STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395286	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broad Mountain Health and Rehabilitation Center	500 West Laurel Street Frackville, PA 17931

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 48277 Based on observations, a review of clinical records, and resident and staff interviews, it was determined the facility failed to reasonably accommodate residents' need for call bell accessibility for four out of 30 residents sampled (Residents 35, 77, 75, and 83) and to ensure the accessibility of resident room display boards as expressed by 2 out of 6 residents during a resident group interview (Residents 24 and 45). Findings include: Observation on April 8, 2025, at 10:41 AM in resident room revealed that Resident 77 and Resident 75 were in their respective beds and unable to reach or access their call bells to summon staff assistance if needed. The call bells for both residents were observed on the floor, behind the head of the bed, and out of the residents' reach. Observation on April 8, 2025, at 10:50 AM revealed Resident 35 seated in a wheelchair along the right side of his bed in his room. The resident's call bell was on the floor on the left side of the bed, behind the headboard, and out of the resident's reach. During an interview at the time of the observation, Resident 35 stated the call bell is frequently on the floor and out of reach. He stated that if he required staff assistance, he would need to find another means to get the staff's attention, as the call bell was inaccessible in the current location behind the headboard. Observation on April 8, 2025, at 11:19 AM revealed Resident 83 awake and lying in bed. The resident's call bell was on the floor behind the resident's headboard and out of the resident's reach. An interview with Employee 3 (nurse aide) on April 8, 2025, at 11:40 AM confirmed the observation that Residents 77, 75, 35, and 83 did not have access to a call bell to summon staff assistance if needed. An interview with the Director of Nursing on April 10, 2025, at approximately 10:00 AM verified that call bells are to be placed within reach of each resident at all times. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a group interview with alert and oriented residents on April 9, 2025, at 10:30 AM, Residents 24 and 45 indicated the facility installed room display boards for their activity calendars. The residents explained the display boards were placed too high for them to access while seated in their wheelchairs. An observation on April 9, 2025, at 12:30 PM of the resident's room confirmed the display board was eye level at approximately 6 ft. At the time of the observation, Resident 45 confirmed the board was placed too high for her to access or read. An observation on April 9, 2025, at 12:35 PM of the resident's room confirmed the display board was just below eye level while standing at approximately 5 ft. At the time of the observation, Resident 24 confirmed the board was placed too high for her to access or read. During an interview on April 10, 2025, at approximately 12:30 PM, the Nursing Home Administrator (NHA) confirmed it is the facility's responsibility to ensure the facility makes reasonable accommodations to meet the needs of the residents. The NHA confirmed the corkboards were to be lowered in Resident 45 and Resident 24's rooms to ensure residents' accessibility. 28 Pa. Code 211.12 (d)(5) Nursing Services 28 Pa. Code 201.29 (a) Resident Rights

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records, the Resident Assessment Instrument (RAI), and staff interview, it was determined the facility failed to ensure the Minimum Data Set Assessments accurately reflected the status of one resident out of 30 sampled (Resident 106). Findings include: According to the Resident Assessment Instrument (RAI) User's Manual (an assessment tool utilized to gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan, and the RAI also assists staff to evaluate goal achievement and revise care plans accordingly by enabling the facility to track changes in the resident's status) dated October 2024, Section A2105: Discharge Status indicates to review the medical record, including the discharge plan and discharge orders, for documentation of discharge location. A clinical record review revealed Resident 106 was admitted to the facility on [DATE], and discharged on [DATE]. A review of the discharge return not anticipated minimum data set (MDS) assessment, dated January 22, 2025, Section A Identification Information; Subsection A2105 Discharge Status indicated Resident 106 was discharged to a short-term general hospital (acute hospital). A progress note dated January 22, 2025, at 10:15 AM revealed Resident 106 was discharged to another long-term care nursing facility. During an interview on April 10, 2025, at approximately 12:30 PM, the Nursing Home Administrator (NHA) confirmed Resident 106's discharge return-not-anticipated MDS assessment dated [DATE], was not accurate. The NHA confirmed Resident 106 was discharged to a long-term care facility and not transferred to a community hospital. 28 Pa. Code 211.12(d)(3) 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** 51726 Based on clinical record review and staff interview, it was determined the facility failed to ensure that a resident's comprehensive care plan was reviewed and revised as needed to accurately reflect their current needs and services required by one of 30 residents sampled (Resident 101). Findings include: A clinical record review revealed Resident 101 was admitted to the facility on [DATE], with diagnoses to include bipolar disorder (a condition characterized by periodic, intense emotional states affecting a person's mood) and diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces). A review of Resident 101's psychiatric consult dated March 18, 2025, at 1:22 PM indicated the assessment and plan included monitoring and documenting any signs of depression, anxiety, mood swings, paranoia, hallucinations, delusions, irritability, lack of motivation, and changes in sleep or appetite. A review of Resident 101's comprehensive plan of care, last revised on March 26, 2025, failed to reflect any assessment, goals, or interventions for bipolar disorder including the monitoring of behavioral symptoms. A review of the facility policy entitled Comprehensive Care Planning last reviewed on March 20, 2025, revealed the facility will develop a comprehensive person-centered care plan for each resident that includes measurable goals and timetables to meet the resident's medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment. An interview with the Director of Nursing on April 10, 2025, at approximately 11:00 AM, confirmed the facility failed to review and revise Resident's 101 care plan to accurately reflect their current mental health status, risks, and required interventions. 28 Pa. Code 211.12(d)(3)(5) Nursing services

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on a review of clinical records and select facility policy, observations, and resident and staff interview it was determined the facility failed to ensure that a resident dependent on staff for assistance with activities of daily living (ADLs) consistently was provided showers as planned to maintain good personal hygiene and failed to provide a resident dependent on staff for ADLs, the necessary services to maintain good nutrition for two residents out of 30 sampled (Residents 35 and 103). Findings include: A review of Resident 35's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include cerebral infarction (a stroke caused by a blockage of blood flow to the brain, leading to tissue damage and potential cell death), and type 2 diabetes (trouble controlling blood sugar and using it for energy) with diabetic neuropathy (nerve damage caused by long-term high blood sugar levels). A quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated February 2, 2025, indicated the resident required moderate assistance from staff for showering/bathing. The resident was cognitively intact with a BIMS score of 15 (brief interview for mental status, a tool to assess the residents' attention, orientation, and ability to register and recall new information, a score of 13-15 indicates the resident is cognitively intact). During an interview with Resident 35 on April 8, 2025, at 10:50 AM, he reported that staff are not consistent with providing him a shower on his scheduled shower days. He stated, last month there were quite a few days I didn't get a shower. A review of the Resident 35's physician's order dated October 8, 2024, revealed the resident was scheduled to be showered on Wednesdays and Saturdays on the evening shift. A review of the March 2025 shower logs for Resident 35 revealed the resident did not receive a shower on Saturday March 1, 2025, Saturday March 15, 2025, and Wednesday, March 26, 2025. The resident also did not receive a shower but instead received a bed bath on Wednesday, March 5, 2025, Saturday March 8, 2025, and Wednesday, March 12, 2025. There was no documented evidence the resident refused a shower. There was no documented evidence the resident preferred a bed bath instead of a shower. There was no documented evidence the facility showered the resident twice each week as planned. During an interview with the Nursing Home Administrator (NHA) on April 10, 2025, at approximately 1:00 PM the NHA confirmed that Resident 35 should have been showered as scheduled and was unable to state why showers were not provided as scheduled and desired. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 103's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include diffuse large B-cell lymphoma (aggressive, fast growing form of non-Hodgkin's lymphoma cancer of the lymphatic system) that affects B-cells, (a type of white blood cell that produces antibodies), and dysphagia (difficulty swallowing food or liquid). An admission MDS dated [DATE], indicated the resident was severely cognitively impaired with a BIMS score of 6 (0-7 represents severe cognitive impairment) and the resident performed eating tasks (the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident) with supervision. Observation conducted on April 8, 2025, at 11:47 AM in the 2nd floor East dining room revealed Resident 103 seated upright in a Geri lounger (large padded cushioned reclining chair with a wheeled base designed to assist residents with limited mobility) at a table with a blanket on his lap. At 11:49 AM staff placed Resident 103's lunch tray on the table in front of him, which consisted of meatloaf, mashed potatoes with gravy, green beans and fruited gelatin. Staff provided setup assistance (cut meat, removed lid from dessert bowl, and removed lids from beverage cups) and walked away to continue to deliver lunch trays to other residents in the dining room. Continued observation of Resident 103 during lunch in the dining room revealed the resident grabbed the blanket on his lap and placed it in his mouth. The resident continued to put the blanket into his mouth and chew on the blanket for the next 24 minutes. At 12:13 PM the resident pulled the blanket out of his mouth and placed it on top of his food. At 12:14 PM, 25 minutes after his tray was setup in front of him, a staff member approached Resident 103 and offered to assist him with eating. The resident made no attempts to initiate or engage in self-feeding and allowed the staff member to feed him. A review of Resident 103's care plan dated March 24, 2025, identified a problem area related the resident's ADL functional status/rehabilitation potential with interventions to include: transfers with assist of two with a rolling walker (walker with front wheels); do not rush the resident, allow extra time to complete ADLs; follow PT/OT/ST recommendations; have consistent approach amongst caregivers; monitor for presence of pain/intolerance during self-care; provide adequate rest periods between activities; provide assistance as needed; and report any further deterioration in status to the physician. The current care plan, in effect at the time of the survey ending April 11, 2025, failed to identify Resident 103's functional ability to participate in activities of daily living such as eating, grooming, oral hygiene and dressing, and the staff assistance required to safely and successfully engage in these daily tasks. Review of nurse documentation dated April 1, 2025, at 12:00 PM revealed that Resident 103 was sent to the emergency room due to abnormal laboratory values. Nursing documentation dated April 4, 2025, at 6:18 PM revealed Resident 103 was readmitted to the facility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Occupational Therapy Evaluation dated April 6, 2025, revealed the resident's self-feeding ability was assessed as total dependence (level of support where a person requires constant and complete assistance from another to complete a task- the resident is unable to perform the task while the caregiver performs 100% of the task). Interview with the Nursing Home Administrator on April 10, 2025, at 10:30 AM revealed the residents' self-feeding ability is documented in the care plan, Point of Care History and the CNA huddle binder located at each nursing station. Review of the facility's Point of Care History (care tasks completed for the resident) for Resident 103 failed to identify the level of staff assistance required for the resident to safely perform self-feeding tasks. Interview with Employee 2 (Registered Nurse Supervisor) on April 10, 2025, at 1:45 PM revealed the residents' functional statuses (ability to self-feed, bathe, transfer, ambulate) are communicated to the nursing staff via a CNA huddle binder. Employee 2 explained that the huddle binder contains a document for each resident indicating the level of staff assistance required to perform activities of daily living. Review of the CNA huddle binder revealed that Resident 103 did not have a current file in the huddle binder. Employee 2 confirmed that based upon the current huddle binder information, staff would not know the functional status, or the level of staff assistance required, to safely and appropriately feed Resident 103. Review of an Occupational Therapy treatment encounter note dated April 10, 2025, revealed nursing staff requested re-assessment of self-feeding and beverage management. Resident with intermittent alertness but demonstrated no functional ability to grasp utensils or cups despite simple cueing and hand over hand assistance from therapist. Resident demonstrated no functional ability to load utensils in prep for placement of food item on utensil. Resident with periods of inattention and confusion noted throughout AM breakfast meal with inability to follow 1-step commands for utensil management or beverage management. Reviewed with primary caregivers for need of supportive feeding and beverage management. Interview with Employee 1 (Occupational Therapist) on April 11, 2025, at 8:50 AM indicated Resident 103 exhibited a significant decline in his functional status since returning from the hospital on April 4, 2025. She noted that Occupational Therapy did not establish self-feeding goals because therapy was asked to establish safe in and out of bed positioning so that staff could safely feed the resident. She reported that when a decline in functional status is noted by therapy, the Director of Rehab notifies the IDT team (interdisciplinary team) who then notifies the charge nurse, unit managers and primary caregivers. The physician orders and care plan would then be updated to reflect the resident's status. The facility was unable to provide documented evidence the facility communicated Resident 103's decline in self-feeding ability and the required staff assistance to the IDT team, nursing staff and his primary caregivers. The facility failed to effectively communicate Resident 103's functional decline and increased need for staff assistance for self-feeding. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Nursing Home Administrator on April 11, 2025, at approximately 11:30 AM confirmed the facility failed to document Resident 103's self-feeding status and the level of staff assistance required in the resident's care plan, physician orders and CNA huddle binder to provide the necessary services to maintain good nutrition for Resident 103. 28 Pa. Code 211.12 (c)(d)(5) Nursing services.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 21738 Based on staff interview and a review of employee personnel records it was determined the facility failed to ensure the qualified part-time professional activities director responsibilities included directing the development, implementation, supervision and ongoing evaluation of the activities program, which includes the completion and/or directing/delegating the completion of the activities component of the comprehensive assessment; and contributing to and/or directing/delegating the contribution to the comprehensive care plan goals and approaches that are individualized to match the skills, abilities, and interests/preferences of each resident. Findings include: Interview with the administrator on April 11, 2025, at approximately 10:00 AM revealed that the previous full-time qualified activities director resigned on September 20, 2024. The administrator stated that a qualified activities director from a sister facility was assisting with coverage until December 6, 2024. Since December 6, 2024, Employee 5 (activities director) has been the activity director with remote oversight from Employee 6 (vice president of life enrichment) who was a qualified activities professional. Review of Employee 5's (activity director) personnel file confirmed that Employee 5 (activity director) was hired as the activity director on December 5, 2024, and that employment was contingent on receiving certification as an activities professional. The facility has enrolled Employee 5 in a program which will begin on June 10, 2025, to obtain the required activities professional certificate. Interview with the administrator on April 11, 2025, at approximately 11:00 AM confirmed that Employee 6's (vice president of life enrichment) role at the facility was limited and failed to include directing/delegating the completion of the activities component of the comprehensive assessment; and contributing to and/or directing/delegating the contribution to the comprehensive care plan goals and approaches that are individualized to match the skills, abilities, and interests/preferences of each resident. 28 Pa. Code 201.3 Definitions. 28 Pa. Code 201.18(b)(3) (e)(6) Management 28 Pa. Code 201.19 (3) Personnel policies and procedures

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on clinical record review, select facility policy, and resident and staff interviews, it was determined the facility failed to provide person-centered care for diabetes management and professional standards of practice for one resident out of 30 sampled (Resident 45). Findings include: A review of facility policy entitled Diabetic Protocol, last reviewed on March 20, 2025, indicated the provider and staff will work together to give appropriate treatment to manage diabetes, and for residents who have or are suspected to have diabetes, the provider will order pertinent testing. A review of the clinical record revealed Resident 45 was admitted to the facility on [DATE], with diagnoses to include diabetes (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of sugar in the blood and urine) and end-stage renal disease dependent on dialysis (the process of removing waste products and excess fluid from the body when the kidneys are not able to adequately filter the blood). A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 25, 2025, revealed that Resident 45 is 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). A review of Resident 45's clinical record revealed a laboratory report dated April 25, 2023, of a hemoglobin A1C (HgbA1c) result of 6.0% (a blood test that measures your average blood sugar levels over the past two to three months) of 6.0 and indicated that it was high. A review of a physician order dated April 4, 2024, revealed the resident had an order for Trulicity 3 mg/0.5 ml (milliliter) subcutaneous (under the skin) weekly for diabetes. A review of a physician order dated April 5, 2024, revealed the resident had an order for Lantus 8 units subcutaneous (under the skin injection) once a day at bedtime for diabetes. A review of the resident's physician orders to the skilled nursing facility revealed blood glucose (sugar) monitoring was not ordered by the resident's attending physician at the skilled nursing facility. A review of a May 2024 Consultant Pharmacist Medication Regimen Review revealed the consultant pharmacist indicated the resident had diabetes and did not have routine blood glucose monitoring documented in the medical record and recommended monitoring fingerstick blood glucose levels. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a physician's order dated June 2, 2024, revealed an order to obtain fingerstick blood glucose levels twice a day for two weeks and to notify the physician if less than 60 mg/dl or greater than 250 mg/dl, to start June 3, 2024, and end on June 17, 2024, in response to the consultant pharmacist recommendation. A clinical record review of Resident 45's fingerstick blood glucose monitoring revealed elevated glucose levels of greater than 250 mg/dl on several dates, which included, June 3, 2024, at 12:35 PM - glucose 288 mg/dl June 3, 2024, at 9:41 PM - glucose 309 mg/dl June 9, 2024, at 10:46 AM - glucose 273 mg/dl June 11, 2024, at 9:44 PM - glucose 260 mg/dl June 12, 2024, at 8:18 PM - glucose 277 mg/dl June 15, 2024, at 8:45 PM - glucose 299 mg/dl A review of a progress notes dated June 3, 2024, at 10:06 PM, revealed the nurse had made the physician aware of a fingerstick blood glucose of 309 mg/dl on June 3, 2024, at 9:41 PM. There was no documentation that nursing staff had informed the physician of the remaining elevated blood glucose levels as ordered by the physician to notify of any glucose over 250 mg/dl between June 3, 2024, and June 17, 2024. There was no documentation that nursing staff had consulted the physician regarding the resident's diabetes management needs at the skilled nursing facility. A review of resident 45's care plan for the problem of diabetes, dated June 3, 2024, revealed the resident was at risk for unstable blood sugars due to diabetes and to administer medications as ordered and evaluate, record, and report effectiveness. An interview with Resident 45 on April 8, 2025, at 12:40 PM, revealed she would like the facility to monitor her blood glucose levels more frequently. Resident 45 stated she could not remember the last time she had her blood glucose levels monitored. Further review of the clinical record revealed Resident 45's last documented blood glucose was on June 17, 2024, at 8:55 PM. Following inquiries made during the week of the survey regarding Resident 45's diabetes management and resident requests for more frequent monitoring of her diabetes, a physician's order dated April 9, 2025, revealed a laboratory order for hemoglobin A1C to be obtained on April 10, 2025. A review of a laboratory report dated April 10, 2025, revealed hemoglobin A1C result of 7.9% and indicated it was high, and referenced per the American Diabetes Association (ADA) target for diabetic control should be under 7%. Furthermore, a review of a physician's order dated April 10, 2025, revealed an order for a fingerstick blood glucose once every other day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Director of Nursing on April 10, 2025, at 2:00 PM, confirmed the physician was not made aware of Resident 45's elevated blood sugars between June 3, 2024, and June 17, 2024, and confirmed there was no documented evidence of a person-centered care plan developed to address adequate diabetes management. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records, select facility policy, and resident and staff interviews, it was determined the facility failed to ensure that pain management is provided to residents consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one resident out of 30 sampled (Resident 36). Findings include: A review of the facility policy titled Pain Management Policy, last reviewed by the facility on March 20, 2025, revealed it is the facility policy to ensure any resident admitted to the facility is assessed for pain and potential for pain in order for the resident to reach and maintain his or her highest practicable level of physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The policy indicated a pain evaluation will occur with an onset of new pain. The evaluation will include the presence of indicators of pain or active pain, including type, intensity, characteristics, and frequency. The evaluation of the presence or severity of pain will occur using the appropriate pain scale for each resident: numeric pain rating scale, faces rating scale, or verbal descriptor rating scale. A clinical record review revealed Resident 36 was admitted to the facility on [DATE], with diagnoses that included systemic lupus erythematosus (a chronic autoimmune disease where the body's immune system attacks its own healthy tissues and organs, causing inflammation and potential damage) and poly-osteoarthritis (a condition where cartilage, the tissue that cushions the ends of bones in joints, wears down, causing pain, stiffness, and limited movement). A review of Resident 36's current plan of care identified acute and chronic pain, and potential for pain related to lupus and polyosteoarthritis. The plan of care indicated that the resident was on a regimen of pain medications and was assessed to be able to tolerate a pain level of 8 out of 10. Interventions listed in the care plan to address the resident's pain included: providing education to the resident and family regarding pain and available options for pain management; implementing non-pharmacological interventions to assist in reducing pain; assessing for both verbal and nonverbal signs and symptoms of pain; administering pharmacological interventions as ordered by the physician; and monitoring the effectiveness of the medication. A review of the clinical record revealed that a physician's order for acetaminophen (a non-opioid analgesic medication) 325 mg tablets, with instructions to administer two tablets (650 mg total) by mouth every six hours as needed for pain rated 1 to 3 on a pain scale of 0 to 10, was initiated on September 23, 2024. A review of the clinical record revealed a physician's order for oxycodone (an opioid analgesic) 5 mg tablets, with instructions to administer one tablet by mouth every four hours as needed, was initiated on April 5, 2024. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 4, 2025, revealed that Resident 36 is 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). A nursing progress note dated January 24, 2025, at 6:33 AM indicated Resident 36 reported pressure in her lower left side, was tearful, and had a low-grade fever. The note documented that acetaminophen was administered for fever and that the nursing supervisor and physician were notified. No documentation was observed to indicate a comprehensive pain assessment was completed at that time. A progress note dated January 24, 2025, at 10:52 AM documented that Resident 36 continued to complain of lower back pain and had been assessed by nursing staff. The note indicated that the resident was alert and oriented and that acetaminophen was administered in accordance with the physician's order. It was also noted that the resident was afebrile and not in visible distress. The physician and resident representative were notified. The note did not include a numerical pain scale rating or further characterization of the pain such as duration, location, or exacerbating/relieving factors. A progress note dated January 24, 2025, at 2:39 PM indicated that Resident 36 was transported to the emergency department per her request. The note stated that the physician was notified. A review of the Medication Administration Record (MAR) for January 2025 indicated that Resident 36 received acetaminophen 325 mg, two tablets (650 mg), on January 24, 2025, at 4:57 AM for a fever of 100.4 F. The MAR also documented that Resident 36 received oxycodone 5 mg at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, and 4:00 PM on the same day. A review of documented vital signs for January 24, 2025, revealed two recorded pain assessments. At 7:04 AM, the pain level was recorded as 0 out of 10, and at 1:49 PM, the pain level was again recorded as 0 out of 10. These assessments did not correspond with the multiple documented complaints of pain on that date or the administration of five doses of oxycodone. There was no accompanying documentation found to indicate whether the resident's pain was assessed prior to or following administration of the oxycodone on January 24, 2025, nor was there documentation of the effectiveness of the medication administered. During an interview conducted on April 8, 2025, at 10:45 AM, Resident 36 stated that she had been experiencing low back pain for approximately two weeks prior to her hospitalization in January 2025. She reported the pain had been mild initially but became extreme during the early morning hours of January 24, 2025. Resident 36 indicated that she experiences pain daily and described the pain on the morning of January 24 as very extreme. She stated that although nursing staff administered acetaminophen, they did not appear to understand the severity of her pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted on April 10, 2025, at approximately 1:30 PM, the Nursing Home Administrator (NHA) acknowledged that the clinical record indicated Resident 36 was tearful and had documented complaints of lower back pain. The NHA confirmed that the clinical record lacked documentation of a comprehensive pain assessment on January 24, 2025, including a pain scale rating, intensity, frequency, or description of the pain. The NHA also confirmed that it is the facility's responsibility to ensure pain management is provided in accordance with professional standards of practice, including ongoing evaluation and monitoring of pain. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on a review of clinical records and staff interviews it was determined the facility failed to ensure a resident's drug regimen was free of unnecessary antibiotic drugs for one out of 30 residents sampled (Resident 105). Findings include: A review of the clinical record revealed Resident 105 was admitted to the facility on [DATE], with diagnoses to include multiple sclerosis (disease in which the immune system eats away at the protective covering of the nerves), chronic obstructive pulmonary disease (COPD- group of lung diseases that block airflow and make it difficult to breathe), and dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning). A review of a nurse's note dated February 22, 2025, at 8:35 AM, indicated Resident 105 was assessed following staff reports of labored breathing. The note documented the resident was lethargic, responsive to verbal stimuli but quickly fell back asleep. The resident's pupils were equal and reactive to light. The note further indicated the resident exhibited increased respiratory rate, use of accessory muscles to breathe, and was diaphoretic (excessively sweating). Lung sounds were diminished, and the respiratory rate was documented as 40 breaths per minute. Additional documented vital signs were as follows: blood pressure 118/62, heart rate 136 beats per minute, temperature 99.2 F, oxygen saturation (SpO2) 93% on room air, and blood glucose 383 mg/dL. The abdomen was noted to be soft, non-distended, with positive bowel sounds in all four quadrants, and no edema was observed. The nurse's note indicated the certified registered nurse practitioner (CRNP) was notified of the assessment findings. New physician orders were received to obtain vital signs every shift; a stat complete blood count (CBC) with differential, basic metabolic panel (BMP), and respiratory panel; a stat chest x-ray; and to administer Ceftriaxone (Rocephin, an antibiotic) 1 gram intramuscularly (IM) as a one-time dose. A voice message was left for the resident's representative. A review of the physician order dated February 22, 2025, confirmed an order for Ceftriaxone 1 gram IM (intramuscular- medication given by needle into the muscle) one time only. However, the order did not include a documented diagnosis or clinical indication for the initiation of the antibiotic. Review of Resident 105's February 2025 Medication Administration Record revealed that Resident 105 received one dose of Ceftriaxone on February 22, 2025. Further review of Resident 105's clinical record did not contain any documentation from the physician or CRNP outlining the clinical rationale for initiating the antibiotic therapy prior to receiving the results of the stat laboratory tests and chest x-ray. During an interview on April 10, 2025, at approximately 11:00 AM, the Director of Nursing confirmed that the facility did not have any documentation from the practitioner providing the clinical justification for the use of the antibiotic for Resident 105. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.2 (3) Medical Director 28 Pa. Code 211.9 (k) Pharmacy Services 28 Pa. Code 211.5 (f)(ii)(ix) Medical records

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on a review of select facility policy, clinical records and staff interviews it was determined the facility failed to timely notify the physician of abnormal lab results for one resident out of 30 sampled (Resident 96). Findings included: A review of facility policy entitled Resident Change in Condition Policy, last reviewed on March 20, 2025, indicated that nursing will recognize and intervene in the event of a change in resident condition and the physician and family/responsible party will be notified as soon as the nurse has identified the change in condition, including the most recent labs. A review of the clinical record revealed that Resident 96 was admitted to the facility on [DATE], and had diagnoses that include diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces) and malignant neoplasm of the brain (a cancerous growth in the brain that typically grows rapidly, invades surrounding brain tissue, and can spread to other parts of the brain or the body). A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 25 2025, revealed that Resident 96 had moderately impaired cognition with a BIMS score of 11 (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 8-12 indicates cognition is moderately impaired). A review of a physician's order dated February 6, 2025, revealed a laboratory order for CBC with differential, comprehensive metabolic panel (CMP), urinalysis (UA), and C & S (culture and sensitivity) every 2 weeks from February 9, 2025, until April 25, 2025. A review of the nursing progress notes dated April 8, 2025, at 7:05 PM, revealed the physician had reviewed laboratory results for Resident 96, including a complete blood count (CBC) with differential, comprehensive metabolic panel (CMP), and urinalysis (UA). A review of the final urine culture (C&S) results dated April 9, 2025, identified abnormal findings of greater than 100,000 colonies per milliliter of Enterococcus faecalis (a bacterium normally found in the intestines that can cause urinary tract infections, especially in individuals with compromised immune systems). Resident 96 was documented as being immunocompromised due to a brain tumor diagnosis and was receiving chemotherapy (a treatment that destroys rapidly dividing cancer cells, thereby also reducing immune function). (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of additional nursing progress notes revealed that the abnormal C&S result from April 9, 2025, was not communicated to the physician by staff, until April 11, 2025, at 12:51 PM-two days after the result was available and only after surveyor inquiry. There was no documentation to support earlier physician notification. During an interview on April 11, 2025, at approximately 1:15 PM, the Nursing Home Administrator (NHA) and Employee 4, a Registered Nurse Unit Manager, confirmed that laboratory results are sent to the nursing department, and it is the responsibility of nursing staff to notify the physician of any abnormal results. Employee 4 acknowledged that abnormal lab results should be communicated to the physician on the same day they are received and confirmed that the urine culture results were not relayed to the physician in a timely manner for Resident 96. Additionally, the Nursing Home Administrator (NHA) was unable to provide documentation that a urinalysis or culture and sensitivity test had been completed for Resident 96 during the month of February 2025, despite physician orders. 28 Pa. Code 211.12 (d)(3)(5) Nursing services

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on observation, clinical record review, payor source data, and resident and staff interview, it was determined the facility failed to provide timely and necessary dental services for one resident who is a Medicaid recipient (Resident 35) out of 30 residents reviewed. Findings included: A review of Resident 35's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include cerebral infarction (a stroke caused by a blockage of blood flow to the brain, leading to tissue damage and potential cell death), and type 2 diabetes (trouble controlling blood sugar and using it for energy) with diabetic neuropathy (nerve damage caused by long-term high blood sugar levels). A quarterly Minimum Data Set Assessment (MDS a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated February 2, 2025, indicated the resident was cognitively intact with a BIMS score of 15 (brief interview for mental status, a tool to assess the residents' attention, orientation, and ability to register and recall new information, a score of 13-15 indicates the resident is cognitively intact). During an interview with Resident 35 on April 8, 2025, at 10:55 AM he expressed concern the facility had not scheduled a dental appointment for him to have his teeth extracted. He reported during his last dental appointment, the dentist told him he needed to have his remaining teeth removed to avoid a major infection. Review of Resident 35's Dental Consult Sheet dated January 15, 2025, revealed the resident was seen by the dentist for a full mouth x-ray. Review of Resident 35's Dental Treatment Plan Recommendation dated January 15, 2025, revealed the following treatment plan recommendations based on the doctor's visit of January 15, 2025: Impression for full upper denture, impression for full lower denture, extraction of tooth # 21, #23, #24, #25, and #26. The Treatment Plan Recommendation also stated the following Consider having treatments performed as soon as possible to prevent possible complications. Recommendations: Extractions are removal of teeth that could be infected, loose or decayed. Infection may spread throughout the body if not extracted. Full dentures are needed to fill the void of all missing teeth on the jaw so the patient can eat and not lose weight . During an interview on April 11, 2025, at approximately 11:00 AM the Nursing Home Administrator (NHA) was unable to produce documentation to demonstrate that timely and appropriate dental services were provided following Resident 35's dental report and recommendations on January 15, 2025. The NHA could not explain the delay in the dental referral or the prolonged timeline for dental services. 28 Pa Code 211.12 (c)(d)(3)(5) Nursing services

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records and select facility policy and staff interviews, it was determined the facility failed to implement procedures for smoking safety, as evidenced by three out of the three residents sampled for smoking.(Residents 45, 51, and 79). Findings include: A review of the facility policy titled Resident Smoking Policy, last reviewed by the facility on March 20, 2025, revealed it is the facility policy to establish resident smoking processes that take into account both smoking and non-smoking residents and that comply with applicable federal, state, and local laws and regulations regarding smoking, smoking areas, and smoking safety. The policy indicated any resident that chooses to smoke will be further assessed for smoking safety awareness and the need for reasonable physical or safety accommodations. The assessment is completed thereafter on readmission, quarterly, and with any significant change in the resident's condition. A clinical record review of Resident 45 revealed the resident was admitted to the facility on [DATE], with diagnoses to include diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces) and depression (a mental health condition characterized by low mood or loss of pleasure or interest in activities for long periods of time). A clinical record review revealed a care plan indicating Resident 45 currently uses tobacco, initiated on May 20, 2024. Interventions in place to assist Resident 45 to safely smoke include staff supervision while smoking. A smoking risk observation report dated November 22, 2024, revealed Resident 45 is considered a safe smoker and can follow the facility policy for safe smoking. Further clinical record review for Resident 45 revealed no subsequent smoking risk observation reports or assessments for safe smoking. Following surveyor inquiry, a smoking safety assessment was completed on April 9, 2025, confirming the resident remained a safe smoker. This assessment occurred 138 days after the prior evaluation, exceeding the 90-day quarterly requirement established by the facility's policy A clinical record review revealed Resident 51 was admitted to the facility on [DATE], with diagnoses that included chronic pulmonary edema (a condition where fluid builds up in the lungs over a prolonged period, leading to difficulty breathing). A clinical record review revealed a care plan indicating Resident 51 currently used tobacco, initiated on April 18, 2024. Interventions in place to assist Resident 51 to safely smoke include staff supervision while smoking and staff assistance to and from the resident's room to the smoking area. A smoking risk observation report dated November 3, 2024, revealed Resident 51 is considered a safe smoker and can follow the facility policy for safe smoking. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further clinical record review revealed no subsequent smoking risk observation reports or assessments for safe smoking. The resident was reassessed on April 9, 2025-158 days after the last evaluation-following inquiries made during the survey. A clinical record review revealed Resident 79 was admitted to the facility on [DATE], with diagnoses that included end stage renal disease (condition in which the kidneys lose the ability to remove waste and balance fluids). A smoking risk observation report dated December 29, 2024, revealed Resident 79 is considered a safe smoker and can follow the facility policy for safe smoking. Review of the resident's care plan initially dated December 29, 2024, failed to address that Resident 79 was a smoker. The care plan failed to address interventions which were to be implemented to ensure safe smoking for the resident. No updated smoking safety assessments were found in the clinical record prior to a reassessment completed on April 9, 2025-100 days after the initial assessment-following surveyor inquiry. During an interview on April 9, 2025, at approximately 12:30 PM, the Director of Nursing (DON) confirmed it is the facility's policy to assess residents' ability to safely smoke at least quarterly (90 days). The DON confirmed resident 45 had not been assessed to safely smoke for over 138 days. The DON confirmed resident 51 had not been assessed to safely smoke for over 158 days. The DON confirmed that Resident 79 had not been assessed to safely smoke for 100 days. The DON confirmed that Resident 79's care plan failed to address safe smoking. The DON confirmed it is the facility's responsibility to implement procedures to ensure residents are assessed and monitored for smoking safety. 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 209.3 (a) Smoking