STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395309	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34631 Based on document review and staff interview, it was determined that the facility failed to ensure each resident is periodically informed of charges for services not covered under Medicare or Medicaid for one of three residents reviewed at the termination of Medicare A services (Resident 239). Findings Include: A review of Resident 239's clinical record revealed an admitted [DATE], with diagnoses that included hypertension (elevated blood pressure) and heart failure (A lifelong condition in which the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen). According to the clinical record, Resident 239 was admitted for short-term rehabilitation with a planned discharge to return to the community. A review of Resident 239's Notice of Medicare Non-Coverage (NOMNC) form revealed the last covered day of Medicare A services ending on January 30, 2024. As of January 31, 2024, Resident 239 would be responsible for privately paying, or out of pocket, for the facility's daily rate for the non-covered services provided at the facility. Continued review of Resident 239's clinical record revealed the facility had not provided Resident 239 with the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF-ABN) form detailing the estimated cost of the facility's inpatient skilled nursing services beginning January 31, 2024, until Resident 239's eventual discharge from the facility on February 14, 2024. An interview with the Nursing Home Administrator on June 25, 2024, at 9:45 AM, revealed the facility had knowledge of the lack of issuance of the SNF-ABN form to residents and began to initiate steps for compliance in February 2024. 28 Pa. Code 202.14 (a) Responsibility of licensee

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 37817 Based on observations and staff interviews, it was determined that the facility failed to maintain a safe, clean, comfortable, and home-like interior in three of four resident shower rooms (first and second floor nursing units). Findings include: Observations in the second floor men's shower room on June 26, 2024, at 12:48 PM and at 1:50 PM, with Employee 3 (Director of Housekeeping), revealed in two of the three showers there was a black substance on the floor at the base of the wall. Observations in the second floor women's shower room on June 26, 2024, at 12:49 PM and at 1:55 PM, with Employee 3, revealed there was a pink and black substance on the floor at the base of the wall on all 3 sides of the shower, the blue mat on the shower gurney was cracked in seven areas with the foam exposed, and the ceiling vent in front of shower on the right wasn't functioning. Observations in the first floor shower room on June 26, 2024, at 12:54 PM and at 2:00 PM, with Employee 3, revealed there was a black substance on the floor at the base of the wall on two sides, the sink was separated from the wall and was loose, and the ceiling vent on the right wasn't functioning. During an interview with Employee 3 on June 26, 2024, at 2:00 PM, it was revealed that shower rooms are cleaned every other day and as needed. It was also revealed that a request was submitted to Maintenance to replace the silicone in the women's shower room on the second floor about one week ago. During an interview with Nursing Home Administrator (NHA) on June 26, 2024, at 2:05 PM, the surveyor discussed the aforementioned concerns regarding resident shower rooms. It was revealed that work orders for maintenance would be submitted and housekeeping contacted. During an interview with NHA on June 26, 2024, at 3:30 PM, revealed housekeeping cleaned the aforementioned areas, and maintenance is in the process of replacing the silicone, will fixing the sink that evening, and will investigate the ventilation. The shower bed mat would be ordered the following day and be replaced. 28 Pa. Code 201.18 (e)(1)(2.1)Management

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 34631 Based on policy review, document review, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure that all allegations of abuse, neglect, or mistreatment are reported no later than 24 hours to other officials, including Adult Protective Services, for two of three resident abuse investigations reviewed (Residents 40 and 61). Findings Include: A review of the facility's policy, titled Abuse Prohibition, revised October 24, 2022, defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, injury or mental anguish. Verbal abuse is defined as any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to patients . A continued review of the policy revealed, regarding reporting allegations of abuse, read The Administrator and/or DON [Director of Nursing] will verify that the state reporting occurs within required time frames and via appropriate method of reporting. The policy continued under the section titled When to Report, which read, Immediately but no later than 24 hours after forming the suspicion. Section To Whom to Report, read Adult Protective Services where state law provides jurisdiction in long-term care facilities. A review of Resident 40's clinical record revealed diagnoses that included dementia (a term used to describe a group of symptoms affecting memory, thinking, and social abilities) and anxiety (Intense, excessive, and persistent worry and fear about everyday situations). A review of facility-provided documentation revealed on December 4, 2023, the physical therapist (Employee 6) reported to staff that she overheard Employee 7 (Nurse Aide) tell Resident 40 to go change your pants your ass stinks. According to the documentation, Employee 7 was immediately sent home and the facility began an investigation. The investigation was eventually substantiated as verbal abuse of Resident 40 by Employee 7. According to the final report, the facility did not report the incident to the Area Agency on Agency (AAA) until December 28, 2023. A review of Resident 61's clinical record revealed diagnoses that included morbid obesity (A disorder that involves having too much body fat, which increases the risk of health problems) and muscle weakness (A decrease in muscle strength). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility provided documentation revealed on June 12, 2024, Resident 61 reported to the Director of Nursing (DON) that the respiratory therapist (Employee 8) on June 10, 2024, entered his room and asked if his BIPAP (Bilevel positive airway pressure - a machine that helps you breathe) equipment was working. Resident 61 stated that his response to Employee 8's question was Shouldn't you have checked it? The only thing that's not working is the mask that I asked you for 3 weeks ago. Resident 61 then stated that Employee 8 responded, The mask is fine, you just don't know how to wear it properly. Resident 61 expressed that he felt the situation was escalating and responded to Employee 8 You're useless. Why don't you get out of here before things blow up. According to the document, Resident 61 stated Employee 8 then leaned in towards him and said, You just lay there and do nothing. At least I can walk out of here. A review of the facility's investigation revealed at the time of the incident, revealed the licensed practical nurse (Employee 9) reported that she saw Employee 8 leaning very close to Resident 61's bed whispering That is something you will never do. Employee 9 stated she remained in the room with Resident 61 and waited for the Resident to calm down. According to Employee 9's statement, Resident 61 reported Employee 8 stated At least I can get up and move around and walk, that is something you will never be able to do. After the investigation, the facility determined Employee 8 verbally abused Resident 61 and, as a contracted employee, Employee 8's regional manager was contacted and informed Employee 8 was no longer able to return to provide services at the facility. According to the facility-provided final report, the incident was not reported to the local AAA until June 18, 2024. An interview with the Nursing Home Administrator on June 27, 2024, at 12:47 PM, revealed the reporting of the abuse allegations were not within the regulatory timeframes or according to facility policy. 28 Pa. Code 201.14 (a) Responsibility of licensee

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 34631 Based on observation, clinical record review, and staff interviews, it was determined that the facility failed to ensure that a comprehensive, person-centered care plan was developed for four of 31 residents reviewed (Residents 38, 67, 68, and 82). Findings include: Review of a facility policy, titled Person-Centered Care Plan, with a review date of May 28, 2024, revealed that: Care plans will be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, and as needed to reflect the response to care and changing needs and goals. Review of Resident 38's clinical record revealed diagnoses that included dementia (A group of thinking and social symptoms that interferes with daily functioning) and hypertension (elevated blood pressure). Review of Resident 38's clinical record revealed an admission to hospice care and services on June 17, 2024. Review of Resident 38's interdisciplinary plan of care revealed none developed to address Resident 38's need for hospice care and services. Continued review of Resident 38's clinical record revealed the placement of an external urinary catheter (A tube placed in the body to drain and collect urine from the bladder), dated June 1, 2024. Review of Resident 38's interdisciplinary plan of care revealed none developed to address Resident 38's use of the catheter. An interview with the Director of Nursing (DON) on June 27, 2024, at 11:09 AM, confirmed Resident 38 had no hospice or catheter care plans in place. Review of Resident 67's clinical record revealed diagnoses that included peripheral vascular disease (a slow and progressive disorder of the blood vessels) and gastro-esophageal reflux disease (a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach). Review of Resident 67's clinical record revealed an admission to hospice care and services on February 21, 2024. Review of Resident 67's interdisciplinary plan of care revealed none developed to address Resident 67's need for hospice care and services. During an interview with the DON on June 27, 2024, at 11:12 AM, confirmed Resident 67 did not have a care plan for Hospice, and would have expected one to have been created. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 68's clinical record revealed diagnoses of chronic obstructive pulmonary disease (COPD - a lung disease that causes obstructed airflow from the lungs) and neuromuscular dysfunction of the bladder (a condition that occurs when the nerves that control bladder function are damaged). Observation on Resident 68 on June 25, 2024, at 8:21 AM, revealed Resident 68 sitting in a bed. The Resident was using supplemental oxygen via nasal canula and had a urinary catheter. Review of Resident 68's care plan, on June 26, 2024, failed to reveal any guidance regarding Resident 68's use of supplemental oxygen or urinary catheter. Interview with the DON on June 27, 2024, at 9:45 AM, revealed that Resident 68's care plan should have been updated and it would be updated to include Resident 68's use of supplemental oxygen or urinary catheter. Review of Resident 82's clinical record revealed diagnoses that included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills) and peripheral vascular disease (a slow and progressive disorder of the blood vessels). Review of Resident 82's MDS (Minimum Data Set is part of the federally mandated process for clinical assessment of all Medicare and Medicaid certified nursing homes) dated May 30, 2024, revealed that Section H0100 Appliances A. Indwelling Catheter (including suprapubic catheter and nephrostomy tube) was marked Yes. Review of Resident 82's active physician orders revealed an order to change drain sponges around the Foley site every evening shift, with an active date of May 11, 2024. Review of Resident 82's interdisciplinary plan of care revealed none developed to address Resident 82's use of the catheter. During an interview with the DON on June 27, 2024, at 11:12 AM, confirmed Resident 82 did not have a catheter care plan and she would have expected one to have been created. 28 Pa. Code 211.12(d)(3) Nursing services 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. 37817 Based on observations, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure the care plan was reviewed and revised for three of 31 residents reviewed (residents 32, 62, and 70). Findings include: Review of Resident 32's clinical record revealed diagnoses that included hemi-paresis (partial paralysis) right dominate side, stroke (damage to the brain from interruption of blood supply), and aphagia (language disorder that affects a person's ability to communicate). Review of Resident 32's care plan documented a focus area for neurological deficiencies and dysfunction of activities of daily living related to stroke, initiated August 13, 2014, revised September 18, 2023. Interventions included for Resident to wear a palm protector as ordered, initiated September 28, 2022, revised on May 16, 2024. Further review of the care plan included a focus area for activities of daily living self-care deficit secondary to stroke, initiated August 13, 2014, revised September 18, 2023. Interventions included cam boot to right lower extremity, initiated October 12, 2022, and revised May 16, 2024. Review of Resident 32's physician orders failed to document an order for use of palm protector or cam boot (medical device worn during treatment and recovery of a variety of foot injuries). Observation on June 24, 2024, at 11:44 AM, and June 25, 2024, at 2:15 PM, revealed Resident 32 was in bed, and not wearing a palm protector or cam boot. During an interview with the Director of Nursing (DON) on June 26, 2024, at 1:30 PM, it was revealed that the right palm protector and the cam boot have been discontinued and should've been removed from the care plan. Email communication with Nursing Home Administrator (NHA) on June 27, 2024, at 1:20 PM, revealed the cam boot was discontinued on December 12, 2023. It was also revealed the facility doesn't obtain a physician orders for a palm protector. Occupational therapy was evaluating Resident 32 for continued need of the palm protector, as the Resident refuses to wear it, and her refusal to wear it was care planned. Review of Resident 62's clinical record revealed diagnoses that included amyotrophic lateral sclerosis (ALS - a nervous system disease that affect nerve cells in the brain and spinal cord, causes loss of muscle control), abnormal posture, chronic obstructive pulmonary disease (COPD - lung disease that causes breathing problems and air-flow blockage), muscle weakness, and diabetes mellitus (the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 62's care plan included a focus area for risk for alteration in skin integrity, initiated June 20, 2023, revised July 13, 2023. Interventions included apply geri-sleeve to prevent skin tears, initiated March 29, 2024, revised May 21, 2024. Focus area for actual skin breakdown, skin tear left forearm, frail fragile skin, initiated June 17, 2024. Focus areas included to provide treatment to skin tear per physician order and observe for signs of infection until healed and report changes, initiated June 17, 2024. Review of Resident 62's physician orders included: aspirin for history of pleural effusion (buildup of fluid between the tissues that line the lungs and the chest) 81 milligrams one time a day, start date June 15, 2023; cleanse left elbow skin tear with normal saline solution, keep steri-strips in place until they fall off naturally, apply Vaseline gauze, cover with foam boarder dressing dayshift Tuesday until wound care on July 1, 2024, start June 25, 2024; cleanse left forearm skin tear with normal saline solution apply Vaseline gauze, cover with foam dressing dayshift Tuesday until wound care July 5, 2024, start June 25, 2024; cleanse right arm skin tear with normal saline solution apply Vaseline gauze, cover with foam dressing dayshift Tuesday until wound care July 5, 2024, start June 21, 2024. Further review of physician orders failed to document orders for use of geri-sleeves (skin protector sleeves for sensitive thin skin from tears brise and sun). Interview with DON on June 26, 2024, at 1:30 PM, revealed that the Resident's geri-sleeves were discontinued and should've been removed from the care plan. Review of Resident 70's clinical record revealed diagnoses of fracture of the first lumbar vertebra (a compression fracture that can occur when too much pressure is put on the vertebral body) and other abnormalities of gait and mobility (Gait abnormalities can be caused by a number of conditions, including injuries, neurological conditions, and muscle weakness). Review of Resident 70's care plan on June 25, 2024, revealed a care plan with a focus area of, Resident is at Risk for decreased ability to perform activities of daily living in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: recent hospitalization resulting in fatigue, activity intolerance, and confusion, created June 17, 2024. Interventions for the focus area were inititiated but the resident specific information was not filled it. The interventions stated: Further review of the above-mentioned care plan revealed an intervention to, provide resident with ___ (specify: set-up, supervision, limited, extensive, total) assist of ___ (specify #) for bed mobility, created June 17, 2024. Further review of the above-mentioned care plan revealed an intervention to, provide resident with ___ (specify: set-up, supervision, limited, extensive, total) assist of ___ (specify #) for toileting, created June 17, 2024. Further review of the above mentioned care plan revealed an intervention to, provide resident with ___ (specify: set-up, supervision, limited, extensive, total) assist of ___ (specify #) for ambulation using a ___ (specify: walker, rolling walker, quad cane, straight cane, no device, ect.) ___ times per day, created June 17, 2024. Interview with the DON on June 27, 2024, at 11:20 PM, revealed that Resident 70's care plan was entered as a template and should have been revised and updated with Resident care information specific to Resident 70. 28 Pa. Code 211.12(d)(5) Nursing services

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 40010 Based on clinical record review, facility policy review, observations, and resident and staff interviews, it was determined that the facility failed to provide care and services regarding shaving facial hair for one of 31 residents reviewed (Resident 72). Findings include: Review of facility policy, titled Activities of Daily Living (ADLs), revised May 1, 2023, revealed, A patient who is unable to carry out ADLs will receive the necessary level of ADL assistance to maintain good nutrition, grooming, and personal and oral hygiene. Review of Resident 72's clinical record revealed diagnoses that included Alzheimer's disease (loss of cognitive functioning) and pleural effusion (a condition that occurs when fluid builds up in the pleural space, the thin cavity between the layers of tissue that line the lungs and chest cavity). Observation of Resident 72 on June 25, 2024, at 8:45 AM, revealed the Resident lying in bed. At that time, Resident 47 was observed to have significant facial hair above her upper lip and on her chin. An interview with Resident 72 revealed that she would like to have the hair removed, but that she is unable to do it herself. Observation of Resident 72 on June 26, 2024, at 9:45 AM, revealed the Resident lying in bed. At that time, Resident 47 was observed to have significant facial hair above her upper lip and on her chin. Review of Resident 72's current care plan dated June 25, 2024, revealed a focus area of, ADL Self-care deficit as evidenced by weakness related pleural effusion, created April 24, 2024, with an intervention of, Assist with daily hygiene, grooming, dressing, oral care and eating as needed, created on April 24, 2024. Interview with the Director of Nursing on June 26, 2024, at 8:30 AM, revealed that Resident 72 had been shaved and that her care plan would be updated to specify that shaving would be offered during ADL care. 28 Pa code 211.12(d)(1)(5) Nursing services

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 33879 Based on observation, clinical record review, and staff interview, it was determined that the facility failed to ensure treatment and services were provided to promote healing and prevent infection for one of four resident's reviewed for pressure injury (Resident 78). Findings include: Review of Resident 78's clinical record revealed diagnoses that included congestive heart failure (CHF - decreased ability of the heart to pump blood throughout the body) and peripheral vascular disease (decreased blood circulation to extremities due to a narrowing of the arteries). Review of Resident 78's clinical record revealed Resident 78 had a stage 4 pressure ulcer (wound of the skin over a bony prominence that extends to the bone or other connective tissue) to the sacrum, stage 4 pressure ulcer to the right heel, and non-pressure full thickness ulcer (wound of the skin that extends below the layers of the skin to the muscle, bone, or other connective tissue) of the lower right leg. During wound treatment change observation conducted on June 26, 2024, at approximately 10:00 AM, Employee 1 was observed utilizing a paper measuring tape to measure the pressure ulcer of the right heel, non-pressure ulcer of the lower right leg, and sacral pressure ulcer. Employee 1 used the same paper measuring tape for each wound in the order of right heel wound, lower right leg wound, then the sacral wound. During the observation, Employee 1 was observed making contact with the tape measure and each wound. During the wound treatment observation, Employee 1 was observed not changing gloves or performing hand hygiene between applying a dressing to the right lower leg wound, removal of the sacral dressing, cleansing of the sacral wound, and applying a new dressing to sacral wound. During a staff interview on June 27, 2024, at approximately 11:15 AM, Director of Nursing (DON) revealed that disposable items (gauze and paper measuring tape) should not be used on multiple wounds. DON also revealed that Employee 1 should have changed gloves and performed hand hygiene between wounds and between removing a soiled dressing, cleansing, and applying a new dressing to a wound. 28 Pa code 211.12(d)(1)(5) Nursing services

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 47966 Based on record review and staff interview, it was determined the facility failed to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for one of 31 residents reviewed (Resident 56). Findings include: Review of Resident 56's clinical record revealed diagnoses that included peripheral vascular disease (a slow and progressive disorder of the blood vessels) and hypertension (high blood pressure). Review of Resident 56's clinical record revealed a diagnosis of a urinary tract infection (UTI), with an active date of April 30, 2024. Review of Resident 56's May 2024 Medication Administration Record revealed the Resident was prescribed Keflex Oral Capsule 500 milligrams, one capsule by mouth three times a day for UTI for seven days. The last day Resident 56 received a dose of Keflex was on May 8, 2024, at 2:00 PM. Review of Resident 56's clinical record revealed a progress note on May 8, 2024, at 2:58 PM, with the following text: Continues Keflex/UTI, no adverse reactions noted. Afebrile. Continues with burning when urinating. Review of Resident 56's clinical record revealed a Urine culture was ordered on June 6, 2024. Further review of Resident 56's clinical record revealed there was no follow-up relating to their UTI prior to then. Review of Resident 56's interdisciplinary plan of care revealed a focus area of Urinary incontinence related to physical limitations, and an intervention to report signs and symptoms of UTI such as flank pain, complaints of burning, pain, fever, hematuria, change in mental status, etc., with an initiation date of February 17, 2022. During an interview with the Director of Nursing on June 27, 2024, at 11:10 AM, she confirmed that there was nothing done to follow-up on the progress note from May 8, 2024, indicating Resident 56 reported to have burning when urinating, and that she would have expected additional follow -up to have been completed prior to June 6, 2024. 28 Pa Code 201.14(a) Responsibility of Licensee 28 Pa Code 201.18(b)(1) Management 28 Pa Code 211.12(d)(1)(5) Nursing Services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 37817 Based on observations, facility policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to provide respiratory care/oxygen services consistent with professional standards of practice for one of three residents reviewed for respiratory care (Resident 62). Findings Include: Review of facility policy, titled Bi-level Positive Airway Pressure (Bi-PAP- non-invasive ventilation is the use of breathing support administered through a face mask) /Continuous Positive Airway Pressure (CPAP- a machine that uses mild air pressure to keep breathing airways open while you sleep) including Trilogy (an all-in-one ventilation device capable of delivering both invasive and non-invasive ventilation modes) , revised April 1, 2022, failed to include information pertaining to cleaning and storage of equipment. Review of Resident 62's clinical record revealed diagnoses that included amyotrophic lateral sclerosis (ALS - a nervous system disease that affect nerve cells in the brain and spinal cord, causes loss of muscle control), abnormal posture, chronic obstructive pulmonary disease (COPD-lung disease that causes breathing problems and air-flow blockage), muscle weakness, and diabetes mellitus (the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine). Review of Resident 62's physician orders included: trilogy-Avads-AE Rate 12, TV 400mls, ps 5-35, peep 4-20cms, max pressure 40 on at bedtime (rate and pressure of oxygen), off in the morning for ALS, and COPD, start date June 14, 2023. Observation on June 24, 2024, at 12:13 PM, revealed a trilogy mask was on the floor behind nightstand. During an interview with Resident 62 on June 24, 2024, at 12:15 PM, it was revealed he requires assistance to don and store the trilogy mask. Observations June 25, 2024, at 2:30 PM and at 2:33 PM, with Employee 5, revealed the trilogy mask was on top of nightstand, and the mask had a light tan substance in the fold of the lower portion of the mask. Interview with Employee 5 on June 25, 2024, at 2:33 PM, revealed that the mask should be stored in a plastic bag that was in the drawer. It was also revealed that the mask should be replaced once a month and cleaned weekly and as needed. Interview with the Nursing Home Administrator on June 26, 2024, at 1:30 PM, it was revealed that the mask should be stored in the plastic bag and should be changed weekly and cleaned as needed. 28 Pa code 211.12(d)(1)(2)-Nursing Services

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 33879 Based on facility policy review, facility document review, and staff interview, it was determined that the facility failed to complete a performance review for one of five nurse aides reviewed at least once every 12 months (Employee 2). Findings include: Review of facility policy, titled HR616 Performance Appraisal, last reviewed June 20, 2024, revealed the facility policy stated, Managers will meet with their regular full-time, regular part-time and regular casual employees at least annually to conduct a performance appraisal or have a performance based conversation. In-service education will be provided based on the outcome of these reviews. Review of facility documentation revealed Employee 2's hire date was December 10, 2022. On June 26, 2024, a request was made for Employee 2's yearly performance evaluation. During a staff interview on June 27, 2024, at approximately 11:15 AM, Nursing Home Administrator (NHA) revealed that Employee 2 did not have a performance evaluation conducted. During the interview, the NHA revealed employees should have performance reviews conducted yearly (ever 12 months). 28 Pa code 201.18(b)(3) Management 28 Pa code 201.19(2) Personnel policies and procedures

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37817 Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to appropriately monitor the pH of the sanitizer sink for manual ware-washing, and failed to store and serve food/beverages in accordance with professional standards for food safety in the kitchen area and two of three nourishment pantries (second floor and Arcadia units). Findings include: Review of Facility policy, titled Manual Ware-washing and Sanitizing, effective May 1, 2023, read, in part, sanitizing is accomplished in the third sink by use of chemical sanitizer. Measure the concentration of the sanitizer utilizing a quaternary test strip; the strip should darken to the range of 200-400 parts per million. If the test strip doesn't turn the appropriate darkness, corrections are made before the sanitizing process can take place. The result of the test is recorded on the Manual Ware-washing Sanitation Long at each wash period. Review of facility policy, titled Pantry/Nourishment Room Sanitation, effective date May 1, 2023, read, in part, food and beverages are to be covered, labeled, and dated with use by dates. Review of facility policy, titled Food Brought in For Residents, revised January 26, 2024, read, in part, items that require refrigeration must be labeled with the resident's name and date the food was brought in; and will be discarded after three days. Observation on June 24, 2024, at 9:23 AM, with Employee 4 (Food Service Director), in the reach-in beverage refrigerator revealed one-half case of thawed chocolate nutritional supplement wasn't date marked with a pull date from the freezer. The aforementioned product is good for 14 days once thawed. During an interview with Employee 4 on June 4, 2024, at 9:23 AM, it was revealed that the box of nutritional supplements should've been date marked when pulled from the freezer. Observation of the Manual Ware-washing Sanitization logs on June 24, 2024, at 9:28 AM, it was revealed that there was no documentation for the months of May 2024 and June 2024. The facility didn't have possession of pH test trips (a strip of litmus paper with which you can measure the pH value of a liquid). During an interview with Employee 4 on June 24, 2024, at 9:28 AM, it was revealed that the contracted chemical supply company was to order more pH strips, and they haven't been delivered. It was also revealed that the facility should document the pH of the solution in the sanitize sink three times a day. During an interview with Employee 4 on June 26, 2024, at 12:25 PM, it was revealed that pH strips were obtained on June 24, 2024. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation in the second floor nourishment pantry on June 24, 2024, at 9:49 AM, with Employee 4, the following items in the freezer weren't marked with a resident identifier: one 8-ounce (oz) vanilla ice cream sundae, one 14 oz container mint chocolate chip ice cream, one 14 oz container mint chocolate cookie ice cream, one 64 oz container strawberry ice cream, and one-gallon vanilla ice cream. In the refrigerator, there were two pre-packaged hot dogs in a bun with a label that read, in part, keep under refrigeration good for 14 days. The hot dogs were not marked with a date. During an interview with Employee 4 on June 24, 2024, at 9:50 AM, it was revealed that the items in the freezer should've been marked with a resident name, and the hot dogs should've been date marked when stored in the refrigerator. Observation in the Arcadia unit nourishment pantry refrigerator on June 24, 2024, at 9:58 AM, with Employee 4, revealed: one 32 oz container nectar thick cranberry juice open with continents partially removed and not date marked and one thawed chocolate nutritional shake and one thawed strawberry nutritional shake not date marked with a pull/thawed date. During an interview with Employee 4 on June 24, 2024, at 9:58 AM, it was revealed that the thickened juice should've been date marked when opened, and the shakes should've been marked with a snack label. During an interview with the Nursing Home Administrator on June 26, 2024, at 1:30 PM, it was revealed that the pH of the sanitizer sink should be monitored and documented with each use. Further, food items are to be dated when removed from the freezer and when opened, and resident food should be marked with a resident identifier and date marked. 28 Pa code 211.6 - Dietary Services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 33879 Based on clinical record review, policy review, observations, and staff interviews, it was determined that the facility failed to maintain infection control practices to prevent the spread of infection for two of 31 residents reviewed (Resident 78 and 82). Findings include: Review of facility policy, titled Procedure: Enhanced Barrier Precautions, last revised May 1, 2024, revealed enhanced barrier precautions should be used when a resident has, Chronic wounds .regardless of [multi-drug resistant organism] colonization status. Further review of the document revealed that implementation of enhanced barrier precautions included posting a sign on the resident's door, indicating the resident is on enhanced barrier precautions and the use of a gown and gloves during wound care. Review of Resident 78's clinical record revealed diagnoses that included congestive heart failure (CHF - decreased ability of the heart to pump blood throughout the body) and peripheral vascular disease (decreased blood circulation to extremities due to a narrowing of the arteries). Further review of Resident 78's clinical record revealed Resident 78 had a stage 4 pressure ulcer (wound of the skin over a bony prominence that extends to the bone or other connective tissue) to the sacrum, stage 4 pressure ulcer to the right heel, and non-pressure full thickness ulcer (wound of the skin that extends below the layers of the skin to the muscle, bone, or other connective tissue) of the lower right leg. Observation of Resident 78's room on June 24, 25, and 26, 2024, revealed no enhanced barrier precaution sign was posted on Resident 78's door. During wound treatment change observation conducted on June 26, 2024, at approximately 10:00 AM, Employee 1 was observed performing wound dressing change on Resident 78's three wounds without donning a gown per the facility's enhanced barrier precaution policy. During a staff interview on June 27, 2024, at approximately 10:00 AM, Director of Nursing (DON) confirmed that Resident 78's door should have had a sign indicating that Resident 78 is on enhanced barrier precautions and that Employee 1 should have worn a gown during the wound treatment change. Review of Resident 82's clinical record revealed diagnoses that included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills) and peripheral vascular disease (a slow and progressive disorder of the blood vessels). Review of Resident 82's MDS (Minimum Data Set is part of the federally mandated process for clinical assessment of all Medicare and Medicaid certified nursing homes) dated May 30, 2024, revealed that Section H0100 Appliances A. Indwelling Catheter (including suprapubic catheter and nephrostomy tube) was marked Yes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 82's active physician orders revealed an order to change drain sponges around Foley site every evening shift, with an active date of May 11, 2024. Observation of Resident 82's room on June 24, 2024, at 10:15 AM, revealed no enhanced barrier precaution sign was posted on Resident 82's door. Observation of Resident 82's room on June 24, 2024, at 11:52 AM, revealed a staff member putting an enhanced barrier precaution sign on Resident 82's door, as well as a personal protective equipment cart outside of their room. During an interview with the Director of Nursing (DON) on June 27, 2024, at 11:09 AM, she confirmed that Resident 82 was placed on enhanced barrier precautions ever since their catheter was place, and that Resident 82 should have had signage posted on their door prior to June 24, 2024. 28 Pa code 201.18(b)(1)(3) Management 28 Pa code 211.12(d)(1)(5) Nursing services

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33879 Based on clinical record review and staff interview, it was determined that the facility failed to ensure residents were educated on influenza vaccination for one of five residents reviewed (Resident 82). Findings include: Review of Resident 82's clinical record revealed diagnoses that included type 2 diabetes mellitus (decreased ability of the body to utilize insulin for the transport of glucose from the blood stream into the cells for nourishment) and hypertension (elevated/high blood pressure). Review of Resident 82's clinical record revealed that Resident 82 was admitted to the facility on [DATE]. Further review the clinical record revealed that staff documented that Resident 82 refused the influenza vaccination for the 2023-2024 influenza season (period of time between October to May). During a staff interview on June 27, 2024, Director of Nursing revealed the facility did not have documentation of Resident 82's declination of the 2023-2024 influenza vaccination nor evidence that Resident 82 was provided education along with a vaccine information statement regarding the influenza vaccination. 28 Pa code 211.12(d)(1)(5) Nursing services