STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395282	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis Center for Rehabilitation & Healthcare	1412 Lansdowne Avenue Darby, PA 19023

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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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 41471 Based on the observations and staff interviews, it was determined that the facility failed to ensure that the residents were treated with dignity and respect for one of four nursing units reviewed (Fourth Floor Main). Findings include: Observation of fourth floor main dining room on September 25, 2024, from 12:00 p.m. to 12:40 p.m. revealed that there were 14 residents in the dining room. It was revealed that there were two residents on table eating the lunch, five other residents on the same table were not served their meals. Two residents who received lunch tray early were finished by 12:30 p.m. while all other residents on the same table were not served. Further observation revealed that cart with trays for other residents arrived at the unit at 12:32 p.m., and were served by 12:35 p.m.11 trays arrived for the rest of 12 residents in the dining room. One resident did not receive the tray until 12:40 p.m. Interview with Nurse Aide, Employee E8, on September 25,2024, from 12:30 p.m stated two of five residents sitting at the center table received the lunch tray around 11:30 a.m., remaining residents lunch tray arrived an hour later at 12:30 p.m. Interview with Employee E9 Unit Manager, on September 25, 2024, from 12:40 p.m., confirmed that the residents who were eating in fourth floor main nursing were not served at the same time for residents in the same table. 28 Pa. Code: 201.29(j) Resident rights.

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 36609 Based on review of clinical records, interview with staff, and review of facility documentation, it was determined that the facility failed to ensure a resident was treated with dignity and respect when staff attempted to provide care for one of 35 residents reviewed (Resident R322). Findings include: Review of a facility reported incident dated August 25, 2024 indicated a 11-7 aide mistakenly thought Resident R322 needed her brief changed and took the covers off the resident without asking. The facility documentation revealed in Resident R322's interview the resident said the aide came over to her bed and pulled the sheets off of her. The resident asked, 'What are you doing.' The resident said the aide stopped and apologized and said I am sorry I just thought you needed to be changed. The resident felt he should have asked first and felt, violated when he took her blankets off without asking. Facility documentation stated the resident said 'He didn't touch me-He thought I wore a brief -He should have asked.' 28 Pa Code 201.18(e)(1)(h) Management 28 Pa Code 201.29 (a)(c)(j)(k) Resident rights

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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** 47975 Based on review of facility policy, review of clinical records, and interviews with staff, it was determined that the facility failed to develop a baseline care plan within 48 hours of a resident's admission relating to oxygen administration for one of thirty-five residents reviewed. (Resident R99) Findings Include: Review of the facility policy titled, Resident Plan of Care with a revision date of June 2024 states, Policy Statement- Our facility's Care Planning/Interdisciplinary Team is responsible for the development of a plan of care for each resident. Policy Interpretation and Implementation states, The care plan is based on the resident's assessment and is developed by a Care Planning/Interdisciplinary Team. The Interdisciplinary Team, resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development and revisions to the resident's care plan. Review of Resident R99's clinical record revealed the resident was admitted to the facility on [DATE] with the following diagnoses: chronic obstructive pulmonary disease, Congestive Heart Failure, and Hypertension. Observation of Resident R99 on September 24, 2024 at 11:01 a.m. revealed the resident was in bed resting with his oxygen administered. Review of resident R99's physician orders revealed an order for oxygen 2 liters via nasal canula continuously dated August 20, 2024. Review of Resident R99's baseline care plan dated August 20, 2024 revealed there was no focus area for oxygen therapy. Interview held on September 25, 2024 at 10:21 a.m. with licensed nurse, Employee E3 who confirmed that there was no current care plan in place for oxygen for Resident R99 although he has been on oxygen since being admitted to the facility. 28 Pa Code 201.18(b)(1) Management 28 Pa Code 211.10(c) Resident care policies 28 Pa Code 211.12(d)(2) 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471 Review of facility policies, observations, review of clinical records, and interviews with residents and staffed revealed that the facility failed to ensure resident care plan were revised related to bed rails, beds against the wall, oxygen therapy, and diet for five of thirty-five residents reviwed. (Residents R106, R42, R96, R125, and R574). Findings Include: Review of Resident R106's clinical record revealed the diagnoses of paraplegia (paralysis of the legs and lower body), need for assistance with personal care, pressure ulcer of sacral region- stage IV (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer), and osteomyelitis (infection in the bone) of vertebra. Interview with Resident R106 on Monday, September 23, 2024, at 11:46 a.m., revealed that she has been requesting bed side rails since she was transferred on second floor unit - 2 Main on September 12, 2024. Per R106's statement - she is paraplegic and bed side rails are helpful for her to be able to pull herself up in bed. Further review of clinical record revealed admission 'Bed Rail Evaluation,' completed on August 16, 2024, at 2:58 p.m. which indicated that Resident R106 expressed a desire to have bed side rails raised while in bed for safety and comfort, that resident is currently using the bedrail for positioning or support, and bedrails are indicated at this time. Review of R106's care plan revealed no evidence of goals or interventions related to bedrail use. Review of Resident R42's clinical record revealed Resident R42 was admitted to the facility on [DATE] with a diagnosis of orthopedic aftercare following surgical amputation, acute kidney failure, and muscle weakness. Resident R125 was admitted on to hospice services on September 17, 2024 with a diagnosis of atherosclerotic heart disease (damage in the hearts major blood vessels). Observation of Resident R42 on September 23, 2024 at 10:05 a.m. revealed Resident R42 was receiving oxygen 2 liters via nasal cannula. Review of Resident R42's care plan revealed no care plan related to oxygen therapy. Interview with Employee E2, Director of Nursing, on September 25th, 2024 at 1:50 p.m. confirmed Resident R42 did not have a care plan for oxygen therapy. Review of Resident R96's physician order dated May 29, 2024, revealed a diet order for regular diet. Observation of Resident R96's meal ticket on September 25, 2024, at 12:35 p.m. revealed that the resident was receiving regular diet with regular consistency. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an active care plan for Resident R96 dated July 20, 2023, revealed that the resident was on renal (a diet that helps people with chronic kidney disease or who are on dialysis maintain balanced levels of minerals, electrolytes, and fluids in their bodies) /no added salt/chopped diet with thin liquids. Interview with Registered Dietician on September 26, 2024 at 11:50 a.m. confirmed that the diet order for Resident R96 did not match the care and the care plan was not revised to reflect the changes. Review of Resident R125's clinical record revealed Resident R42 was admitted to the facility on [DATE] with a diagnosese of acute and chronic respiratory failure, cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it), and muscle weakness. Observation of Resident R125 on September 23, 2024 at 10:35 a.m. revealed Resident R125 had the right side of her bed pushed against the wall. Interview on September 23, 2024 at 10:40 a.m. with Employee E5, Registered Nurse, confirmed Resident R125's right side of bed was against the wall. Clinical record review revealed Resident R125 did not have a care plan in place for Resident R125's bed against the wall. Observation of Resident R574 on September 25, 2024 at 11:54 a.m. revealed the resident had her bed positioned with the left side fully against the wall. Interview with licenssed nurse Employee E3 on September 25, 2024 at 11:57 a.m. confirmed Resident R574's right side of the bed was against the wall. Review of Resident R574's clinical record revealed the resident was admitted to the facility on [DATE] with the following diagnoses: Muscle Weakness, Difficulty in Walking, Heart Failure, and Unspecified Fall Subsequent Encounter. Clinical record review revealed Resident R574 did not have a care plan in place for Resident R574's bed against the wall. Interview with the Director of Nursing Employee E2 on September 27, 2024 at 12:25 p.m. revealed the resident's bed was moved against the wall after a fall Resident R574 had on September 21, 2024 based on her request. The Director of Nursing Employee E2 confirmed that this preference was not added to the resident's care plan. 28 Pa Code 211.12(d)(5) Nursing Services

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609 Based on a resident's interview, clinical record review and review of the facility policy, it was determined that the facility failed to provide the necessary care and services to ensure that a resident's abilities of daily living was maintained and did not diminish for one of 35 resident records reviewed (Resident R141). Finding include: Review of the facility policy titled, Restorative Therapy effective March 2020, states Restorative Nursing Programs (RNP) will be provided and considered for residents admitted to the facility with restorative needs and who will benefit from a restorative program in conjunction with formalized rehabilitation therapy. The rehabilitation staff will assist with the identification of residents who will benefit from Restorative nursing; work with nursing to identify and design appropriate programs; and provide restorative program training to the Certified Nurse Assistant (aka Nursing Assistant). When a restorative nursing program is established by a therapist, the residents' individualized restorative program goals and plans will be written by the rehab staff. Restorative Program documentation will provide a summary of the resident's overall monthly achievements. The Staff Development Coordinator and the Rehab staff will work as a team to provide education to facility staff as required. Review of Resident R141's clinical record revealed that the resident was admitted to the facility on [DATE], with the diagnoses of chronic pain syndrome, muscle wasting and atrophy, not elsewhere classified, in his bilateral upper arms, muscle weakness, osteoarthritis, contracture of muscle, multiple sites, and was morbidly obese. During an interview with Resident R141 on September 24, 2024, at 12:30 p.m. indicated he no longer received restorative therapy. The resident stated, There are ten of us that should be getting restorative therapy, five days a week and I walk with them. When the facility is short staffed, the restorative nurses are taken off their assignments and put on as aides. I don't get the therapy like I was, and I see a difference. I was able to walk and now I can't. Review of Resident R141's physician orders instructed to evaluate and treat the resident to address TherAct, (therapeutic activities), TherEx,(therapeutic exercises) NMR, (neuromuscular re-education) WC Mgmt Training (wheelchair management training), gait training, patient and caregiver education and safe discharge planning that started on January 9, 2024, and ended on February 8, 2024. Review of Resident R141's clinical record revealed a care plan was developed for the resident's Impaired ability to walk related to fall risk that may benefit from a restorative nursing program (RNP), date initiated on February 12, 2024. The goal dated February 12, 2024, revised on July 5, 2024, target date of October 15, 2024, Will maintain or improve distance walked through the next review. The RNP care plan included intervention dated February 12, 2024, for ambulation, to Maintain or increase self-performance in walking and to oversee restorative interventions provided and document progress at least monthly. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's clinical record revealed a nursing progress note from the Director of Nursing dated March 31, 2024, stating, Decreased range of motion and flexibility related to muscle weakness that may benefit from a restorative nursing program, the note continued to say that the resident participated in RNP for March 2024 and ambulated a total of 150 feet with FWW (front wheeled walker) and WC (wheelchair) to follow. Program will continue as a maintenance program as it's beneficial to him. Review of Resident R141's Restorative Nursing Task dated February 12, 2024, indicated The resident will walk to the nursing station from their room, 200 feet with a rolling walker to increase independence. Further review of the RNP revealed in the past 30 days from August 28 to September 26, 2024 the resident was documented receiving only six days of restorative therapy on September 7,9,12,18,20, 25, 2024. Interview with the Director of Nursing on September 26, 2024, at 9:00 a.m. confirmed when the facility is understaffed the restorative aides will be reassigned as nursing aides. 28 Pa. Code 211.109d) Resident care policies 28 Pa. Code 211.12(c)(d)(1) Nursign services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 41471 Based on the review of clinical record, interview with resident and staff, it was determined that the facility failed to administer the medication in a timely manner as ordered by the physician and according to the professional standards of practice for two of 35 residents reviewed. (Resident R179 and Resident R147) Findings Include: Review of facility policy Administering Medication dated June 2024, revealed Medications shall be administered in a safe and timely manner, and as prescribed. Medications must be administered one hour before and after the prescribed times. Standard prescribed times will include but not limited to a. Morning Medication b. Afternoon meds c. Early evening meds d. Late evening meds e. Night meds f. Specific prescribed medication times Interview with Resident R147 on September 23, 2024, at 10:24 a.m. stated he received the medication often late; he stated sometimes the medications that needed to be taken with meals and medications that needed to be taken before meals were not given timely. He stated sometimes his morning medication which he usually takes before 9 a.m. are not given until noon. Review of physician order for Resident R147 for the month of September 2024, revealed, orders for: Apixaban Oral Tablet 5 MG, Give 1 tablet by mouth two times a day for chronic atrial fibrillation in the morning and evening. Cymbalta Oral Capsule Delayed Release Particles 30 MG (Duloxetine HCl) Give 1 capsule by mouth one time a day related to homelessness. Farxiga Oral Tablet 10 MG, give 1 tablet by mouth one time a day related to type 2 diabetes mellitus. Furosemide Oral Tablet 40 MG, give 1 tablet by mouth one time a day related to congestive heart failure. Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25 MG Give 1 tablet by mouth one time a day related to hypertension. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Mometasone Furoate Inhalation Aerosol 100 MCG/ACT 2 puff inhale orally two times a day related to chronic obstructive pulmonary disease. Sacubitril-Valsartan Oral Tablet 24-26 MG Give 1 tablet by mouth two times a day related to hypertension. Review of Medication Administration Audit Report for Resident R147 dated September 22, 2024 revealed the following: On September 22, 2024: Apixaban scheduled for morning and evening, given at 12:08 p.m., and 5:31 p.m. which is only 5.30 hours apart. Cymbalta scheduled for morning, given at 12:07 p.m., Farxiga scheduled for morning, given at 12:07 p.m., Furosemide scheduled for morning, given at 12:08 p.m., Metoprolol Succinate scheduled for morning, given at 12:08 p.m., Mometasone Furoate Inhalation scheduled for morning and evening, given at 12:08 p.m., and 5:31 p.m. Sacubitril-Valsartan scheduled for morning and evening, given at 12:07 p.m., and 5:32 p.m. which is only 5. 30 hours apart. Review of physician order for Resident R179 for the month of September 2024, revealed, orders for: Baclofen Oral Tablet 5 MG Give 1 tablet by mouth three times a day muscle spasm. Gabapentin Oral Capsule 400 MG, give 1 capsule by mouth three times a day related to neuralgia and neuritis morning dose scheduled at 9:00 a.m. Review of Medication Administration Audit Report for Resident R179 dated September 22 and September 23, 2024, revealed that Resident R22 received all the above medications as follows: Baclofen scheduled for 9:00 a.m., 2 p.m. given at 11:27 a.m., and 2:19 p.m. less than 3 hours apart. Gabapentin scheduled for 9:00 a.m., 2 p.m. given at 11:27 a.m., and 2:19 p.m. less than 3 hours apart. Drug information report for Sacubitril-Valsartan revealed that take it at the same time each day-for example, when you first wake up and again before you go to bed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Drug information report for Mometasone Furoate Inhalation revealed that take Mometasone Furoate Inhalation every day, with 2 puffs in the morning and 2 puffs in the evening. If you miss a dose of Mometasone Furoate Inhalation, skip your missed dose and take your next dose at your regular time. Do not take Mometasone Furoate Inhalation more often or use more puffs than you have been prescribed. Drug information report revealed that Gabapentin capsules, tablets, and oral solution are usually taken with a full glass of water (8 ounces [240 milliliters]), with or without food, three times a day. These medications should be taken at evenly spaced times throughout the day and night; no more than 12 hours should pass between doses. Interview with the Pharmacist on September 26, 2024, at 2.10 p.m. stated Eliquis should be taken 2 times a day, it had to be separated by at least 8 hours, 5 hours apart was not appropriate. Interview with the Director of Nursing on September 26, 2024, at 2.30 p.m. stated twice daily medication such as Apixaban, blood pressure medication should have scheduled and administered at 9:00 a.m. and 9:00 p.m. and morning medications should not be given at lunch time. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(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. 47975 Based on review of facility policy, review of clinical records, and interviews with staff, it was determined that the facility failed to ensure physician orders were followed in relation to oxygen administration for one of thirty-five residents reviewed. (Resident R98) Findings Include: Review of facility policy titled, Oxygen Administration- Resident with a revision date on December 2022 states, Purpose- The purpose of this procedure is to provide guidelines for safe oxygen administration. Steps in the procedure state, . 4. Turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate ordered. 5. Place appropriate oxygen device on the resident. 6. Adjust the oxygen delivery device so that it is comfortable for the resident. 7. Securely anchor the tubing so that it does not rub or irritate the resident's nose, behind the resident's ears, etc. 8. Check the mask, tank, humidifier, etc., to be sure they are in good working order and are securely fastened. 9. Observe the resident upon setup and periodically thereafter to be sure oxygen is tolerated. Review of Resident R98's record revealed the resident was admitted to the facility with the diagnosis of chronic obstructive pulmonary disease (lung condition cause by damage and inflammation to the lungs). Observation of Resident R98 in her room on September 24, 2024 at 10:01 a.m. revealed the resident was in bed resting wearing oxygen. The oxygen level was checked and was running at 3 liters. Review of resident R98's physician orders revealed an order from August 5, 2024 that read, Oxygen 2L via nasal cannula continuously. Review of Resident R98's oxygen level on September 25, 2025 at 11:33 a.m. revealed the resident's oxygen level was running at 3 liters. The level was confirmed by licensed nurse Employee E3 as being incorrect. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12 (d)(3) Nursing Services 28 Pa. Code 211.12 (d)(5) Nursing Services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 36609 Based on clinical record review and facility policy, it was determined that the facility failed to ensure the timely availability of medication for one of 35 residents reviewed (Resident R12). Findings include: Review of the facility policy titled Pharmacy Services effective March 2020 states, The facility shall accurately and safely provide or obtain pharmacy services including the provision of routine and emergency medication and biologicals and the services of a licensed Pharmacist. The same policy states, The facility shall contract with a licensed Pharmacist to help obtain and maintain timely and appropriate pharmacy services that support residents' needs, are consistent with current standards of practice, and meet the state and federal requirements. Review of Resident R12's physician orders indicated Ativan gel 0.5mg/ml be applied to the resident three times a related to the resident's diagnosis of anxiety disorder. Review of Resident R12's nursing progress notes and the medication administration record revealed the Ativan gel was not administered due to pharmacy services as follows: Nursing note dated January 29, 2024, noted the medication was Awaiting on pharmacy to deliver. Nursing Note dated, January 30, 2024, noted the medication was Awaiting on pharmacy to deliver. Nursing notes on January 31, 2024, at 9:01 a.m. and 2:08 p.m. noted the medication was still pending due to pharmacy delivery. Nursing note on February 16, 2024, noted the medication was Awaiting pharmacy. Nursing note, on March 17 at 10:52 a.m. indicated the medication was, Unavailable. Nursing notes for June 21, 2024, indicated at 2:01 p.m. the medication was Awaiting delivery and at 6:07 p. m. was Pending from the pharmacy. Nursing notes for June 22, 2024 indicated at 2:10 p.m. nursing spoke with the pharmacy and the pharmacy indicated the Ativan gel would be sent out on the next run. At 6:37 p.m. nursing noted the medication was is still on order. Nursing notes for June 23, 2024, indicated at 9:33 a.m. pharmacy would send out the Ativan gel on the next run, at 12:04 p.m., the mediction was noted Awaiting delivery' and at 2:15 p.m stated the Ativan gel was still Awaiting delivery. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.9(d) Pharmacy services

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	395282	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis Center for Rehabilitation & Healthcare	1412 Lansdowne Avenue Darby, PA 19023

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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. 41471 Based on observations and staff interviews, it was determined that the facility failed to implement an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections during dining services for one of four nursing units reviewed (Fourth Floor Main). Findings Include: Observation of fourth floor main dining room on September 25,2024, from 12:32 p.m. revealed that there were 14 residents in the dining room. Five employees were serving lunch to residents in the dining room. It was observed that Employee E8, Nurse Aide, passed tray to a resident sitting at the table, set up the tray, opened the utensils, touched residents clothing protector and table and proceeded to pass and set up the lunch tray for the next residents. There was no hand hygiene observed during the lunch service. Further observation revealed that Employee E8 was sitting next to a resident started helping the resident in front of her with utensils, drinks, and setting up the tray. She then turned to her right side touched other residents tray, utensil and opened the tray without any hand hygiene. Further observation revealed that Employee E12, Nurse Aide, who collected finished trays from two residents delivered and set up the tray for a resident sitting at the center table. There was no hand hygiene observed during the observation. Continued observation revealed that four of 12 residents in the dining room who was waiting for the tray were touching their clothes, the table and their wheelchair. There was no hand hygiene observed prior to serving meal trays for any of the 12 residents who received trays. One resident was observed eating with her hands. Observation also revealed that there was a total of 5 employees who assisted with meal tray for residents in the dining room, none of the five employees performed hand hygiene prior to the tray delivery or set up. Observation of the dining room revealed that there was two wall hand sanitizer unit in the middle of the dining room, which was available for the staff and residents. Interview with Employee E9 Unit Manager, on September 25, 2024, from 12:40 p.m., confirmed that staff did not perform hand hygiene before or during meal services in the fourth floor dining room. Employee stated all the residents were cognitively impaired or had diagnosis of dementia who required assistance from staff for hygiene. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 41471 Based on a review of facility documentation, facility policies and staff interviews, it was determined that the facility failed to maintain an effective antibiotic stewardship program that includes a system that includes antibiotic use protocols and a system to effectively monitor antibiotic usage for four of four months of antibiotic stewardship program data reviewed. (May 2024, June 2024, July 2024 and August 2024). Findings Include: A review of CDC (Centers for Disease Control and Prevention) guidelines, The core element of Antibiotic Stewardship for Nursing Homes, revealed that Improving the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance is a national priority. 1. Antibiotic stewardship refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use.2 The Centers for Disease Control and Prevention (CDC) recommends that all acute care hospitals implement an antibiotic stewardship program (ASP) and outlined the seven core elements which are necessary for implementing successful ASPs.2 CDC also recommends that all nursing homes take steps to improve antibiotic prescribing practices and reduce inappropriate use. Nursing homes monitor both antibiotic use practices and outcomes related to antibiotics in order to guide practice changes and track the impact of new interventions. Data on adherence to antibiotic prescribing policies and antibiotic use are shared with clinicians and nurses to maintain awareness about the progress being made in antibiotic stewardship. Clinician response to antibiotic use feedback (e.g., acceptance) may help determine whether feedback is effective in changing prescribing behaviors. Integrate the dispensing and consultant pharmacists into the clinical care team as key partners in supporting antibiotic stewardship in nursing homes. Pharmacists can provide assistance in ensuring antibiotics are ordered appropriately, reviewing culture data, and developing antibiotic monitoring and infection management guidance in collaboration with nursing and clinical leaders. Identify clinical situations which may be driving inappropriate courses of antibiotics such as asymptomatic bacteriuria or urinary tract infection prophylaxis and implement specific interventions to improve use. Perform reviews on resident medical records for new antibiotic starts to determine whether the clinical assessment, prescription documentation and antibiotic selection were in accordance with facility antibiotic use policies and practices. When conducted over time, monitoring process measures can assess whether antibiotic prescribing policies are being followed by staff and clinicians. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Track the amount of antibiotic used in your nursing home to review patterns of use and determine the impact of new stewardship interventions. Some antibiotic use measures (e.g., prevalence surveys) provide a snap-shot of information; while others, like nursing home initiated antibiotic starts and days of therapy (DOT) are calculated and tracked on an ongoing basis. Selecting which antibiotic use measure to track should be based on the type of practice intervention being implemented. Interventions designed to shorten the duration of antibiotic courses, or discontinue antibiotics based on post-prescription review (i.e., antibiotic time-out), may not necessarily change the rate of antibiotic starts, but would decrease the antibiotic DOT. Review of facility documentation from the month of May 2024 revealed that the facility had a total of 9 urinary tract infection (UTI) which were treated with antibiotic orders. There was one UTI for a resident with foley which was treated with antibiotic orders There were other infections which was treated with antibiotic orders. It was also revealed that the surveillance tool did not contain a stop date, total days of therapy, outcome and adverse events. There was no antibiotic review completed to determine the appropriateness of the antibiotic usage. Review of facility documentation from the month of June 2024 revealed that the facility had a total of 9 urinary tract infection (UTI) which were treated with antibiotic orders. There was two UTI for residents with foley which was treated with antibiotic orders There were other infections including skin, respiratory and wound which was treated with antibiotic orders. It was also revealed that the surveillance tool did not contain a stop date, total days of therapy, outcome, and adverse events. There was no antibiotic review completed to determine the appropriateness of the antibiotic usage. Review of facility documentation from the month of July 2024 revealed that the facility had a total of 6 urinary tract infection (UTI) which were treated with antibiotic orders. There was one UTI for a resident with foley which was treated with antibiotic orders. There were other infections including skin, intestinal and wound which was treated with antibiotic orders. It was also revealed that the surveillance tool did not contain a stop date, total days of therapy, outcome, and adverse events. There was no antibiotic review completed to determine the appropriateness of the antibiotic usage. Review of facility documentation from the month of August 2024 revealed that the facility had a total of 7 urinary tract infection (UTI) which were treated with antibiotic orders. There were other infections including skin, respiratory and wound which was treated with antibiotic orders. It was also revealed that the surveillance tool did not contain a stop date, total days of therapy, outcome and adverse events. There was no antibiotic review completed to determine the appropriateness of the antibiotic usage. Interview with Employee E11, Infection Preventionist, on September 24, 2024, confirmed that the facility antibiotic stewardship program did not include use protocols for antibiotics, review of facility antibiotic orders to determine the appropriateness of the antibiotics and a system to effectively monitor antibiotic usage. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Put firmly secured handrails on each side of hallways. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471 Based on observation and interviews with staff, it was determined that the facility failed to equip corridors with safe handrails on each side, for one of four nursing floors observed (Fourth Floor Main). Findings include: Observation of the corridor handrail revealed that the following corridor handrails were loose/not secured properly, -near resident room [ROOM NUMBER] -near resident room [ROOM NUMBER] -near resident room [ROOM NUMBER] -near resident room [ROOM NUMBER], -near resident room [ROOM NUMBER], -near resident room [ROOM NUMBER] -near resident room [ROOM NUMBER] -near resident room [ROOM NUMBER] -near resident room [ROOM NUMBER] -near resident room [ROOM NUMBER] -near resident room [ROOM NUMBER] -near resident room [ROOM NUMBER] -near resident room [ROOM NUMBER] -near resident room [ROOM NUMBER] Observation of the corridor handrail revealed that the following corridor handrails were detached off the wall. - next to attic access wall next to room [ROOM NUMBER] towards the nurses station. -next to elevator B (continued on next page)

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-near room [ROOM NUMBER] There was missing handrail next to attic access wall next to room [ROOM NUMBER]. Interview on September 25, 2024, at 1:15 p.m. the Maintenance Director confirmed that handrails were broken, detached or missing, and she would have the maintenance correct the issue. 28 Pa Code 201.14(a) Responsibility of licensee