STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395288	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sapphire Care and Rehab Center	221 East Brown Street East Stroudsburg, PA 18301

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on observation, clinical record review and staff interview, it was determined the facility failed to provide meal service in an environment that maintains each resident's dignity for one of 20 sampled residents (Resident 42). Findings include: Review of Resident 42's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including unspecified dementia. Observation of the third floor nursing unit on October 22, 2024, at approximately 12:20 p.m. revealed Resident 42 was in the dining room. Resident 42's lunch tray was placed in front of her on the table at approximately 12:22 p.m. Resident 42 required assistance with feeding and was unable to feed herself. Further observation revealed that Resident 42 was not assisted with her lunch meal until approximately 12:47 p.m. approximately 25 minutes after it was placed in front of her. Interview with the Nursing Home Administrator on October 22, 2024, at approximately 1:45 p.m. confirmed that Resident 42 should have been served and assisted with her lunch meal within the same time frame as the other residents on the third floor unit. The NHA confirmed the facility failed to provide a dignified dining experience for Resident 42 and confirmed the lunch meal service on the third floor was not conducted in a manner that promotes each residents' dignity. 28 Pa Code: 201.29 (i) 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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 39929 Based on a review of the facility's abuse prohibition policy and employee personnel files and staff interviews, it was determined the facility failed to fully develop and implement established abuse prohibition procedures for screening five of five employees for employment. (Employee 3, 4, 5, 6, and 7) Findings include: According to regulatory requirements under SS483.12(a)(3) and 483.12(b)(1) the facility must have written procedures for screening prospective employees, to include reviewing: the employment history (e.g., dates of employment position or title), particularly where there is a pattern of inconsistency; information from former employers, whether favorable or unfavorable; and/or documentation of status and any disciplinary actions from licensing or registration boards and other registries. A review of the facility's Resident Abuse policy last reviewed by the facility January 24, 2024, revealed no procedures for screening potential employees that included obtaining references from current/previous employers. Review of employee personnel files revealed that Employee 3 (Nurse Aide) was hired October 7, 2024. The employee's application indicated that she had previous employers. There was no indication that the facility had contacted any of the employee's previous employers. Review of employee personnel files revealed that Employee 4 (LPN) was hired October 7, 2024. The employee's application indicated that she had previous employers. There was no indication that the facility obtained information from former employers. Review of employee personnel files revealed that Employee 5 (Activities) was hired September 30, 2024. The employee's application indicated that she had previous employers. There was no indication that the facility obtained information from former employers. Review of employee personnel files revealed that Employee 6 (NA) was hired August 19, 2024. The employee's application indicated that she had previous employers. There was no indication that the facility obtained information from any former employers. Review of employee personnel files revealed that Employee 7 (RN) was hired August 19, 2024. The employee's application indicated that she had previous employers. There was no indication that the facility obtained information from the former employers. Interview with the Administrator on October 24, 2024, at 12:15 p.m. the NHA verified that there was no evidence that previous employers were contacted for information regarding the employees past employment. 28 Pa. Code 201.18 (e)(1) Management (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.29 (a)(c)Resident Rights 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.19 (1) Personnel records.

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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. 48277 Based on a review of clinical records, the Resident Assessment Instrument, and staff interview, it was determined that the facility failed to ensure that the Minimum Data Set Assessments accurately reflected the status of one resident out of 20 sampled (Resident 94). Findings include: A review of the clinical record of Resident 94 revealed a physician's order dated August 2, 2024, for the resident to be discharged to home on August 6, 2024. A review of a nurses note dated August 6, 2024, at 11:53 AM revealed that Resident 94 was discharged home via facility transport. The resident was able to walk independently. Discharge instructions provided to the resident. All discharge paperwork was signed by the resident. Medications, prescriptions, and education provided. All personal belongings brought home. Resident not in any form of distress and in good spirits. A review of Resident 94's Discharge MDS Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated August 6, 2024, Section A 2105, indicated that the resident was discharged to an acute care hospital. Interview with the Nursing Home Administrator on October 25, 2024, at 9:30 AM, confirmed Resident 94 was discharged home and that the MDS Assessment was not accurate with respect to the resident's discharge location. 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460 Based on observation, clinical record review and staff interview, it was determined the facility failed to develop and implement a person-centered comprehensive care plan to meet the needs of three out of 20 residents sampled (Residents 86, 28, and 13) Findings including: Clinical record review revealed that Resident 86 was admitted to the facility on [DATE], with diagnoses to include hypertension (elevated blood pressure), Type 2 diabetes (body has trouble controlling blood sugar and using it for energy), and hyperlipidemia (high cholesterol). A review of Resident 86's hospital records sent to the facility on [DATE], revealed the resident underwent a pacemaker placement (device implanted in the body to deliver electrical impulses to the heart to help the heartbeat at a normal rate and rhythm) on June 15, 2022. A review of chest x-ray results dated June 12, 2024, confirmed the placement of the pacemaker device. A physician's order dated August 1, 2024, revealed on order for the resident to see a cardiologist for a pacemaker check. During an interview with Resident 86 on October 22, 2024, at 11:00 AM the cognitively intact resident confirmed he had a pacemaker for two years. During an observation of Resident 86's room during the time of the interview, a remote pacemaker monitoring device (sends data from the pacemaker directly to the physician's office using Wi-Fi or cellular data) was located on the resident bedside table. A review of the resident's current plan of care, in effect at the time of the survey ending October 25, 2024, failed to identify the presence of, or the care for, the resident's implantable pacemaker on the resident's current plan of care. Clinical record review revealed Resident 28's was initially admitted to the facility on [DATE], with diagnoses to include chronic obstructive pulmonary disease (COPD- lung disease that blocks airflow and makes it difficult to breathe), chronic respiratory failure with hypoxia (not enough oxygen passes from the lungs to the blood, making it difficult to breath), and tracheostomy status [surgical procedure that creates an opening in the neck into the trachea (windpipe) to allow air and oxygen to reach the lungs]. A physician's order dated August 5, 2024, revealed on order to apply the SmartVest to the resident for cough assist (SmartVest is an inflatable vest that is attached to a machine that mechanically performs chest therapy by vibrating at a high frequency. The machine sends air through hoses, which cause the vest to inflate and deflate rapidly. The vest vibrates the chest to loosen and thin mucus. The resident then coughs to clear the mucus), two times a day for cough assistance. Apply 10 Hz for 10 minutes at each treatment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's current plan of care, in effect at the time of the survey ending October 25, 2024, identified that Resident 28 had a need for oxygen therapy due to COPD, pneumonia, chronic respiratory failure with hypoxia and tracheostomy status and that the resident had a tracheostomy due to shortness of breath and vocal cord paralysis. The facility failed to identify the presence and daily use of, or the care for, the resident's SmartVest on the resident's current plan of care. A clinical record review revealed that Resident 13 was most recently admitted to the facility on [DATE], with diagnoses which included dementia with behavioral disturbance (refers to drastic changes in behavior, perception, thoughts, and mood caused by deterioration of memory, language, and other thinking abilities), anxiety, and major depressive disorder. Observation of Resident 13's room during initial observation on October 22, 2024, at approximately 9:46 a.m. revealed the room had a strong fungal/rotten food like odor. Interview with Employee 8, nurse aide, on October 23, 2024, at approximately 10:12 a.m. confirmed there was an unpleasant odor in the room. Employee 8 further stated Resident 13 is known to hide food in her room. Additional observation of the resident's room revealed an orange semiliquid substance in a clear plastic container that appeared to be Jello, multiple opened small chip bags, and used Styrofoam cups stacked on the windowsill. The overbed table was positioned in front of the resident's closet door. Employee 8 stated that the resident places table in front of closet to prevent people from entering her closet where she is known to hide additional food/snack items. A review of Resident 13's current plan of care, in effect at the time of the survey ending October 25, 2024, identified the resident hoards sweaters and other belongings behind her on her wheelchair with a goal to remain free from injury or illness when avoidable through the next review. Intervention included fall risk management. There was no evidence at the time of the survey ending October 25, 2024, the facility had developed and/or implemented a person-centered plan of care related to Resident 13's hoarding of food items. Interview with the Director of Nursing on October 24, 2024, at 2:00 PM confirmed the facility failed to ensure that comprehensive care plans were developed in manner to meet the resident's medical and treatment needs. 28 Pa. Code 211.12 (d)(5) 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** 41460 Based on clinical record review, observation, and resident and staff interviews, it was determined the facility failed to ensure a resident's comprehensive care plan was reviewed and revised as needed to accurately reflect the resident's current needs and services required by one of 20 residents reviewed (Resident 22). Findings include: Review of the clinical record of Resident 22 revealed initial admission to the facility on [DATE], with diagnoses to include congestive heart failure (a serious condition that occurs when the heart can't pump enough blood to meet the body's needs), stroke, and anxiety. A review of Resident 22's Elopement/Wander Risk Evaluation dated May 21, 2024, revealed that the resident was a low wander risk as indicated by a score of 1 (a score of 0-4 indicated low risk for wandering/elopement). Review of Resident 22's current physician orders revealed an order dated September 18, 2024, which permitted the resident to go out on pass by himself via the bus. A review of a quarterly Minimum Data Set Assessment (MDS - federally mandated assessment of a resident's abilities and care needs) dated September 23, 2024, indicated that Resident 22 was cognitively intact with a BIMS (brief interview for mental status) score of 15 (13-15 represents intact cognitive responses). According to the assessment, Section E0900. Wandering, the resident did not have the presence of wandering during the 7-day lookback period. A review of Resident 73's current care plan revealed a focused area of potential for elopement and associated injury related to exit seeking behavior, dated August 24, 2022, with interventions to include door alarms on at all times, and answer alarms promptly, encourage group activity and attempt to keep occupied, make receptionist and other staff aware of elopement risk, provide diversional activities when exit seeking, notify social services for persistent attempts to leave building and not responding to redirection, refuses to wear Wanderguard (a wearable alert system that helps keep track of patients or residents who are at risk of wandering), check resident's whereabouts frequently, and redirect from exits as needed based on behavior. Review of the resident's care plan revealed that the focus area of potential for elopement and interventions had not been revised since November 1, 2023. There was no documented evidence that Resident 22's care plan had been reviewed and revised related to his potential for elopement. Interview with the Director of Nursing on October 25, 2024, at approximately 1:30 PM confirmed that the facility failed to review and revise Resident 22's plan of care to accurately reflect the resident's current status and needs. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(3)(5) Nursing 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460 Based on a review of clinical records and staff interviews it was determined the facility failed to provide nursing services consistent with professional standards of quality to ensure that licensed nurses administered medications as prescribed to one resident of 20 sampled residents (Resident 22) Findings included: According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates that the registered nurse was to collect complete ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health-care team by exercising sound judgement based on preparation, knowledge, skills, understandings and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) Document and maintain accurate records. According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care: Assessments Clinical problems Communications with other health care professionals regarding the patient Communication with and education of the patient, family, and the patient ' s designated support person and other third parties. A review of Resident 22's clinical record revealed admission to the facility on [DATE], with diagnoses to include congestive heart failure (a chronic condition that occurs when the heart can't pump enough blood to meet the body's needs), stroke, and anxiety. A physician order dated January 9, 2024, was noted for Midodrine HCL 10mg three times a day related to essential hypotension (low blood pressure), hold if systolic blood pressure (SBP - top number on blood pressure reading that measures the pressure in the arteries when the heart beats) more than 120 mm/Hg (millimeters of mercury). The medication was scheduled for 8:30 AM, 12:30 PM, and 4:30 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 22's Medication Administration Record for the month of September 2024, revealed on the following dates the blood pressure medication was administered: September 3, 2024, at 4:30 PM, for a blood pressure of 127/68 mm/Hg . September 5, 2024, at 8:30 AM and 12:30 PM, for a blood pressure of 132/72 mm/Hg . September 15, 2024, at 8:30 AM, for a blood pressure of 127/54 mm/Hg . September 16, 2024, at 4:30 PM, for a blood pressure of 124/65 mm/Hg . September 19, 2024 at 8:30 AM, for a blood pressure of 134/73 mm/Hg . September 19. 2024, at 12:30 PM, for a blood pressure of 137/69 mm/Hg . September 28, 2024, at 12:30 PM for a blood pressure of 128/68 mm/Hg . Each dose was administered when the resident's SBP was greater than 120 mm/Hg . Interview with the Director of Nursing on October 25, 2024, at approximately 1:30 PM confirmed the nursing staff failed to hold Resident 22's Midodrine medication as prescribed by the physician when the resident's systolic blood pressure was greater than 120 mm/Hg . 28 Pa. Code 211.12 (d)(3)(5) Nursing services 28 Pa. Code 211.5(f) Medical records

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460 Based on observation and staff interview it was determined the facility failed to maintain an environment free of potential accident hazards during medication administration on one of two resident care units. (First floor). Findings include: An observation on the first floor nursing unit on October 24, 2024, at 8:56 AM, during medication administration revealed there were medications located on overbed table in room [ROOM NUMBER]-1. One clear plastic medication cup with what appeared to be crushed medications in a liquid, a second medication cup with a red colored liquid, and a large plastic cup filled with a pink liquid, on Resident 83's overbed table. During an interview with Resident 83, who resides in room [ROOM NUMBER] on October 24, 2024, at 8:56 AM revealed the resident stated the nurse left the medications on the table. Resident 83 further stated, she will give them to me eventually. A review of Resident 83's Medication Administration Record (MAR) dated October 2024, revealed the resident was scheduled to receive Allopurinol 100mg (used to decrease high blood uric acid levels) Ferrous sulfate 325 mg (iron supplement), Furosemide 20mg (diuretic or water pill), Sitagilptin phosphate 50mg (antidiabetic mediation), Apixaban 5mg (anticoagulant), Juven (nutritional supplement) one packet, Metoprolol tartrate 50mg (blood pressure medication), Proheal liquid protein, and Hydroxyzine HCL 25mg (antihistamine), daily via feeding tube at 8:30 AM. An interview with Employee 9, LPN (license practical nurse) on October 24, 2024, at 8:58 AM, indicated Resident 83 administers her own medications via the feeding tube once prepared by the nurse. Employee 9 confirmed the prepared medications were left unattended at the resident's bedside. A review of Resident 83's current physician orders revealed an order dated October 4, 2024, which indicated the resident is to administer her own bolus feedings after staff setup. There was no evidence the resident was to administer her own medications via the feeding tube. The observation was confirmed with the Director of Nursing (DON) on October 24, 2024, at approximately 9:10 AM. The DON further confirmed that Resident 83 was not to administer her own medications via the feeding tube and the medications were not to be left at the bedside which created a potential accident hazard if accidently consumed by another resident. 28 Pa. Code 211.9 (a)(1) Pharmacy services. 28 Pa Code 211.12 (c)(d)(5) Nursing services

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460 Based on observations, a review of clinical records and staff interview, it was determined the facility failed to provide the necessary care and services to prevent potential urinary tract infections to the extent possible for one resident with an indwelling urinary catheter out of 20 sampled residents (Residents 83). Findings included: A review of Resident 83's clinical record revealed the resident was admitted on [DATE], with diagnoses, which included retention of urine and required the use of an indwelling catheter for urination. Review of physician orders revealed an order dated October 4, 2024, for Acetic Acid irrigation solution 0. 25%, use 1 dose via irrigation every day and evening shift. The physician order failed to identify what was to be flushed or the amount of Acetic Acid to be administered. Observation of Resident 83's room on October 22, 2024, at 10:25 a.m. revealed there were two opened irrigation kits with a piston syringes and two opened undated bottle of Acetic Acid 0.25% behind each resident's television. Each piston syringe kit was labeled Foley flush. Further observation of the opened undated 1000mL containers of Acetic Acid 0.25% revealed the container is a single-dose container. One container had approximately 500mL remaining and the other container had approximately 800mL remaining. A review of manufacturer instructions revealed that the contents of an opened container should be used promptly to minimize the possibility of bacterial growth or pyrogen formation. Discard the unused portion of irrigation solution since no antimicrobial agent has been added. Interview with Employee 2, licensed practical nurse, on October 22, 2024, at approximately 11:00 a.m. confirmed the irrigation supplies were not stored and/or discarded in a sanitary manner. During an interview with the Director of Nursing (DON), and in the presence of the Nursing Home Administrator (NHA) on October 25, 2024, at 1:30 p.m., confirmed that the facility failed to maintain resident 83's foley catheter supplies in a sanitary manner to prevent the possible spread of infection. 28 Pa. Code 211.12 (d)(3)(5) Nursing services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on review of select facility policy, clinical records, and staff interview it was determined the facility failed to monitor the nutritional parameters for one resident with an identified significant weight loss out of 20 residents sampled (Resident 60). Findings include: Review of a facility policy titled Weight Assessment last reviewed by the facility in January 2024, revealed that any weight change of 5 pounds or more since the last assessment will be retaken for confirmation. If the weight loss is verified nursing will notify the physician and dietician. A review of Resident 60's clinical record revealed admission to the facility on [DATE], with diagnoses to include dementia (the loss of thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities). A review of the resident's weights noted the following: July 1, 2024 125.0 lbs August 2, 2024 122.0 lbs September 4, 2024 117.0 lbs September 10, 2024 114.0 lbs indicating a 6.6% weight loss in 30 days. The dietician requested a reweight after the five pound weight loss between August 2, 2024 and September 4, 2024. The facility failed to reweigh the resident in a timely manner, six days elapsed between the weight on September 4, and September 10, 2024. A review of a dietary note dated September 12, 2024, revealed the dietitian noted the resident's significant weight loss and noted variable intakes. The dietician added nutritious shakes twice a day and requested weekly weights to prevent further weight loss. Further review of the resident's clinical record revealed the facility failed to complete the weekly weights as requested by the dietician. There was no evidence at the time of the survey ending October 25, 2024, the facility had timely acted upon the resident's weight loss and developed and implemented nutritional support measures to maintain acceptable nutritional parameters and deter progressive weight loss. Interview with the Director of Nursing on October 24, 2024, at approximately 9:20 AM, confirmed that the facility failed to timely identify, address, and implement weight loss interventions. 28 Pa Code 211.5(f)(ix) Medical records (continued on next page)

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	395288	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sapphire Care and Rehab Center	221 East Brown Street East Stroudsburg, PA 18301

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on review of clinical records, select facility policy, observation, and staff interview, it was determined the facility failed to follow physician orders for oxygen therapy and failed to maintain oxygen equipment in a functional and sanitary manner for three residents out of 20 sampled (Residents 28, 61, and 52). Findings include: Review of the facility policy titled Equipment Changing last reviewed by the facility on January 24, 2024, revealed that all respiratory equipment must be changed in order to prevent nosocomial infections (healthcare associated infections). The equipment should be marked with the date that it was changed. All equipment should be changed on a weekly basis as well as prn (as needed) if it becomes soiled or falls on the ground. Review of Resident 28's clinical record revealed the resident was initially admitted to the facility on [DATE], with diagnoses to include chronic obstructive pulmonary disease (COPD- lung disease that blocks airflow and makes it difficult to breathe), chronic respiratory failure with hypoxia (not enough oxygen passes from the lungs to the blood, making it difficult to breath), and tracheostomy status (surgical procedure that creates an opening in the neck) into the trachea (windpipe) to allow air and oxygen to reach the lungs. The resident had three current physician's orders dated August 5, 2024, for the following: (1) provide supplemental oxygen therapy at 5.0 liters/minute via the tracheostomy; (2) provide Albuterol Sulfate inhalation nebulization solution (2.5 mg/3 ml) 0.083% a medication inhaled into the lungs using a nebulizer machine (a small machine that turns liquid medicine into a mist that can be inhaled into the lungs) via tracheostomy every 4 hours as needed for wheezing/shortness of breath; and (3) change the oxygen tubing and clean the oxygen filter (on the oxygen concentrator- a bedside machine that concentrates ambient air to supply an oxygen-rich gas stream) every Sunday during night shift. An observation conducted on October 22, 2024, at 11:45 AM revealed that Resident 28 was awake and sitting upright in bed with supplemental oxygen in place via an oxygen concentrator with the liter flow set at 5. 0 liters per minute. The resident's oxygen tubing and trach mask were not dated and the resident's oxygen concentrator filter was visibly covered in dust. Further observation revealed the resident's nebulizer machine, including the tubing and mask, were placed on the bedside table. Also on the bedside table were two pillows and a blanket that were stacked on top of the nebulizer mask and tubing. The nebulizer mask was uncovered, not bagged, and not dated. Review of Resident 61's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include chronic obstructive pulmonary disease, and chronic respiratory failure with hypoxia. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident had a current physician's order dated June 5, 2024, for continuous oxygen therapy administration via nasal cannula (flexible plastic tubing with small prongs inserted into the nostrils to deliver supplemental oxygen) at 4.0 liters per minute. The resident also had a current physician order dated June 11, 2024, to change the oxygen tubing every Tuesday during night shift. An observation conducted on October 22, 2024, at 12:21 PM revealed that Resident 61 was sitting on the edge of his bed with supplemental oxygen in place via an oxygen concentrator with the liter flow set at 4.0 liters per minute. The resident's oxygen tubing was not dated. The resident's oxygen concentrator filter was visibly covered in dust. Interview with Employee 1 LPN (licensed practical nurse) on October 22, 2024, at 12:25 PM confirmed that Resident 28 and 61's oxygen tubing was not dated and the oxygen concentrator filters were covered in dust. Review of Resident 52's clinical record revealed the resident was initially admitted to the facility on [DATE], with diagnoses to include chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, and dependence on supplemental oxygen. The resident had a current physician's order dated June 11, 2024, to change oxygen tubing every Tuesday on night shift and an order dated June 12, 2024, for oxygen administration at 2 liters per minute per nasal cannula. An observation conducted on October 22, 2024, at 1:10 PM revealed Resident 52 was awake and lying in bed with supplemental oxygen in place via an oxygen concentrator with a liter flow set at 4.0 liters per minute. Further observation revealed Resident 52's oxygen tubing was not dated, and the oxygen concentrator filter was visibly covered in dust. Interview with Employee 2 LPN (licensed practical nurse) on October 22, 2024, at 1:15 PM confirmed Resident 52 was prescribed 2.0 liters per minute of oxygen continuously, but the resident was currently receiving 4.0 liters per minute. Employee 2 also confirmed the oxygen tubing was not dated, and the oxygen filter was covered with dust. Interview with Nursing Home Administrator on October 24, 2024, at 1:45 PM confirmed the facility failed to follow physician orders for the administration of oxygen and the condition of the oxygen concentrators was not consistent with facility policy for maintenance of oxygen delivery equipment. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services 28 Pa. Code 211.10 (a)(c) Resident Care Policies

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 41460 Based on observations, clinical record review, and resident and staff interview it was determined that the facility failed to ensure the ready availability of necessary emergency supplies for a resident receiving hemodialysis for one of 20 residents sampled. (Resident 85) Findings include: According to the National Kidney Foundation patients receiving hemodialysis (a machine filters wastes, salts, and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately) should keep emergency care supplies on hand. A review of Resident 85's clinical record revealed the resident was admitted to the facility was on August 11, 2024, with diagnoses that included end stage renal disease (a chronic kidney disease that occurs when the kidneys can no longer function properly) and dependence on renal hemodialysis. A review of the resident's current plan of care dated August 15, 2024, and last revised August 27, 2024, revealed that the resident required dialysis with the potential for infection, fluid volume excess/deficit, pain, and trauma related to end stage renal failure. Planed interventions included monitor dialysis catheter right internal jugular site for signs and symptoms of infection, swelling, bleeding, and pain. The facility failed to develop planned interventions for emergency supplies for the resident's dialysis access site. An observation conducted on October 22, 2024, at 10:08 AM, revealed that there were no emergency supplies available in the resident's room or on the resident's wheelchair. An interview with Resident 85 on October 22, 2024, at time of observation confirmed that there were no emergency supplies available in the resident's room or on the resident's wheelchair. An interview with Employee 10 LPN (licensed practical nurse) on October 22, 2024, at approximately 11:58 AM, confirmed no emergency supplies for Resident 85's dialysis access site were available in the resident's room or on her wheelchair. Employee 10 further confirmed that the emergency supplies were to be available at the bedside. Interview with the Director of Nursing on October 25, 2024, at approximately 1:45 PM, confirmed the facility failed to ensure the ready availability of necessary emergency supplies at the resident's bedside and that the care plan failed to reflect interventions for the dialysis access site in the event of an emergency. 28 Pa. Code 211.12 (d)(3)(5) Nursing Services

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on clinical record review and staff interviews, it was determined the facility failed to ensure each resident received the necessary behavioral health care in a timely manner to attain or maintain the highest practicable mental and psychosocial well-being for one of 20 residents sampled (Resident 10). Findings include: A review of Resident 10's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania). Further review of Resident 10's clinical record revealed the resident exhibited behaviors, including agitation, restlessness, crying and yelling out. Observations on October 22, 2024, between 8:45 a.m. and 9:30 a.m., revealed Resident 10 to be wheeling in and out of her room appearing restless and agitated. The resident was observed to be crying and mumbling. No behavioral interventions were observed to be implemented during the observations. Review of Resident 10's care plan, initiated by the facility on January 11, 2024, did not indicate the resident had a behavioral problem. The resident's care plan did not address the resident's specific behavioral problems or symptoms that were noted in the nursing documentation. Review of Psychological evaluations revealed the last psychological evaluation was dated August 17, 2024, and indicated Resident 10 was continuing to have intermittent behaviors and would benefit from continued behavioral health services. These episodes occurred often and were not easily redirectable. A review of a nursing progress notes between August 2024 and October 2024 revealed the resident had continued and increased behaviors during this time period. The facility failed to update the resident's care plan to address the mental health needs of the resident and failed to provide continued psychological services to promote the highest practicable mental health condition. During an interview with the Nursing Home Administrator (NHA), on October 25, 2024, at approximately 10:00 a.m., the NHA was unable to provide evidence that Resident 10 was being provided psychological services to maintain the highest practicable level of mental and psychosocial wellbeing. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 41460 Based on a review of clinical records, select facility policy, and medication records, and staff interviews, it was determined that the facility failed to implement pharmacy procedures for accounting for controlled drugs on one of six medication carts. (First Floor Back) Findings included: A review of the facility's policy entitled Controlled Substances last reviewed by the facility on January 24, 2024, revealed that nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They much document and report any discrepancies to the Director of Nursing services. A review of the facility's Change of Shift Controlled Substances Count Sheet revealed that the signature of nurse arriving on duty and nurse departing from duty indicates that controlled drugs on the cart have been counted and that the quantity of each medication counted is in agreement with the quantity stated on the Daily Narcotic Count Sheet and that the controlled substance log was reconciled and found to be accurate. Observation of the First Floor Back medication cart narcotic log on October 24, 2024, at 9:21 a.m., in the presence of the Director of Nursing, found the logbook on the desk at the nurse's station while the assigned nurse was actively passing morning medications. Further observations revealed on the following dates the shift to shift sign off was not completed: October 9, 2024, off-going nurse 3pm to 11pm shift. October 17, 2024, off-going nurse 3pm to 11pm shift. October 23, 2024, off-going nurse 7am to 3pm shift. The Director of Nursing confirmed on October 24, 2024, at time of observation the logbook should be with the medication cart in order for controlled substances to be signed out when administered. The DON further confirmed that the nursing staff failed to consistently sign shift-to-shift reconciliation of narcotic medications. Interview with the Director of Nursing on October 25, 2024, at approximately 12:30 p.m. confirmed that the facility failed to implement procedures for accurately accounting of controlled drugs at the beginning and end of each shift. 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing Services 28 Pa. Code 211.9 (d)(j.1)(1)(2)(3)(5) Pharmacy services 28 Pa. Code 211.10 (a)(c)(d) Resident care policies

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on review of clinical records and staff interview, it was determined the facility failed to ensure that the attending physician acted upon on the pharmacist's reports of irregularities in the drug regimen of four resident of 20 residents reviewed (Residents 28, 10, 73, and 36). Findings include: A review of Resident 28's clinical record revealed admission to the facility on [DATE], with diagnoses to include Thrombophilia (blood disorder that makes the blood in the veins and arteries more likely to clot), chronic obstructive pulmonary disease (COPD- lung disease that blocks airflow and makes it difficult to breathe), and chronic respiratory failure with hypoxia (not enough oxygen passes from the lungs to the blood, making it difficult to breath). A review of the consultant pharmacist's Consultant Pharmacist Communication to Physician dated August 13, 2024, addressed the physician's order for Lovenox (an anticoagulant- blood thinner used to prevent blood clots). The pharmacist recommended the physician identify the duration of the therapy for Lovenox, currently ordered for DVT (deep vein thrombosis). The facility failed to provide written documentation of the attending physician's response to the consultant pharmacist's recommendation and there was no documentation the resident's physician acknowledged this identified pharmacy report. A review of facility documentation entitled Pharmacy Review dated September 14, 2024, revealed the consultant pharmacist conducted a medication regimen review and recommendations were made. The document indicated to review the Clinical Pharmacy Report for the recommendations. The facility was unable to provide the Clinical Pharmacy Report or documentation as to what the pharmacy recommendation included and the physician's response to the recommendation. Review of the consultant pharmacist's Consultant Pharmacist Communication to Physician dated October 13, 2024, identified that Resident 28 was prescribed two medications: Lovenox and nonsteroidal anti-inflammatory agents (NSAIDs-used to treat mild-moderate pain, fever, and inflammation). The pharmacist's recommendation was to consider therapy modification indicating that NSAIDs may enhance the anticoagulant (blood thinning) effect of Lovenox. The pharmacist further recommended to discontinue NSAIDs prior to the initiation of Lovenox whenever possible. If co-administration cannot be avoided, monitor the resident closely for clinical laboratory results and evidence of bleeding. The facility failed to provide written documentation of the attending physician's response to the consultant pharmacist's recommendation and there was no documentation the resident's physician acknowledged this identified pharmacy report. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 10's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania). A review of facility documentation entitled Pharmacy Review dated August 2024, revealed the consultant pharmacist conducted a medication regimen review and recommendations were made. The document indicated to review the Clinical Pharmacy Report for the recommendations. The facility was unable to provide the Clinical Pharmacy Report or documentation as to what the pharmacy recommendation included and the physician's response to the recommendation. The facility failed to provide written documentation of the attending physician's response to the consultant pharmacist's recommendation and there was no documentation the resident's physician acknowledged this identified pharmacy report. A review of Resident 73's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including dementia (loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities). A review of facility documentation entitled Pharmacy Review dated March 2024, revealed the consultant pharmacist conducted a medication regimen review and recommendations were made. The document indicated to review the Clinical Pharmacy Report for the recommendations. The facility was unable to provide the Clinical Pharmacy Report or documentation as to what the pharmacy recommendation included and the physician's response to the recommendation. The facility failed to provide written documentation of the attending physician's response to the consultant pharmacist's recommendation and there was no documentation the resident's physician acknowledged this identified pharmacy report. A review of Resident 36's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including dementia. A review of facility documentation entitled Pharmacy Review dated April 2024, revealed the consultant pharmacist conducted a medication regimen review and recommendations were made. The document indicated to review the Clinical Pharmacy Report for the recommendations. The facility was unable to provide the Clinical Pharmacy Report or documentation as to what the pharmacy recommendation included and the physician's response to the recommendation. The facility failed to provide written documentation of the attending physician's response to the consultant pharmacist's recommendation and there was no documentation that the resident's physician acknowledged this identified pharmacy report. An interview with Director of Nursing on October 24, 2024, at 11:00 AM confirmed the facility was unable to provide documented evidence the attending physician acted upon the pharmacy recommendations. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.2 (d)(3)(9) Medical director 28 Pa Code 211.5 (f)(vii) Medical records 28 Pa. Code 211.9 (k) Pharmacy services

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on review clinical records and staff interviews, it was determined that the facility failed to ensure that a resident was free from unnecessary psychoactive drugs by failing to ensure the presence of clinical rationale for the continued use of an as needed psychotropic medication for two of five residents reviewed (Residents 44 and 20). Findings include: A review of Resident 44's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include Bipolar Disorder (a mental illness that causes extreme mood swings, along with changes in energy, sleep, thinking, and behavior). A review of Resident 44's clinical record revealed a physician's order for lorazepam (used to treat anxiety) give 0.5 mg by mouth every 12 hours as needed for Anxiety with a start date of September 9, 2023, and no end date . A review of the October 2024 Medication Administration Records (MAR) revealed that the medication (alprazolam) was administered to the resident four times during the month of October 2024. A review of the physician's notes for the months of September and October 2024, revealed that the physician failed to document the clinical rationale for the continued use or identify the need for the extended duration for the prn (as needed) order for the psychoactive drug without re-evaluation of its necessity. A review of Resident 20's clinical record revealed admission to the facility on [DATE], with diagnoses which included anxiety and depression. A review of Resident 20's clinical record revealed a physician's order dated October 7, 2023, for Lorazepam 1mg give one tablet every 8 hours as needed for anxiety, and no end date. A review of the controlled substance record for Resident 20's Lorazepam revealed that the medication was last administered on December 13, 2023, at 9:00 p.m. A review of pharmacy recommendation dated January 27, 2024, revealed that the pharmacist recommended the physician review the Lorazepam medication and implement a 14-day stop date. Further review revealed that the pharmacist again reviewed the antianxiety medication with recommendations for a stop date and/or gradual dose reduction. The physician failed to document the clinical rationale for the continued use or identify the need for the extended duration for the prn (as needed) order for the psychoactive drug without re-evaluation of its necessity. An interview was conducted with the Director of Nursing on October 24, 2024, at approximately 12:30 p.m. verified that there was no physician documentation of the clinical rationale for the prn medication to be used more than 14 days. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.9 (k) Pharmacy services. 28 Pa Code 211.5 (f) Medical records 28 Pa. Code 211.2 (d)(7) Medical director

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41460 Based on a review of select facility policy, observations, and staff interview, it was determined that the facility failed to adhere to acceptable storage and use by dates for multi-dose medication on two of six medication carts observed. Findings include: A review of facility policy entitled Administering Medications last reviewed by the facility on January 24, 2024, indicated that insulin pens will be clearly labeled with the resident's name or other identifying information. The expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be recorded on the container. An observation of a first floor medication cart on October 24, 2024, at 9:07 a.m., revealed Employee 9 LPN (license practical nurse) was working medication cart. One Basaglar insulin pen, two Lispro insulin pens, and one Humulin 70/30 insulin pen were opened and available for use. There was no evidence that the insulin pens were dated when opened or with an expiration/beyond use date. Further observations of the first floor medication cart revealed a Fiasp insulin pen labeled as opened on September 19, 2024. According to manufacturer instructions, once opened, the Fiasp insulin pen should be discarded after 28 days. An interview with Employee 9 on October 24, 2024, at the time of the observation, confirmed the all insulin pens should have been dated when opened and the Fiasp insulin pen should have been discarded. An observation of a second floor medication cart On October 24, 2024, at approximately 9:38 a.m., revealed Employee 1 LPN was working the medication cart. Two Lispro insulin pens were observed to be opened and available for use. Neither of the two pens were dated when opened or with an expiration/beyond use date. Further observations of the Lispro insulin pens revealed that one of the pens was not properly labeled with resident identification. An interview with the Director of Nursing (DON) on October 25, 2024, at approximately 10:51 a.m., confirmed the that the facility failed to correctly label and date multi-dose medications when opened to assure acceptable storage times and adhere to expiration dates. 28 Pa. Code 211.9 (a)(1)(k) Pharmacy Services 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services

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	395288	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sapphire Care and Rehab Center	221 East Brown Street East Stroudsburg, PA 18301

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on review of clinical records, payor source data, and staff interview, it was determined the facility failed to offer routine annual dental services for one resident with Medicaid as a payor source (Resident 52) and failed to promptly refer a resident with mouth pain and a physician's order for a dental consult with Medicaid as a payor source (Resident 86) out of 20 residents sampled Findings include: Review of Resident 52's clinical record revealed admission to the facility on [DATE], and the resident's current payor source was Medicaid. There was no documented evidence at the time of the survey ending October 25, 2024, the resident had been offered dental services in the past year. Review of resident 86's clinical record revealed admission to the facility on [DATE], and the resident's current payor source was Medicaid. A physician's order dated August 1, 2024, revealed on order for a dental consult for left side mouth pain. At the time of the survey ending October 25, 2024, the facility was unable to provide documented evidence the facility had provided timely assistance to obtain dental services needed by the resident to evaluate and provide treatment for mouth pain. Interview with the Director of Nursing on October 24, 2024, at 2:00 PM confirmed the facility had not offered Resident 52 routine dental services in the past year and the facility was unable to provide documented evidence that Resident 86 was provided a dental consult as ordered by the physician. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on review of the facility's infection control tracking log, observations, and staff interview, it was determined that the facility failed to maintain and implement a comprehensive program to monitor and prevent infections in the facility, including protocols and provisions for Enhanced Barrier Precautions for 6 of six residents observed (Residents 70, 66, 52, 12, 83, and 33). Findings include: A review of a memo from The Center for Clinical Standards and Quality/Quality, Safety & Oversight Group, Ref: QSO-24-08-NH, CDC, Centers for disease control, dated March 20, 2024 regarding, Enhanced Barrier Precautions in Nursing Homes to Prevent Spread of disease revealed, CMS is issuing new guidance for State Survey Agencies and long term care (LTC) facilities on the use of enhanced barrier precautions (EBP) to align with nationally accepted standards. EBP recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism (MDRO) status. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Review of information provided by the facility indicated Residents 70, 66, 52, 12, 83, and 33 required enhanced barrier precautions. Review of the clinical record revealed Resident 70 was admitted to the facility on [DATE], with diagnoses including malnutrition. The resident required enhanced barrier precautions due to a tube feeding. Review of the clinical record revealed Resident 66 was admitted to the facility on [DATE] with diagnoses including neurogenic bladder. The resident required enhanced barrier precautions for a foley catheter. Review of the clinical record revealed Resident 52 was admitted to the facility on [DATE], with diagnoses including adult failure to thrive. The resident required enhanced barrier precautions due to a tube feeding. Review of the clinical record revealed Resident 12 was admitted to the facility on [DATE], with diagnoses including a stage 4 pressure ulcer of the sacral region. The resident required enhanced barrier precautions due to an open wound on her buttocks and a foley catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the clinical record revealed Resident 83 was admitted to the facility on [DATE], with diagnoses, which included retention of urine. The resident required enhanced barrier precautions due to an indwelling urinary catheter, a feeding tube, and chronic open wounds. Review of the clinical record revealed that Resident 33 was admitted to the facility on [DATE], with diagnoses which included neuromuscular dysfunction of the bladder (a condition that occurs when the nerves and muscles that control the bladder don't work properly). The resident required EBP due to use of an indwelling catheter. Observations during the initial environmental tour including the rooms of the above mentioned residents on October 22, 2024, at 9:30 a.m., revealed there was no evidence of EBP for any of the above noted residents in the facility. Interview with the Director of nursing on October 22, 2024, at 1:00 p.m., confirmed that there were no EBP implemented for any resident in the facility at the time of the survey despite meeting the above criteria. 28 Pa. Code 211.12 (c)(d)(5) Nursing services.

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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. 39929 Based on review of the facility's infection control policies and procedures and staff interview, it was determined the facility failed to implement an antibiotic stewardship program for 6 of 12 months reviewed. (April 2024-September 2024). Findings include: Review of the facility policy entitled Antibiotic Stewardship last reviewed January 2024 indicated antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The purpose of the antibiotic stewardship program is to monitor the use of antibiotics in the residents. Review of the facility's Infection Control surveillance for September 2023 through September 2024, failed to include documentation to indicate that antibiotic monitoring was completed for 6 months (April 2024 through September 2024). During an interview on October 25, 2024, at 9:45 a.m. the Director of Nursing confirmed the facility failed to implement an antibiotic stewardship program that included a system of surveillance to monitor antibiotic use and laboratory correlation for infections for 6 of 12 months and was unable to produce the tracking records from April 2024 through September 2024 for review. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 39929 Based on staff interview, it was determined the facility did not have one or more individuals serving as the Infection Preventionist (IP) responsible for the facility's infection prevention plan. Findings included: The Centers for Medicare and Medicaid Services regulation S483.80(b)(3) states the facility must designate one or more individuals as the infection preventionist (IP) who are responsible for the facility's Infection Prevention and Control Program. The IP must work at least part-time at the facility, physically work onsite in the facility, cannot be an off-site consultant, or perform the IP work at a separate location. During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on October 22, 2024, at 11:40 AM, revealed the prior IP left the role in the beginning of April 2024, and there was currently no designated IP. Further they stated the facility has hired a new IP but she had not started in the position as of the end of survey October 25, 2024. In an interview on October 24, 2024, at 9:47 a.m., the Director of Nursing confirmed that the facility had no staff that were credentialed infection preventionists. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management