STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395279	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinecrest Manor	763 Johnsonburg Rd St Marys, PA 15857

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31185 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to initiate a baseline care plan for one of 23 residents reviewed (Resident R99). Findings include: A facility policy entitled, Care Plan: Baseline (IPOC) dated 2/06/25, revealed Baseline PCM IPOC will be entered and developed for each resident within 48 hours. Resident R99 's clinical record revealed an admitted [DATE], with diagnoses that included diabetes, high blood pressure, anemia, and acute kidney injury. Resident R99 's clinical record lacked evidence that a baseline care plan was initiated for Resident R99. During an interview on 2/12/25, at 1:00 p.m. the Nursing Home Administrator confirmed that the clinical record of Resident R99 lacked evidence that a baseline care plan was initiated. 28 Pa. Code 211.12(d)(1) Nursing services

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

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 40832 Based on reveiew of clinical records, observations and staff and resident interviews, it was determined that the facility failed to provide sufficient nursing staff to promote the physical and mental well-being and meet the needs of seven of 23 residents interviewed (Residents R80, R12, R34, R37, R93, R79, and R51). Findings include: Independent interview on 2/10/25, at 4:13 p.m. revealed that Resident R51 disclosed that he/she cannot walk, uses an electric wheelchair for mobility, and requires a mechanical lift to transfer. Resident R51 shared that there are times (especially on off shifts and weekends) when he/she waits on the toilet for an hour to get help, and that he/she has waited so long to get to the bathroom, he/she soiled his/her clothing. Resident R51 also stated that staff will come in and turn off the bell, and not return. Interviews during the Resident Council meeting on 2/11/25, between 1:00 p.m. and 2:15 p.m. revealed that six out of six alert and oriented residents were in attendance (Residents R80, R12, R34, R37, R93, and R79) and reported concerns related to staff not responding to their call bells timely, and all six residents confirmed that it is common to wait over an hour for your call bell to get answered, especially on 3-11 shift and weekends, and that they have just learned to do what they can for themselves and let other stuff go because you can't get help anyways. Resident R12 shared that he/she waited this morning until 10:30 a.m. to get his/her shower and then decided he/she would have to go ahead and get dressed before lunch so he/she could attend the meeting at 1:00 p. m. Resident R12 also stated that he/she has not been walked by staff and that his/her walker hasn't been out of the closet in months. Resident R34 shared that he/she can't remember last shower I got, and that he/she washes up at the sink. Resident R34 also stated that he/she sleeps in a recliner because he/she knows they can get out of it on his/her own to get to the bathroom when needed. Resident R79 shared that he/she is independent in his/her room and can transfer from surface to surface on his/her own, but that he/she observes and witnesses long call bell waits. Resident R93 confirmed you just know that if they are short-staffed you aren't going to get help anytime fast, and especially on evenings and weekends, you just don't ring because no one's going to answer it. Resident R80 shared that he/she is supposed to be walked Monday, Wednesday, and Friday and if there are not enough nurse aides, the restorative aides (RA) get pulled to work the floor, and he/she hasn't been walked in a couple of weeks. Review of Resident R80's clinical record revealed a physician's order dated 7/17/24, for walking three times a week, and review of the Restorative Detail Report revealed that he/she hadn't been walked since 1/31/25. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 2/12/25, at 9:45 a.m. Licensed Practical Nurse Employee E8 confirmed Resident R80 had not been walked since 1/31/25, due to restorative staff being pulled to the floor to work as nurse aides, and that today there are two restorative staff on the floor as nurse aides until 11:00 a.m. and then will switch to performing restorative duties. Observation on 2/13/25, at 8:47 a.m. revealed RA Employee E3 was providing feeding assistance to a dependent resident. During an interview at that time, RA Employee E3 verified that they are pulled to the floor to work as nurse aides due to nursing being short staffed and that often only leaves time during the day for restorative duties with about three residents from 1:30 p.m. to 3:00 p.m. and working around other afternoon activities for the residents. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(4)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 48496 Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to store schedule II-V medications in a separately locked, permanently affixed compartment in three of four medication rooms reviewed (A/B, C/D and E/F); the facility failed to prevent the opportunity for potential unauthorized access of medications on two of four medication carts observed (D and F); and the facility failed to appropriately discard outdated medications for one of four medication carts reviewed (E wing). Findings include: Review of facility policy entitled Narcotic Policy PCM dated 2/06/25, revealed Schedule II-V medications are stored in a permanently affixed, double-locked compartment separate from all other medications. Review of facility policy entitled Medication cart: Med Pass Guidelines dated 2/06/25, revealed that Multi-dose vials such as insulin must have either opened on date or used by date which should be checked prior to administration. Review of facility policy entitled Pharmaceutical Services and Medication Storage dated 2/06/25, revealed Medications will be in containers that meet regulatory requirements and stored safely. Except for those medications requiring refrigeration .medications intended for internal use are stored in a medication cart . Review of manufacturer's guidelines revealed that an open pen of Lantus Insulin (medication to treat diabetes and help control blood sugar levels) must be used within 28 days after opening or be discarded, even if the vial still contains insulin. Observation of drug storage on 2/10/25, at 2:55 p.m. of C and D wings medication room refrigerator revealed a clear plastic locked box and inside the clear plastic box were two carpujects (a syringe device for the administration of injectable fluid medications) of Lorazepam (a controlled antianxiety medication). The shelf with the clear plastic box containing the Lorazepam was not permanently affixed to the refrigerator allowing the shelf and the Lorazepam to be removed from the refrigerator. During an interview at the time of observation with Licensed Practical Nurse (LPN) Employee E6, he/she confirmed that the clear plastic box containing Lorazepam was not permanently affixed to the refrigerator. He/she also confirmed that the schedule II-V medications should be stored in a separately locked permanently affixed compartment. Observation of drug storage on 2/10/25, at 3:12 p.m. of A and B wings medication room refrigerator revealed a clear plastic locked box and inside the clear plastic box was one carpuject and one vial of Lorazepam. The shelf with the clear plastic box containing the Lorazepam was not permanently affixed to the refrigerator allowing the shelf and the Lorazepam to be removed from the refrigerator. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview at the time of observation with LPN Employee E7, he/she confirmed that the clear plastic box containing Lorazepam was not permanently affixed to the refrigerator. He/she also confirmed that the schedule II-V medications should be stored in a separately locked permanently affixed compartment. Observation of drug storage on 2/10/25, at 3:16 p.m. of E and F wings medication room refrigerator revealed two carpujects of Lorazepam lying on the refrigerator shelf. The refrigerator lacked a separately locked permanently affixed compartment for the schedule II-V medications which allowed the Lorazepam to be removed from the refrigerator. During an interview at the time of observation with LPN E5, he/she confirmed that the Lorazepam was not in a separately locked compartment that was permanently affixed to the refrigerator. He/she also confirmed that the schedule II-V medications should be stored in a separately locked permanently affixed compartment. Observation of drug storage on 2/10/25, at 3:16 p.m. of E wing medication cart revealed an open pen of Lantus insulin with no date indicating when the pen was opened. During an interview at the time of observation with LPN Employee E5, he/she confirmed that the open Lantus Insulin lacked an opened date. He/she also confirmed that due to the Lantus insulin having no opened date the insulin should have been discarded. Observation of the D wing medication cart on 2/10/25, at 4:30 p.m. revealed that the medication cart was sitting in front of a resident's room with the back of the cart facing into the hallway. On the back of the medication cart were two open shelves with an open bottle of MiraLAX, an open bottle of Pepto-Bismol, and two bottles of Robitussin, one that had been opened. Further observations revealed that the nurse continued to two other resident rooms leaving the back of the cart facing into the hallway and out of view while in a resident's room. During an interview at the time of observations with LPN Employee E4, he/she confirmed that there were medications on the shelf on the back of the medication cart which were out of view and could allowed unauthorized access to the medications. He/she also confirmed that the medications should not be accessible and should be locked in the medication cart. Observation of the F wing medication cart on 2/10/25, at 4:50 p.m. revealed that the medication cart was sitting in front of a resident's room with the back of the cart facing into the hallway. On the back of the medication cart were two open shelves with an open bottle of MiraLAX, an open bottle of Milk of Magnesium, three bottles of Robitussin, two that were opened and two open bottles of Robitussin DM. Further observations revealed that the nurse continued to two other resident rooms leaving the back of the cart facing into the hallway and out of view while in a resident's room. During an interview at the time of observations with LPN Employee E5, he/she confirmed that there were medications on the shelf on the back of the medication cart which were out of view and could allowed unauthorized access to the medications. He/she also confirmed that the medications should not be accessible and should be locked in the medication cart. 28 Pa. Code 201.18(b)(1) Management (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1) Nursing services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832 Based on observations, review of clinical records and facility policy, and staff interview, it was determined that the facility failed to prevent the potential for cross contamination (the spreading of germs/microorganisms from one surface to another) during wound care for one of 23 residents reviewed (Resident R13). Findings include: A facility policy entitled, Handwashing and Hand Hygiene dated 2/06/25, revealed that hand hygiene be performed after handling soiled equipment and after removing gloves. Resident R13's clinical record revealed an admitted [DATE], with diagnoses that included Alzheimer's Disease (brain condition that causes a progressive decline in memory, thinking, learning and organizing skills), Venous stasis (a condition that occurs when blood doesn't flow properly from the legs back to the heart), and congestive heart failure (CHF- long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply). Observation of wound care on 2/12/25, at 9:27 a.m. revealed the following: Licensed Practical Nurse (LPN) Employee E1 donned (put on) a clean gown and gloves, positioned Resident R13's left leg, removed the sock, changed gloves, removed the soiled dressing, changed gloves, cleansed the wound, changed gloves, applied the medication to the wound, changed gloves, and applied the clean dressing. LPN Employee E1 failed to perform hand hygiene each time he/she changed his/her gloves, or four times throughout the dressing change. Registered Nurse (RN) Employee E2 donned a clean gown and gloves, assisted with positioning Resident R13's left leg, removed gloves, used bare hands to pick up and move garbage can next to end of bed, donned gloves, picked up and held Resident R13's left foot at the ball of the foot and near the Achille's, and using his/her gloved finger pointed to areas on wound near the open surface of the wound during the dressing change. RN Employee E2 failed to perform hand hygiene after touching the garbage can before donning clean gloves. During an interview at that time RN Employee E2 and LPN Employee E1 confirmed that they should have performed hand hygiene before donning clean gloves. 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services