STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395285	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barnes-Kasson County Hospital	2872 Turnpike Street Susquehanna, PA 18847

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of clinical records and select facility investigative reports and resident and staff interview it was determined that the facility failed to consistently provide care and services to prevent the development and promote healing of pressure sores for one of 12 residents sampled (Resident 21). Findings include: According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, Standardized pressure ulcer risk assessment and care planning and implementation to address areas of risk. ACP (The American College of Physicians is a national organization of internists, who specialize in the diagnosis, treatment, and care of adults. The largest medical-specialty organization and second-largest physician group in the United States) Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i.e. , support surfaces, repositioning and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement and wound cleansing; using adjunctive therapies; and considering possible surgical repair. A review of the clinical record revealed that Resident 21 was admitted to the facility on [DATE], with diagnoses to include diabetes and urinary retention, with a foley catheter (a flexible tube inserted into the bladder to drain urine into a collection bag). A review of an admission Minimum Data Set assessment dated [DATE], (MDS - a federally mandated standardized assessment process completed periodically to plan resident care) revealed the resident was moderately cognitively impaired with a BIMS score of 19 (Brief interview for Mental Status score is a test which is used to evaluate a person's cognitive status, a score of 8-12 indicated moderate cognitive impairment), required assistance for activities of daily living and was at risk for developing pressure sores. (continued on next page)

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a facility investigation report dated August 19, 2024, at 10:30 A.M. revealed, on August 18, 2024, at 10:30 A.M., during a resident bath, Employee 3 Nurse Aide (NA) noted Resident 21, developed a 2cm-by-2cm open area on the right labia and an excoriation in the vaginal area presumed by Employee 3 to be caused by the Foley catheter tubing rubbing against the area. The skin finding was reported to Employee 4 a licensed practical nurse (LPN) The intervention put into place at that time including included alternating the Foley catheter tubing between the right and left legs daily. However, there was no evidence provided at the time of the survey that this intervention was consistently documented or implemented. Despite these measures, the facility failed to prevent the development of further pressure related skin issues. A review of a facility investigation report dated October 9, 2024, at 7:30 P.M., Employee 7 (NA) identified a blister on resident 21's right inner thigh presumed to be caused by pressure from the Foley catheter. Employee 7 (NA) placed a disposable washcloth between the residents foley catheter tubing and the blister and reported the blister to the nurse. The Physician was contacted, and new orders noted for skin prep (a skin barrier) to be applied every shift. A review of a skin assessment dated [DATE], at 1:54 A.M. revealed, the outer labia was slightly excoriated, the skin was red and intact. An intact blister measuring 1 cm x 0.4 cm was present on the right inner thigh. The presumed cause was noted as pressure from the foley catheter tubing. Preventative measures in place at the time the blister was discovered included alternating the Foley catheter tubing from the right leg to the left leg daily and ensuring a protective barrier was consistently placed between the residence skin and the catheter tubing. However, there was no evidence these measures were consistently implemented as required. This failure to follow established preventative interventions contributed to the development of additional pressure related skin issues. To address this issue staff was reeducated to ensure that all preventative measures and interventions were consistently implemented and documented to prevent further complications. A review of facility investigative documentation dated November 15, 2024, at 12:00 AM revealed Employee 5 identified blood the resident's peri area while assisting her with care. Employee 6 an agency RN assessed the resident and noted. The resident had bleeding from her vaginal area and there were scratches to both her right and left labia. The resident reported itching and scratching in that area. The presumed cause of the skin issue was from the resident's scratching in the area. Despite prior preventative measures to alternate the catheter tubing and use of protective layer, there was no evidence these measures were consistently followed. There was no evidence provided at the time of the survey that interventions to prevent pressure sores for Resident 21 including alternating the foley catheter tubing from the right leg to the left was documented as completed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no evidence at the time of the survey that effective interventions were put into place to prevent continuing pressure areas related to the residents foley catheter tubing. During an interview on January 16, 2025, at approximately 11:00 AM the director of nursing (DON) was unable to provide documented evidence the facility had implemented timely interventions and treatment to prevent the continued pressure areas related to the foley catheter tubing. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing service

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on clinical record review and staff interviews, the facility failed to ensure documented evidence of clinical necessity for the administration of antibiotic medications in accordance with established guidelines for two of five sampled residents for unnecessary medication prescribing practices (Resident 14 and 34). Findings included: A review of Resident 14's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including psychotic disorder with delusions (type of serious mental illness called a psychotic disorder and people who have it can't tell what's real from what is imagined) and history of UTI (urinary tract infection - an infection in any part of the urinary system). A review of nursing progress notes for Resident 14's completed by Employee 1, a Licensed Practical Nurse (LPN), dated November 14, 2024, at 10:59 AM, revealed the resident had increased confusion and complaints of burning upon urination with NON (new orders noted) for a (urinalysis) and C & S (culture and sensitivity - a urine culture is considered positive if it shows the presence of more than 100,000 colony-forming units (CFUs) of bacteria per milliliter of urine and indicates the presence of an infection. The sensitivity test helps select the best medicine to treat the infection). C&S results dated November 18, 2024, at 7:07 AM identified Citrobacter murliniae (a species of bacteria) 70, 000-90,000 CFU/mL and Proteus mirabilis (gram-negative rod-shaped bacteria) 20,000-30,000 CFU/mL and was susceptible (responsive to treatment) to nitrofurantoin, gentamicin, and trimethoprim/sulfamethoxazole (antibiotics). A review of a facility provided form entitled Revised McGeer's Criteria for Infection Surveillance Checklist (an algorithm that uses criteria to make an empiric diagnosis of UTI in nursing home residents. For resident's that do not have an indwelling urinary catheter and with at least three of the following signs and symptoms must be present prior to a practitioner prescribing antibiotic therapy include a fever (temperature of at least 100.4 F), new or increased frequency, urgency, or burning on urination, new flank or suprapubic pain or tenderness, change in character of urine, and worsening of mental or functional status) determined that UTI criteria was not met for an ATB to be prescribed. Despite results not meeting McGeer's criteria for a UTI diagnosis, the physician prescribed Macrobid 100 mg twice daily for 7 days on November 18, 2024, at 12:54 PM. A review of a facility provided form entitled 72-Hour Antibiotic Time-Out form indicated antibiotic appropriateness as no and confirmed that the resident did not meet McGeer's criteria for antibiotic treatment. The resident received 13 of 14 prescribed doses of Macrobid without documented justification for the antibiotic's use. (continued on next page)

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	395285	A. Building B. Wing	01/16/2025

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on January 16, 2025, at 10:15 AM the Infection Preventionist (IP) confirmed the prescribing physician was aware the criteria were not met, and the facility failed to prevent unnecessary antibiotic use. A review of Resident 34's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including dementia (a term used to describe a group of symptoms affecting memory, thinking and social abilities and the symptoms may interfere with individual's daily lives) and a history of UTI. A review of Resident 34's clinical record of nurses' progress notes completed by Employee 2, a LPN, dated December 3, 2024, at 10:18 AM and 1:09 PM, revealed that the resident had increased lethargy and weakness, leading to physician orders for urinalysis and C&S testing. Macrobid 100 mg (an antibiotic that fights bacteria in the body) oral capsule 100 mg (milligrams), twice daily was prescribed the same day. A review of a facility form entitled Newly diagnosed Infection Report dated December 3, 2024, completed by the Director of Nursing (DON) indicated a diagnosis of UTI; the resident was transferred to the ER (emergency room) and returned on Macrobid 100 mg orally twice daily for 7-days. However, the Revised McGeer's Criteria for Infection Surveillance Checklist form was incomplete and did not provide evidence supporting the UTI diagnosis. Further review of physician's orders dated December 4, 2024, at 5:51 PM, revealed an order for Rocephin (ceftriaxone sodium an antibiotic administered via injection and used to treat many kinds of bacterial infections) Sodium Injection Solution Reconstituted, inject 1 gm (gram) intramuscularly two times a day related to UTI until December 9, 2024, at 1:00 PM. Additionally, physician's orders were obtained on December 4, 2024, at 9:27 PM, to discontinue IM Rocephin and change to IV (intravenous therapy is a medical technique that administers fluids, medications, and nutrients directly into a person's vein) Rocephin Solution Reconstituted 1 gm (gram) intravenously every 12 hours for infection related to UTI. A review of culture results dated December 6, 2024, at 7:59 AM, revealed Resident 34's final urinalysis and C & S results that were 80,000-90,000 CFU/mL of E. coli (is bacteria from the intestines is present in fecal matter and trace amounts of fecal matter make their way into the urinary tract through the urethra opening and begin to multiply).Despite this, the 72-Hour Antibiotic Time-Out form indicated the resident did not meet McGeer's criteria for antibiotic treatment. The resident received two doses of Macrobid, one dose of intramuscular (IM) Rocephin, and four doses of intravenous (IV) Rocephin without documented evidence of clinical necessity. During interviews on January 16, 2025, at 10:30 AM, the IP and the Nursing Home Administrator (NHA) confirmed the prescribing physician and staff failed to ensure adherence to prescribing guidelines, and nursing staff inconsistently completed the surveillance checklist. (continued on next page)

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	395285	A. Building B. Wing	01/16/2025

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on January 16th, 2025 at 11:05 AM, the nursing home administrator (NHA) confirmed the facility failed to ensure adherence to antibiotic prescribing criteria for Residents 14 and 34. This failure resulted in the administration of unnecessary medications, inconsistent completion of infection surveillance documentation and non compliance with the established guidelines for the prevention of unnecessary medication use. 28 Pa. Code 211.2 (3) Medical Director 28 Pa. Code 211.9 (k) Pharmacy Services 28 Pa. Code 211.12 (d)(1)(3) Nursing Services 28 Pa. Code 211.5 (f)(ix) Medical records

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 43944 Based on a review of clinical records, staff interview, facility policy, and the facility's infection assessment tool, it was determined the facility failed to consistently implement its antibiotic stewardship protocols for initiating antibiotic use in accordance with the established infection prevention and control guidelines for two residents out of 12 sampled (Resident 14 and Resident 34) Findings included: Review of a facility policy entitled Antibiotic Stewardship last reviewed March 2024, indicated that antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program. When a nurse calls a physician/prescriber to communicate a suspected infection, he or she will have the following information available along with a completed Revised McGeer's Criteria for Infection Surveillance Checklist (an algorithm that uses criteria to make an empiric diagnosis of UTI in nursing home residents. For resident's that do not have an indwelling urinary catheter and with at least three of the following signs and symptoms must be present prior to a practitioner prescribing antibiotic therapy include a fever (temperature of at least 100.4 F), new or increased frequency, urgency, or burning on urination, new flank or suprapubic pain or tenderness, change in character of urine, and worsening of mental or functional status) form that includes the following data: signs and symptoms, when symptoms were first observed, resident's hydration status, current medication list, allergy information, infection type, any order for warfarin (blood thinning medication) and results of last INR (is a laboratory test that measures international normalized ratio (INR) and indicates how long it takes blood to clot), last creatine clearance or serum creatine (if available), and time of the last ATB dose. A review of nursing progress notes for Resident 14's completed by Employee 1, a Licensed Practical Nurse (LPN), dated November 14, 2024, at 10:59 AM, revealed the resident had increased confusion and complaints of burning upon urination with NON (new orders noted) for a (urinalysis) and C & S (culture and sensitivity - a urine culture is considered positive if it shows the presence of more than 100,000 colony-forming units (CFUs) of bacteria per milliliter of urine and indicates the presence of an infection. The sensitivity test helps select the best medicine to treat the infection). C&S results dated November 18, 2024, at 7:07 AM identified Citrobacter murliniae (a species of bacteria) 70, 000-90,000 CFU/mL and Proteus mirabilis (gram-negative rod-shaped bacteria) 20,000-30,000 CFU/mL and was susceptible (responsive to treatment) to nitrofurantoin, gentamicin, and trimethoprim/sulfamethoxazole (antibiotics). A review of the revised McGeer's Criteria for Infection Surveillance checklist completed for resident 14 determined that UTI criteria were not met as the resident did not present with the minimum required clinical signs or symptoms for UTI diagnosis. Despite this, Macrobid 100 milligrams was prescribed. November 18, 2024, based on urine culture results that did not meet diagnostic criteria for antibiotic use. The 72-Hour Antibiotic Time-Out form confirmed the antibiotic appropriateness was marked as no and facility staff failed to justify the continuation of treatment. Resident 14 received 13 of 14 prescribed doses of Macrobid without evidence of clinical necessity. (continued on next page)

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	395285	A. Building B. Wing	01/16/2025

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on January 16th, 2025, at 10:15 AM the infection preventionist IP confirmed the failure to adhere to antibiotic stewardship protocols including ensuring criteria were met before initiating treatment. The facility also failed to follow its antibiotic stewardship protocol when initiating and continuing antibiotic therapy for Resident 34. A review of Resident 34's clinical record of nurses' progress notes completed by Employee 2, a LPN, dated December 3, 2024, at 10:18 AM and 1:09 PM, revealed that the resident had increased lethargy and weakness, leading to physician orders for urinalysis and C&S testing. Macrobid 100 mg (an antibiotic that fights bacteria in the body) oral capsule 100 mg (milligrams), twice daily was prescribed the same day. A review of a facility form entitled Newly diagnosed Infection Report dated December 3, 2024, completed by the Director of Nursing (DON) indicated a diagnosis of UTI; the resident was transferred to the ER (emergency room) and returned on Macrobid 100 mg orally twice daily for 7-days. A review of the revised McGeer's Criteria for Infection Surveillance Checklist form was incomplete for this resident. Evidence supporting a UTI diagnosis was not documented before initiating Macrobid therapy on December 3rd, 2024. Further review of physician's orders dated December 4, 2024, at 5:51 PM, revealed an order for Rocephin (ceftriaxone sodium an antibiotic administered via injection and used to treat many kinds of bacterial infections) Sodium Injection Solution Reconstituted, inject 1 gm (gram) intramuscularly two times a day related to UTI until December 9, 2024, at 1:00 PM. Additionally, physician's orders were obtained on December 4, 2024, at 9:27 PM, to discontinue IM Rocephin and change to IV (intravenous therapy is a medical technique that administers fluids, medications, and nutrients directly into a person's vein) Rocephin Solution Reconstituted 1 gm (gram) intravenously every 12 hours for infection related to UTI. A review of culture results dated December 6, 2024, at 7:59 AM, revealed Resident 34's final urinalysis and C & S results that were 80,000-90,000 CFU/mL of E. coli (is bacteria from the intestines is present in fecal matter and trace amounts of fecal matter make their way into the urinary tract through the urethra opening and begin to multiply).Despite this, the 72-Hour Antibiotic Time-Out form indicated the resident did not meet McGeer's criteria for antibiotic treatment. Despite inconclusive diagnostic evidence, Macrobid therapy was initiated, followed by additional orders for intramuscular IM Rocephin, later revised to intravenous IV Rocephin on December 4th, 2024. The 72-hour antibiotic timeout form confirmed the resident did not meet McGeer's criteria for antibiotic treatment. Resident 34 received 2 doses of Macrobid, 1 dose of I am Rocephin, and four doses of IV Rocephin without documented evidence of clinical necessity. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on January 16th, 2025, at 11:05 AM, the nursing home administrator acknowledged the facility's failure to implement antibiotic stewardship protocols for residents 14 and 34. This failure contributed to the initiation and continuation of antibiotic therapy without documented evidence of clinical necessity, inconsistent use of infection surveillance tools, and noncompliance with infection prevention and control guidelines. Refer F757 28 Pa. Code 211.10(a)(d) Resident care policies 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services