

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395311	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER Bryn Mawr Extended Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 956 Railroad Avenue Bryn Mawr, PA 19010	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>36609</p> <p>Based on observations, interviews with resident and staff and review of clinical records and facility policy, it was determined the facility did not ensure a baseline care plan was developed with interventions to prevent pressure injury or trauma for one resident diagnosed with diabetes of 28 residents reviewed. (Resident R86)</p> <p>Findings include:</p> <p>Review of the facility's policy for Comprehensive Care Planning revised March 2025 states, The facility will develop a comprehensive person centered care plan for each resident that includes measurable goals and timetables to meet the resident's medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment. The policy further states that a baseline care plan will be developed within the first 48 hours of admission to ensure the residents needs are met until the comprehensive care plan is completed.</p> <p>Review of Resident R86's Admission Minimum Data Set (MDS- is a standardized assessment tool used to evaluate resident functional status, cognitive abilities, and health conditions to develop care plans for the residents' needs) dated February 26, 2025, assessed the resident as cognitively impaired with fluctuating inattention, and disorganized thinking, bilateral lower extremity impairment, used a wheelchair to ambulate, incontinent of bowel and bladder, depended on staff for toileting and maintaining toileting hygiene, needed substantial assistants for hygiene (able to do less than half the effort), and needed partial or moderate assistance with bed mobility.</p> <p>Resident R86's MDS included diagnoses of a progressive neurological condition, high blood pressure, diabetes mellitus, cerebrovascular accident (CVA, stroke) dementia, malnutrition, Parkinson disease, and Psychotic disorder. The resident's MDS revealed a weight loss of 5% or more in the past month (Nutritional assessment on admitted d February 26, 2025 noted a significant weight loss of 8.5% in the past month, related to the resident not receiving any nutrition for four or more days in the hospital due to a bowel obstruction).</p> <p>(continued on next page)</p>

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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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The resident's MDS using Braden (a formal assessment tool) and clinical assessment indicated Resident R86's was at risk for developing a pressure ulcer noting no unstageable or unhealed pressure ulcer was found during the assessment. The MDS indicated the skin and ulcer treatments were in place, that include a pressure reducing device for chair and bed, noting there was no turning/repositioning program in place nor any application of dressings to feet were implemented at the time of admission. Continue review of the MDS revealed that the resident was assessed at risk for pressure ulcers. The MDS assessment indicated this care need was addressed in Resident R86's care plan.</p> <p>Further review of Resident R86's clinical record did not reveal a care plan for pressure ulcers nor was a care plan developed for the resident's risk of developing an open area to the skin, or heels, by injury, pressure and/or ulcer due to the resident's diagnosis of uncontrolled diabetes, decreased bed mobility, and substantial weight loss.</p> <p>28 Pa Code 211.10(a) Resident care policies</p> <p>28 Pa Code 211.10(c) Resident care policies</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>48347</p> <p>Based on review of facility policies and documentation, clinical record review, interview with staff, and observations, it was determined that the facility failed to ensure that a licensed nurse maintained professional standards of quality of care for one of four residents reviewed. This failure resulted in delay of medical treatment relating to one resident not receiving medications timely. (Resident R 41)</p> <p>Findings include:</p> <p>Review of facility document titled General Dose Preparation and Medication Administration revised April 4, 2024, revealed that prior to medication administration , the facility staff should take all measures required by the facility policy and applicable law, including but not limited to verifying each time a medication is administered and that it is the correct medication, correct dose correct route at the correct rate, at the correct time and for the correct resident. Further review of this policy states that medication must be administered within timeframes specified by the facility policy or manufacturers information.</p> <p>Review of facility policy titled Administering medications revised January 18, 2025, revealed that medications shall be administered in a safe and timely manner and in accordance with the physician order.</p> <p>Review of Resident R41's medication orders revealed orders for the following medication to be administered at 9:00 a.m.: Allopurinol 100 milligrams (mg) once a day, Amlodipine 10 mg, Cholecalciferol, Dorzolamide, Metoprolol 100 mg and Metoprolol 50 mg.</p> <p>Observation of Licensed nurse, Employee E15 on the first-floor nursing unit B on April 9, 2025 at 10:50 am, two hours after scheduled medication administration revealed Employee E15 appeared to be viewing a video playing on the facility computer on the med cart.</p> <p>Interview with Licensed nurse, Employee E15 at time of this observation, confirmed that she was watching the video on the computer, stating just catching up with Relias training (continuing education, compliance training for healthcare professionals). Asked if she was conducting medication pass, Employee E15 stated yes. Employee E15 shut off the playing of the video and then began preparation of medication to administer to Resident R 41. Employee 15 confirmed that the medications that she was preparing were Resident R41's morning medications which were due two hours prior. Employee E 15 stated she still had a few more residents to give medications to.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277</p> <p>Based on review of clinical records, observations, and staff and resident interviews, it was determined that the facility failed to timely provide assistance with incontinence care for one of 35 residents reviewed (Resident R9).</p> <p>Findings Include:</p> <p>Review of Resident R9's clinical record revealed a quarterly Minimum Data Set Assessment (MDS - federally mandated resident assessment and care screening) dated February 28, 2025, that indicated the resident was able to make her needs known, cognitively intact, and had diagnoses of anxiety, depression, and muscle weakness.</p> <p>Further review of Resident R9's MDS dated [DATE], revealed the resident was always urinary/bowel incontinent (loss of bowel and bladder control) and required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement).</p> <p>Interview on April 8, 2025, at 10:33 a.m. with Resident R9 revealed the resident had a bowel movement after breakfast and was waiting to be assisted with incontinence care. Resident R9 reported staff had been informed multiple times.</p> <p>Interview on April 8, 2025, at 10:36 a.m. with Resident R9's assigned nurse, Employee E7, revealed this nurse was aware Resident R9 was waiting to be assisted with incontinence care. Licensed Nurse, Employee E7, indicated Resident R9 informed the employee not that long ago and that Resident R9's nurse aide was informed and would be in when done helping a different resident.</p> <p>Interview on April 8, 2025, at 11:01 a.m. with Licensed Nurse, Employee E7, revealed the nurse just got done providing incontinence care for Resident R9 because the nurse aide was still assisting other residents.</p> <p>Observations on April 10, 2025, at 11:15 a.m. revealed the call light for Resident R9's room was engaged. Subsequent interview on April 10, 2025, at 11:15 a.m. with Resident R9 revealed the resident had a bowel movement and was in need of incontinence care.</p> <p>Observations on April 10, 2025, at 11:23 a.m. revealed Resident R9's call bell was off. Interview on April 10, 2025, at 11:23 a.m. with Resident R9 revealed a nurse aide came in and turned off the call bell and told the resident she would be back after done assisting another resident.</p> <p>Observations on April 10, 2025, at 11:48 a.m. revealed Resident R9's call bell was still turned off. Interview on April 10, 2025, at 11:48 a.m. with Resident R9 revealed the resident was still waiting for incontinence care.</p> <p>Observations on April 10, 2025, revealed the nurse aide did not provide incontinence care to Resident R9 until 11:50 a.m.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code 211.10 (d) Resident care policies.</p> <p>28 Pa. Code 211.12 (d)(5) Nursing services.</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347</p> <p>Based on observations, review of facility policies, clinical record reviews, and interviews with residents and staff, it was determined that the facility failed to provide an ongoing program to support residents in their choice of activities designed to meet the interests and physical, mental and psychosocial well-being on two of two nursing units. (1st and 2nd Floor)</p> <p>Findings include</p> <p>Review of facility policy titled Life Enrichment Programming Policy last revised May 4, 2023 revealed that it is the facilities policy to maintain an ongoing resident centered life enrichment program based on comprehensive assessments and care plans. The program will be designed to meet the interest including hobbies and preferences, and the abilities of each resident including their physical common mental, emotional, social, spiritual, psychosocial and leisure needs. This life enrichment (activities) program will create opportunities for each resident to have a meaningful life by supporting his or her domains of wellness. The life enrichment director will involve residents in all aspects of programming delivery planning preparation implementation cleanup evaluation, incorporating the residents expressed interest and preferences. Programs offered will reflect the spiritual and cultural diversity of all residents' programs will be designed to appeal to both genders as well as all age groups of residents residing in the community programs will be scheduled and offered 7 days a week including evening and weekend programs.</p> <p>Review of facility document life enrichment director job description revealed the primary purpose of this job is to enhance resident wellness and the quality of life through planning, organizing, developing, implementing and directing the overall life enrichment program and operation of the department in accordance with current federal, state and local standards, guidelines and regulations and established policies and procedures. Essential functions of this position are planned, develop, organize, implement, evaluate, supervise, and direct the life enrichment program of the community including providing adaptive life enrichment programs techniques equipment and materials as related to each resident specific needs.</p> <p>Review of facility activities calendar, the scheduled activities for April 8, 2025, include: morning greeting at 09:00a.m. follow by Daily chronicles at 10:00a.m. Brain Games at 11:00 a.m., Room visits at 1:00p.m., Taco Tuesday at 2:00p.m., and Fresh air break at 3:00 p.m.</p> <p>Review of facility calendar scheduled activities for April 9, 2025, morning greeting at 9:00 a.m., daily chonical at 10:00 a.m., [NAME] fitness at 11:00 a.m., room visits at 1:00 p.m., quarter bingo at 2:00 p.m., and fresh air brake at 3:00p.m.</p> <p>Review of facility calendar scheduled activities for April 10, 2025, revealed at morning greeting at 9:00 a.m., daily chonical at 10:00 a.m., room visits at 1:00 p.m., sunshine ministry at 2:00 p.m., and fresh air brake at 3:00 p.m.</p> <p>Further review of the facility April 2025 Activities Calendar revealed that daily chronicles, greeting, room visits and fresh air brake are offered daily with bingo repeated on ten days, activities of dining (taco Tuesday and ice cream social) offered every Tuesday.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of grievances from December 2024 the resident wanted to be included in activities. The result of this concern was resident was educated on the services and activities of the facility</p> <p>Interview with Resident R9 on April 9, 2025, at 12: 22 p.m. revealed the resident stated there are never any activities, only bingo, I don't like bingo. We have never been out of the facility on an activity, and never are allowed outside.</p> <p>Interview with Resident R84 on April 9 , 2025, at 12:25 p.m., confirmed her roommate allegation that there are never any activities, and stated the calendar is incorrect, the activities listed are never actually happening.</p> <p>Interview with Resident R8 on April 9, at 12:40 p.m. revealed that the facility has not asked what she would like to do and does not have any activities of interest. This resident does not like bingo and the only activity offered is bingo. The activities listed are never actually happening. Resident R8 would really enjoy activities if they were offered and provided.</p> <p>Interview with Resident R502 on April 10, 2025, at 9:20 a.m. revealed there are no activities. There is nothing to do in the facility. No one has ever come in the room to provide any activities or ask of any activities</p> <p>Interview with Resident R132 on April 10, 2025, at 9:20a.m. revealed no one has come to the room except nurses.</p> <p>Interview with Resident R501 on April 10, 2025, at 09:20a.m. revealed no activities that are of interest to this resident, no one has come in to discuss any activities or hobbies or any books or games.</p> <p>Interview with Resident R499 on April 10, 2025 at 9:20 a.m. revealed resident does not leave the room, there has been no one from the activities department to see him and or provide him with any activity or one to one time and conversation.</p> <p>Observation of activity Taco Tuesday on April 8, 2025, at 02:02 p.m. in the facility main dining room, ten resident were all seated side by side facing forward toward the front of the room where an employee was preparing the tacos. Residents were the served by Life Enrichment Assistant, Employee E10. The only activity observed were residents watching Employee E10 plate tacos and residents eating. Which is not providing the interests and physical, mental and psychosocial well-being of the residents.</p> <p>Observation on April 9, 2025, at 11:07 a.m. on the second-floor dining/ activity room where the activity [NAME] fitness was scheduled, four residents were observed seated at a table, one resident coloring in a coloring book, the other three residents observed just sitting at the table along with the Life Enrichment Assistant, Employee E14. The residents were seen not performing any activity specifically not exercising.</p> <p>Interview with Life Enrichment Assistant, Employee E14 at time of the above observation, stated that [NAME] was finished, this activity was held when she arrived at work that morning.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation of First floor nursing units A and B on April 9, 2025, at 1:00 p.m. through 1:25 p.m. revealed that there was no activity staff observed on the floor. According to the facility activity calendar, the activity room visits were scheduled. Continued observation on April 9, 2025, at 1:25 p.m. of the first-floor nursing units A and B revealed Life Enrichment Assistant, Employee E10 propelling a cart filled with snacks down the corridor.</p> <p>Interview with Life Enrichment Assistant, Employee E10 at time of the above observation revealed that as her life enrichment task, she offers the residents and employees the opportunity to purchases snacks. Employee E 10 confirmed that this is included as room visits for resident activity.</p> <p>Observation on April 10, 2025, at 9:00a.m. through 09:30 a.m. of First floor nursing units A and B revealed no activity staff observed on the floor. According to the facility activity calendar, the activity Morning Greeting was scheduled to take place at this time.</p> <p>Observation on April 10, 2025, at 9:40 a.m. revealed Life Enrichment Assistant Employee E10 supervising residents smoking at designated outside area.</p> <p>Interview with Life Enrichment Assistant, Employee E10 at the time of above observation revealed that Employee E10 was responsible for the first-floor unit A activity of greetings. Employee E10 confirmed that she had not conducted that activity as of this time. Asked what the activity greetings entailed, Employee E10 stated I go to all the resident on the unit and just check in with them, tell them about the day events, sometimes plays cards or does manicures</p> <p>Interview with Director of Life Enrichment, Employee E4 April 9, 2025, at 2:00 p.m. this employee stated that she speaks with the residents and attends resident meeting, the only activity she is aware of the residents request is bingo which has been added for additional days. A lot of the resident don't want to leave their room or participate in activities. This employee stated that the residents go outside and those on the second floor really enjoy the parachute game. Employee is not sure why there was a discrepancy of the timing of observed activities or does not know of any complaints of activities.</p> <p>28 Pa. Code 201.29(j) Resident rights</p> <p>28 Pa. Code 211.10 (d) Resident care policies</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>36609</p> <p>Based on observation, interviews with resident and staff, review of clinical records, and facility documentation, it was determined the facility failed to implement interventions to prevent the development of diabetic wound. This failure placed Resident R86 at risk for developing a diabetic wound to the right heel, requiring debridement and antibiotic therapy for one of 28 clinical records reviewed (Resident R86).</p> <p>Finding includes:</p> <p>Review of Resident R86's admission Minimum Data Set (MDS- standardized assessment tool used to evaluate resident functional status, cognitive abilities, and health conditions) dated February 26, 2025, revealed the resident was assessed as cognitively impaired with fluctuating inattention, and disorganized thinking. Continued review of the MDS revealed the resident had bilateral lower extremity impairment, and used a wheelchair to ambulate. Resident R86 needed substantial assistant for hygiene (able to do less than half the effort) and needed partial or moderate assistance with bed mobility.</p> <p>Review of Resident R86's MDS assessment included diagnoses of a progressive neurological condition, Diabetes Mellitus (failure of the body to produce insulin), Cerebral Vascular Accident (stroke), Dementia (progressive degenerative disease of the brain), malnutrition, and Parkinson Disease (progressive disease of the central nervous system).</p> <p>Review of Resident R86's nursing note dated March 24, 2025, revealed a discoloration to Resident R86's right heel, was identified and the resident was to use multi-podus boots (device use to float the heels) to bilateral feet to relieve pressure on the heels.</p> <p>Review of the facility's documentation dated March 24, 2025 revealed the discolored area found on the resident's right heel, included witness statements from nursing staff indicating the resident was observed pressing his/her foot against the foot board, also the resident confirmed to the staff he/she had been doing so.</p> <p>Review of Resident R86's March 2025 physician orders revealed a physician's ordered initiated March 25, 2025, to apply multipodus boot to bilateral feet when in bed.</p> <p>Review of Resident R86's current care plan failed to reveal a care plan for the risk of developing diabetic ulcers to the lower extremities due to the resident's diagnosis of diabetes and decreased bed mobility.</p> <p>Review of Resident R86's initial wound note by a wound physician dated March 27, 2025, revealed the right heel etiology was from the resident's diagnosis of diabetes. The measurements of the wound was 5.x 2.5 cm (unable to determine the depth).</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of same wound note revealed Resident R86 has a chronic wound which may or may not heal and could worsen due to resident's restricted mobility, thinning skin, reoccurring trauma, non-compliance. Continued review of same wound note revealed an overall prognosis determined to be fair and the overall goal for the wound is prevention of wound decline, offloading heels, and to turn the resident per facility protocol.</p> <p>Review of Resident R86's wound physician note dated April 3, 2025, revealed risk factors of diabetes, limited mobility, poor nutritional intake, and dementia and indicated the resident was at risk for developing pressure ulcers due to those risk factors.</p> <p>Interview conducted with Licensed nurse, Employee E5 on April 10, 2025, at 12:00 p.m. revealed the resident developed a pressure injury from his/her feet hitting the footboard and the need for wearing multi-podus boots in bed.</p> <p>Review of Resident R86's surgical note from wound physician dated April 10, 2025, revealed assessment and plans indicated Resident R86 has a wound on the right heel. The wound debrided today was at the right heel wound there was indication of tissue deterioration requiring ongoing administration and may very well need future debridement. No guarantee for wound healing can be made given the patients' risk factors/diagnoses that alter the state of this wound. The patient is also at risk for the development of a pressure injury as a result of the following risk factors of, poor nutritional intake, dementia, diabetes and limited mobility. The same assessment stated the resident has a chronic wound which may not heal and may worsen because of chronic comorbidities, thinning skin, recurring trauma, restricted mobility, noncompliance, maceration of wound edges and peripheral arterial disease resulting in poor tissue perfusion possible further tissue breakdown.</p> <p>Observation conducted on April 10, 2025, at 12:10 p.m. with Licensed Nurse, Employee E4, revealed Resident R86 laying in bed, barefoot with his feet crossed at the ankles. The resident was not wearing multi-podus boots. Resident R86 stated, I don't wear the boots (multi-podus boots). I bang my feet against the footboard because I slide down from the bed and my feet keep hitting the footboard. Nurse, E4 stated, I see (him/her) slide down from the bed and it causes (him/her) to press (his/her) feet against the footboard. It's the reason why (he/she) has the wound. Resident R86 complained it was painful when the nurse removed the dressing. The wound was covered in a medicated dressing that had purulent drainage (thick, opaque, greenish - brown drainage).</p> <p>Interview conducted with the wound doctor on April 10, 2025, at 2:30 p.m. revealed, the wound was debrided today and he placed the resident on antibiotics because the wound is now infected. The physician stated that it may have started as a diabetic wound but now, from the pressure of [his/her] feet without using proper footwear it has become worse. I spoke to the staff I could not stress enough how important proper footwear is and explained bending [his/her] knees propped with a pillow would prevent the resident from sliding and causing the pressure.</p> <p>Review of nursing note dated April 10, 2025 revealed the resident was ordered Keflex 500 milligrams twice a day for 10 days for right heel wound infection.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code: 201.18 (b)(1) Management</p> <p>(continued on next page)</p>		

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code: 211.10 (c)(d) Resident care policies 28 Pa. Code: 211.12 (d)(1) Nursing services 28 Pa. Code: 211.12 (d)(2) Nursing services 28 Pa. Code: 211.12 (d)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395311	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2025
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>48347</p> <p>Based on review of facility policy, review of clinical records, resident and staff interview and observation, it was determined that the facility failed to provide an environment that is free from accident and hazards relating to adequate supervision and smoking safety.</p> <p>Findings include:</p> <p>Review of facility policy titled resident smoking policy last revised December 20, 2022 revealed facility has established residents smoking processes that take into account both smoking and non-smoking residents and that comply with applicable federal, state and local laws and regulations regarding smoking areas and smoking safety.</p> <p>Review of facility policy reveal resident who smoke will be required to sign a safe smoking and agree to abide by the rule regarding safe smoking or they will forfeit the privilege. Residents may only smoke on designate locations. Required supervision will smoke only at designated times independent smokers may smoke at any time but must sign out.</p> <p>Residents who smoke or desire to smoke will be required to sign a safe smoking contract and agree to abide by the rules regarding safe smoking or they will forfeit their smoking privileges residents may only smoke on premise in designated locations. Those requiring supervision will only smoke at designated times.</p> <p>Review of resident safe smoking agreement revealed rules and regulations including residents required supervision may smoke only a designated times and then designate locations when on facility grounds.</p> <p>Review of facility documented resident smoking list revealed</p> <p>resident R131, R14, R132, R51, R15, R88, R139, R19, R6, R66, R81</p> <p>Review Residents' R131, R14, R51, R15, R88, R19, R66, R81 care plan revealed the following interventions: Educate as to the benefits of quitting and the risks associated with smoking, smoking items to be kept at nurse's station or per specific routine. Provide supervision at times of smoking, and smoking apron to be worn when smoking.</p> <p>Observation on April 8, 2025 at 2:00 p.m. revealed the facility main dining room first floor the designated smoking was viewed. Observation of five resident outside smoking, there was no staff member outside supervising the smoking activity .</p> <p>Interview with Life Enrichment Director, Employee E4 at the time of the observation revealed that some of the employees did not like to go outside so they watch from the window.</p> <p>Interview with Resident R14 at time of the observation revealed that they never have staff outside, they do not need a babysitter.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation April 10, 2025 at 9:40 a.m. of the facility designated smoking area revealed 7 residents outside smoking and no staff present with these residents who were smoking.</p> <p>28 Pa. Code 201.18 (b)(1)(e) Management</p> <p>28 Pa. Code 211.12 (d)(1)(5) Nursing services</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609</p> <p>Based on review of clinical records, facility policy and interviews with staff, it was determined that the facility failed to ensure that a follow- up appointment was scheduled with an urologist for a resident with an an indwelling urinary catheter for one of 28 resident records reviewed (Resident R121).</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Continence Management Program revised on June 7, 2023, states the facility will provide services to restore or improve normal bladder function.</p> <p>Resident R121 was admitted to the facility on [DATE], diagnosed with benign prostate hyperplasia with lower urinary tract symptoms (an enlarge prostate gland that can cause various urinary problems).</p> <p>Review of Resident R121's nursing note dated December 14, 2024 stated Resident R121 failed to urinate for eight hours on the 7-3 shift. The nurse assessed the resident's abdomen noting it was distended and painful when palpated. The nurse received orders to straight catheterize Resident R121 (to manually insert a tube to the bladder for voiding). No urine was produced and the resident was sent to the hospital diagnosed with urinary retention, a urinary tract infection and a catheter was inserted for voiding.</p> <p>Review of Resident R121 documentation revealed a urinary consults with the urologist dated January 17, 2025 reminding of an upcoming appointment on January 28, 2025 for a cystoscopy (using a small telescope to look at the bladder). Additional visits to the urologist were made until the last appointment, dated February 19, 2025 that indicated to refer to the doctor for discussion of two treatment options. Continue review of Resident R121's clinical record did not reveal this appointment was scheduled.</p> <p>Unit Manager, Employee E5 confirmed the facility failed to follow-up with Resident R121 regarding the resident's treatment options for the indwelling urinary catheter.</p> <p>28 Pa. Code 201. 18(b)(1) Management.</p> <p>28 Pa code:211.10(c)(d) Resident care policies.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>46508</p> <p>Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to ensure the identified pharmacy review irregularities were implemented for one of five residents reviewed (Resident R63).</p> <p>Findings Include:</p> <p>Review of facility policy on Medication Regimen Review (MRR) Section Procedure, #9 revealed that the facility should encourage the physician/provider or other responsible parties receiving the MRR (Medical Record) and the Director of Nursing to act upon the recommendations contained within the MRR. #9.1 For those issues that require physician/prescriber intervention, facility should encourage physician/prescriber to either accept and act upon the recommendations contained within the MRR or reject all or some of the recommendations contained in the MMR and provide an explanation as to why the recommendation was rejected. #9.2 The attending physician should document in the resident's health record that the identified irregularity has been reviewed and what if any action is taken to address it. #9.2.2 If the attending physician prescriber decided to make no change in the medication, the attending physician document the rationale in the resident's health record.</p> <p>Review of Pharmacy Consultation Report for Resident R63 with recommendation date of December 17, 2024, revealed that under section comment: Resident R63 has received Eszopiclone 2 milligrams at bedtime for insomnia since 5/2024. Under section Recommendation: Please consider if a gradual dose reduction could be attempted at this time.</p> <p>Further review f the Pharmacy Consultation Report revealed an illegible undated, initial on the report. Further the word decline was written below the undated signature.</p> <p>Further review of the Pharmacy Consultation Report revealed no documented evidence that the pharmacist's recommendation has been reviewed by the physician. Further there was no documented evidence of any, action taken by the physician to address the recommendation including rationale if there is to be no change in the medication.</p> <p>Interview with DON (Director of Nursing) Employee E2 conducted on April 10, 2025, at 11:19AM confirmed that the Pharmacy Consultation Report for Resident R63 with recommendation date of December 17, 2024, had an undated initial, did not have documented evidence that the pharmacist's recommendation has been reviewed by the physician. Further Employee E2 also confirmed that there was no documented evidence of any, action taken by the physician to address the recommendation including rationale if there is to be no change in the medication.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Pharmacy Consultation Report for Resident R63 with recommendation date of February 18, 2024, revealed that under section comment: Resident R63 has received Cyclobenzaprine 5 mg three times daily since 10/1/2024 and may be at risk for or experiencing adverse effects related to the anticholinergic properties of this medication. Under section Recommendation: Please reevaluate ongoing use of Cyclobenzaprine and consider if dosing reductions could be attempted. Under section physician's response, the section for I decline the recommendation above and do not wish to implement any changes due to the reasons below was checked off however section Rationale was not filled out. There was no rationale documented in the resident's clinical record.</p> <p>Interview with DON Employee E2 conducted on April 10, 2025, at 11:19AM confirmed that the Pharmacy Consultation Report for Resident R63 with recommendation date of February 18, 2025, had a pharmacy recommendation to reevaluate ongoing use of Cyclobenzaprine and consider if dosing reductions could be attempted and there was no documented rationale for the declination of the pharmacy recommendation.</p> <p>28 Pa. Code 211.9 (a)(1) Pharmacy services.</p> <p>28 Pa Code 211.12 (d)(5) Nursing Services.</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508</p> <p>Based on observations, review of facility documentation and interviews with residents and staff, it was determined that the facility failed to ensure that meals were served timely for one of 28 residents reviewed (Residents R47)</p> <p>Findings include:</p> <p>Review of Resident R47's clinical record revealed that resident was admitted to the facility on [DATE], with diagnoses of but not limited to Type 2 Diabetes (failure of the body to produce insulin), and Anemia (low red blood count).</p> <p>Review of Resident R47's quarterly MDS (minimum data set- a federally required assessment completed at a specific interval) dated March 11, 2025, section C0500 BIMS (brief interview for mental status) revealed a score of 15 suggesting that Resident R47 was cognitively intact.</p> <p>Review of physician's order revealed an order dated August 21, 2024, to: Monitor meal consumption during mealtimes.</p> <p>Further review of physician's order revealed an order dated March 21, 2025, for No added salt large portion diet.</p> <p>Review of April 2025 MAR (Medication Administration Record) revealed that under order for Monitor meal consumption during meal times, on May 7, 2025, 9:00 a.m. was left blank, a.m. and p.m. snack was also left blank.</p> <p>Interview with Resident R47 conducted during tour of the second-floor unit on April 7, 2025, at 11:16 a.m. revealed that Resident R47 did not get breakfast. Further, Resident R47 revealed that she informed the nursing supervisor Employee E3 she did not get her breakfast. Further Resident R47 also revealed that dinner tray was just picked up.</p> <p>Interview with nursing supervisor, Employee E3 conducted on April 7, 2025, at 11:53 confirmed that Resident R47 did not get her breakfast. Further Employee E3 revealed that the staff probably got confused with the dinner tray from the night before that was on her table. Further Employee E3 also revealed that someone is now getting Resident R47's tray from the kitchen.</p> <p>Further observation revealed that staff had brought Resident R47 a cold cereal and milk on April 7, 2025, at 12:02 PM which Resident R47 refused. Interview with Resident R47 conducted at the time of the observation revealed that she didn't want cereal for breakfast and that it was very late, and that lunch will be coming up soon.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(3) Management</p>		

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<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609</p> <p>Based on interviews, and review of clinical records, it was determined the facility failed to provide outside services for one of 28 resident records reviewed (Resident R117).</p> <p>Findings include:</p> <p>Resident R117 was admitted [DATE] diagnosed with Polymyalgia rheumatica (PMR a rheumatic inflammatory disorder characterized by muscle pain and stiffness, primarily in the shoulders and hips, often accompanied by fatigue and systemic symptoms, like fever and weight loss.)</p> <p>Review of Resident R117's progress note dated March 26, 2025 indicated the resident's physiatrist recommended a rheumatology consultation. The note further stated the physician was in agreement.</p> <p>Continue review of Resident R117's clinical record revealed no evidence an appointment for a rheumatologist was scheduled. This was confirmed with the Unit Manager Employee E5 on April 9, 2025, at 3:00 p.m.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609</p> <p>Based on interviews with staff, and review of clinical records, it was determined that the facility failed to ensure that hospice documentation was complete for one of 28 residents reviewed. (Resident R54)</p> <p>Findings include:</p> <p>Resident R54 was readmitted to the facility [DATE], with diagnosed with Senile degeneration of brain, not elsewhere classified, Major depressive disorder, generalized anxiety disorder, Unspecified psychosis not due to a substance or known physiological condition, hypertension, Unspecified glaucoma, Vitamin B deficiency, unspecified, Muscle weakness (generalized), and abnormalities of gait and mobility.</p> <p>Review of Resident R54 physician orders revealed the resident was placed on hospice, [DATE]. Review of the most recent hospice plan of care, and recertification period had expired. Continue review of Resident R54's hospice documentation revealed incomplete/missing correspondence from the hospice staff providing care.</p> <p>The Nursing home administrator confirmed on [DATE], at 2:00 p.m. Resident R54's last day of Hospice was on [DATE], and could not supply further documentation for the missing notes.</p> <p>28 Pa. Code 211.5(f)(ix) Medical records</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347</p> <p>Based on observations, review of facility policies, review of facility documentation, review of clinical records, and staff interviews, it was determined that the facility failed to establish an effective infection control program related to use of personal protective equipment with enhanced barrier precautions for two of four residents reviewed. (Resident R499 and R10)</p> <p>Findings include:</p> <p>Review of Resident R499's clinical record revealed that this resident has diagnosis' including sepsis, acute kidney failure, dysphasia (difficulty swallowing foods or liquids) peritoneal abscess (collection of pus in the abdominal cavity) delirium (disturbance in mental abilities that result in confused thinking) retention of urine(A blockage that prevents urine from leaving the bladder) and malnutrition .</p> <p>Review of Resident R499's care plan dated April 4, 2025, revealed that resident has a diagnosis of Clostridium Difficile. (C-Diff-highly contagious bacteria that can cause serious infections of the colon).</p> <p>Review of Resident R499's care plan dated April 4, 2025, revealed that resident has a diagnosis of sepsis (the body's extreme immune reaction to an infection, potentially life threatening).</p> <p>Review of resident's physician orders revealed an order dated April 6, 2025, for isolation/ transmission-based precautions/ isolation related to diagnosis of C-diff.</p> <p>Review of Resident 499 clinical record revealed that the resident was admitted [DATE] from the hospital with a diagnosis of sepsis with special needs of isolation for MRSA (methicillin- resistant staphylococcus aureus-infection caused by a type of bacteria that is resistant to many antibiotics) , C-diff (highly contagious bacteria that can cause serious infections of the colon), and ESBL (extended spectrum beta- lactamase, an enzyme that make antibiotic ineffective against bacterial infections)</p> <p>Observation of Resident R 499's room door revealed signage stating STOP enhanced barrier precautions . Everyone must clean hands before and after entering or leaving the room. Providers and staff must wear gloves and gown for high contact resident care activities such as dressing, bathing, transferring, changing linens, providing hygiene, changing briefs, device care (central line, urinary catheter, feeding tube, or tracheostomy and while providing wound care.</p> <p>Observation of Licensed nurse, Employee E17 on April 7, 2025 at 11:37 p.m. responding to resident infusion pump alarm (signaling the end of medication administration), ending for Resident R499 intravenous antibiotic, revealed that Employee E17 shut off the matching and flushed both intravenous lines (delivery of medications directly through a vein) and administering the medication Heparin. Licensed nurse, Employee E17 was observed wearing only gloves.</p> <p>Interview with Licensed nurse, Employee E17 at time of the above observation confirmed that she was aware the resident was on enhanced barrier precaution and she did not wear proper PPE.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Nursing Home Administrator, Employee E 1 and Director of Nursing (DON), Employee E 2 on April 7, 2025 at 12:05 p.m. revealed that neither employee is certain of the residents precautions. DON, Employee E2 confirmed that the care plan and physician orders stated that resident R499 was diagnosed with C-idff but not sure why that was documented. Employee E2 stated that the resident was no longer on isolation precaution, the resident no longer had the infection C-diff and was only on antibiotics as prophylactic .</p> <p>Observation on April 7, 2025 at 1:48 p.m. revealed Physical Therapist, Employee E12 and Occupational Therapist Employee E11, both were observed providing physical therapy which involved contact with this resident at bedside. Neither employees were wearing proper PPE.</p> <p>Interview with Occupational Therapist, Employee E11 at time of above observation, revealed that she was only required to wear glove during therapy.</p> <p>Interview with DON, Employee E 2 on April 7, 2025 at 2:14 p.m. revealed that the resident provided hospital documentation that was discharges from hospital being cleared of Cdiff infection and only required the precaution of enhanced barrier.</p> <p>Review of Resident R10's comprehensive MDS (federally mandated resident assessment and care screening) dated February 23, 2025, revealed the resident was cognitively intact and had an indwelling catheter (also known as foley catheter - a flexible tube placed through the urethra into the bladder to help urinate and collect urine into a drainage bag).</p> <p>Interview on April 8, 2025, at 10:26 a.m. with Resident R10 confirmed the resident still had a foley catheter. Observations revealed signage placed on Resident R10's door that indicated that the resident required enhanced barrier precautions.</p> <p>Observations on April 10, 2025, at 11:50 a.m. revealed nurse aide, Employee E8, went in to provide care for Resident R10. Nurse aide, Employee E8, did not have a gown on to provide care. Subsequent interview with Nurse aide, Employee E8, revealed the employee was unaware a gown needed to be worn.</p> <p>28 Pa. Code 211.10(d) Resident Care Policies</p> <p>28 Pa. Code 211.12 (c)(d)(1) Nursing services</p>		