Administrator (NHA) on July 22, 2025, at 1:00 PM, reported the only ice machine in the facility had been in operatable for approximately two weeks and awaiting an estimate for repairs. The NHA reported purchasing bags of ice for staff to fill unit ice chests and complete ice water passes to the residents. The NHA provided an estimate for ice machine repairs dated July 22, 2025, and determined that the cost of repairs was not feasible and decided to purchase a new ice machine for the facility. During on-site survey, the NHA provided a purchase order dated July 23, 2025, for a new ice machine. Refer F804 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18 (b)(1)(3)(e)(1)(2.1) Management |