STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395330	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheltenham Nursing and Rehab C	600 W Cheltenham Avenue Philadelphia, PA 19126

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 36609 Based on interviews with staff, review of clinical records, and facility documentation, it was determined the facility failed to protect Resident R112 from Resident R46 who had a history of verbal aggression towards Resident R112. This failure resulted in actual harm to Resident R112 who sustained a closed head injury and a fractured right finger when Resident R46 became physically violent towards Resident R112 for two of 33 resident records reviewed. (Resident R112 and Resident R46) Findings include: Review of Resident R46's quarterly MDS assessment (Minimum Data Set, assessment tool used to evaluate the functional abilities and cognitive status of a resident) dated July 16, 2024, revealed the resident was alert and oriented, capable of making independent decisions, diagnosed with Epilepsy, (chronic brain disorder that causes seizures) and Hemiplegia (one sided weakness) affecting the right dominate side. The resident was assessed as independent in all activities of daily living (ADL), including walking, and transferring and was continent of bowel and bladder. Review of Resident R112's quarterly MDS assessment, dated August 15, 2024, assessed the resident with severe cognitive impairment, diagnosed with Schizophrenia (chronic mental disorder) and Dementia (progressive degenerative disease of the brain). The resident was occasionally incontinent of urine and frequently incontinent of bowel, used a walker for ambulating and needed supervision with activities of daily needs. Review of Resident R112 care plan dated May 11, 2021, revealed a care plan developed for incontinence care and Activities of Daily Living. The resident was care planned for requiring staff assistance when needed. Review of Resident R46's nurses' notes dated, May 2, 2024, indicated a verbal altercation occurred between Residents R46 and R112. Resident R46 was heard yelling from bathroom door to Resident R112, cursing and threatening the resident, saying he would, 'Beat you the f-k up,' and 'You don't know me.' Resident R46 was asked to close the door and calm down, and social services was notified. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of written statement taken by Social Services during an interview with Resident R112 and Resident R46 dated May 2, 2024 revealed, Resident R112 said [he/she] called the resident the N word because [Resident 46] kept yelling about the toilet. Resident R46 said [he/she] got into an argument because [he/she] keeps leaving the toilet clogged. When Resident R46 told the resident about it, Resident R46 said [he/she] was called the N word. Review of weekly nursing note dated June 3, 2024, states, Resident R46 frequently screams and curses at roommate related to shared bathroom. Review of Resident R112's nursing note dated October 12, 2024 revealed the nurse aide called this nurse around 6:10 a.m. and reported the resident is bleeding from [his/her] head and resident stated that a black guy hit [resident] on [resident] head. This nurse immediately responded and found resident sitting in a chair in front of [his/her] room bleeding from [his/her] head. Nursing supervisor made aware. Upon assessment laceration noted on the top of the head, on the middle of the head and also a laceration noted on the back of [his/her] head with hematoma. Resident also both with a small cut and a swollen and bruised right pinky finger. Resident is alert and awake with some period of confusion, able to make need known with no loss of consciousness. The resident was asked if he/she fell and the resident denied falling. This writer asked resident what happened and resident stated that [he/she] was coming out of the bathroom and a black guy hit [him/her] on [his/her] head with a cane. The physician was notified and order to send resident to the emergency room for evaluation. Review of information dated October 12, 2024 submitted by the facility on October 12, 2024 to the State Agency, revealed Resident R112 was seen walking to [his/her] bedroom with blood on [his/her] face. Resident R112 was noted to have a hematoma on the back of the head, a laceration on top of head and finger. The resident attending physician was notified and Resident R112 was sent to the hospital for evaluation. Continue review of information dated and submitted by the facility on October 12, 2024 to the State Agency revealed Resident R112 was treated at the hospital for a closed non displaced fracture of the proximal phalanx of the right little finger and a closed head injury. Further review of information dated October 12, 2024 and submitted by the facility on October 12, 2024 to the State Agency revealed the Nursing Home Administrator interviewed Resident Resident R107 who was R112's roommate. Resident R107 witnessed next-door-neighbor (Resident R46), who they share a bathroom with, push Resident R112 and hit [Resident R112] with [his/her] cane. The investigation concluded that Resident R46 was identified as the perpetrator and the facility substantiated the resident-to-resident altercation as abuse. The facility failed to ensure that Resident R112 was free from physical abuse from Resident R46 with a history of verbal aggression towards Resident R112. This failure resulted in actual harm to Resident R112 who sustained a closed head injury and a right fractured finger when Resident R46 became physically violent towards Resident R112. 28 Pa. Code 201.29 (c)(3)(4) Resident rights 28 Pa. Code 211.12(d)(1) Nursing services

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609 Based on review of clinical records, review of facility policy,and interviews with staff, it was determined that the facility failed to develop and implement a comprehensive care plan related to Resident R46's diagnosis of physical aggression, paranoia, insomnia and Resident R170 needing oxygen therapy for two of 33 resident records reviewed Findings include: Review of the facility policy titled, Comprehensive Care Plan, dated November 2019, states, It is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Review of Resident R46's quarterly MDS (Minimum Data Set, an assessment tool used to evaluate the functional abilities and cognitive status of a resident) dated July 16, 2024, revealed the resident was alert and oriented capable of making independent decisions, diagnosed with epilepsy, (a chronic brain disorder that causes seizures) and hemiplegia (one sided weakness) affecting the right dominate side. The resident was assessed as independent in all activities of daily living (ADL), including walking, and transferring and was continent of bowel and bladder. Review of Resident R46's nurses' notes dated, May 2, 2024, indicated a verbal altercation between both residents. Resident R46 was heard yelling from bathroom door to Resident R112, cursing and threatening the resident, saying he would, 'Beat you the f-k up,' and 'You don't know me'. Resident R46 was asked to close the door and calm down. Weekly nursing note dated June 3, 2024, states, Resident R46 frequently screams and curses at roommate related to shared bathroom. Review of facility documentation and resident's witness statement revealed on October 12, 2024 Resident R46 was seen to push Resident R112 and hit him/her with his/her cane. This caused Resident R112 a hematoma to the back of his head, a laceration to the front, and a fractured finger. Review of Resident R46's psychiatric note dated October 22, 2024, noted the physical aggression towards another resident. The note further stated that the resident was paranoid and suspicious, and that the resident stated, People been watching my moments too much and I don't like it. The same note, listed medications Trazadone and Melatonin given for insomnia and Risperdal an antipsychotic given for unspecified psychosis. Further review of Resident R46's clinical record revealed no evidence a care plan was developed for the resident's physical aggression, paranoia and suspicious behaviors, including the May 2, 2024, and October 12, 2024 altercation with Resident R112. Furthermore, the facility failed to develop a care plan for Resident R46 for the diagnosis of insomnia and taking an antipsychotic medication for his diagnosis of psychosis. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation conducted on December 16, 2024, at 11:15 am during tour of the second-floor unit revealed that Resident R170 was in bed awake. Further observation revealed that Resident R170 was on oxygen concentrator via nasal cannula running at 2 liters per minute. Interview with Resident R 170 at the time of the observation revealed that she did not know when her oxygen was started. Further Resident R170 did not provide any more information during the interview. Review of Resident R170's clinical record revealed that Resident R170 was admitted to the facility on [DATE], with diagnoses of Anemia and Acute Myeloblastic Leukemia (cancer of the blood and bone marrow). Further review of Resident R170's clinical record revealed a physician's order for 2 liters of oxygen as needed for SOB (shortness of breath) - ordered December 15, 2024. Further review of Resident R170's clinical record revealed that there was no care plan develop to address Resident R170's shortness of breath and the need for oxygen use. Interview with ADON (Assistant Director of Nursing) Employee E9 conducted on December 18, 2024, at 2:43 pm confirmed that there was no care plan for respiratory or oxygen use developed for Resident R170. Refer to F600 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.10 (d)(1) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 06525 Based on review of clinical records, interviews with staff, and facility policy, it was determined the facility failed to provide treatment and services in accordance with professional standards of practice related to a failure to conduct routine testing to verify therapeudic levels of a seizure medication. The facility failed to clarify the orders when a medication for epilepsy was decreased in error, and failed to inform the physician of a recommended psychotropic dose increase for one of 33 resident records reviewed. (Resident R46) Findings included: Review of the facility's policy, Medication and Treatment Orders revised October 2016 states, Orders for medications and treatments will be consistent with principles of safe and effective order writing . Review of Resident R46's quarterly MDS (Minimum Data Set, an assessment tool used to evaluate the functional abilities and cognitive status of a resident) dated July 16, 2024, revealed the resident was alert and oriented capable of making independent decisions, diagnosed with epilepsy, (a chronic brain disorder that causes seizures) and hemiplegia (one sided weakness) affecting the right dominate side. The resident was assessed as independent in all activities of daily living (ADL), including walking, and transferring and was continent of bowel and bladder. On admission, dated October 23, 2024, Resident R46 was ordered Depakote (used to prevent seizures and for certain psychiatric conditions) instructed to give three, 125 milligrams (mg) tablets of Depakote (equally 375 mg), twice a day (daily total of 750 mg) for the resident's diagnosis of Epilepsy. Review of Resident R46's care plan dated October 24, 2024, for the resident's diagnosis of seizures stated seizure medications will be maintained at therapeutic levels with interventions that include to obtain and monitor labs/diagnostics work. Review of Resident R46's nursing note dated June 3, 2024, stated the resident was seen by psychology and the resident's Depakote increased from 125mg to 250mg twice a day. This order was not clarified, instead the dose was decreased, now receiving 250 mg twice a day to equal 500 mg daily. The new order was administered from June 4, 2024, to June 17, 1014. On June 18, 2024, the Depakote was increased back to the original dose of 750 mg a day. On December 18 and 19, 2024 the Nursing Home Administrator (NHA) and the Director of Nursing (DON) were asked what the facility's policy/protocol was for testing residents' Depakote levels. The NHA and DON failed to answer nor provide documentation. During the same time the NHA and DON were questioned as to why Resident R46's Depakote was lowered by psychiatry, when the resident was taking the medication for epilepsy not for a mental illness. The NHA and DON failed to answer, nor provide supporting documentation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident R46's clinical records revealed Depakote levels were tested on admission, dated, October 23, 2023, no further documented evidence therapeutic levels were tested prior to lowering the dose on June 4, 2024. On October 22, 2024, psychiatric note indicated Resident R46's order for Risperdal (an antipsychotic medication) be increased to 1 mg due to the resident's increased paranoia and aggression. Surveyor requested and the NHA confirmed there was no documented evidence the physician was made aware of this recommendation and the dose was not increased. During an interview with the psychiatrist on December 19, 2024, at 12:00 p.m. confirmed the dose of Depakote should not have changed. The psychiatrist explained it was to simplify the number of pills given to the resident at one time, from three-125 mg of Depakote twice a day to one 250 mg pill in the morning and 2-250 mg pill in the evening. The psychiatrist indicated Depakote levels should be done every six months to ensure they are at the therapeutic levels for residents taking the medication for seizures. During the same interview it was also confirmed the recommended increase in Risperdal to 1 mg was not completed. 28 Pa. Code 211.12(d)(1) Nursing services

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508 Based on observations, review of facility policy, review of clinical records, and staff and resident interviews, it was determined that the facility failed to ensure that residents with limited range of motion received treatment and services to maintain or improve range of motion/mobility for two of 36 residents reviewed for limited range of motion (Resident R7 and Resident R37). Findings include: Observation conducted during the tour of the second-floor unit on December 16, 2024, at 9:34 am revealed that Resident R7 was in bed with his left arm in a fixed position on his chest. Review of Resident R7's clinical record revealed that Resident R7 was admitted to the facility on [DATE], with diagnoses of but not limited to Paraplegia, Multiple Sclerosis, Acquired Absence of Right and Left Leg, Muscle Weakness, Contractures of Muscles Multiple Sites. Review of Resident R7's quarterly MDS (Minimum Data Set, a federally required assessment completed at a specific interval) dated October 7, 2024 section GG0115 (Functional Limitation in Range of Motion), revealed that A. Upper extremity (shoulder, elbow, wrist, hand) was coded 1 indicating that resident R7 had impairment on one side, B. Lower extremity (hip, knee, ankle, foot) was coded 2, indicating that Resident R7 had impairment on both sides Review of occupational therapy notes revealed that resident was receiving occupational therapy services from November 25, 2024, through October 11, 2024, with discharge recommendations to continue with previously established splinting. Review of Resident R7's clinical record revealed the following previously established restorative nursing program: Nursing Maintenance Program- Passive ROM (range of motion) in all planes 2 x15 as tolerated to prevent further joint stiffness daily dated 12/19/23 Nursing Maintenance Program-Don bilateral resting hand splint 2 hour/day with skin checks pre/post, and hygiene performed before and after as tolerated-dated 8/9/24 Nursing Maintenance Program-Resident will wear left hand palm protector with finger separators for 3 hours/day. assess [NAME] at donning/doffing and provide hygiene daily as tolerated dated 12/3/23 Nursing Maintenance Program-Splinting- Patient to tolerate left elbow extension splint for 2 hours/day with skin checks pre/post as tolerate-dated 8/12/24 Further review of Resident R7's clinical record revealed no documented evidence that restorative nursing program/splinting was provided to Resident R7. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with ADON (assistant director of nursing) Employee E9 conducted on December 19, 2024, at 10:57 a.m. confirmed that there was no documentation indicating that that restorative nursing program/splinting was provided to Resident R7. Review of Resident R37's clinical record revealed that Resident R37 was originally admitted to the facility on [DATE], with the most recent readmitted [DATE]. with diagnoses of CVA (Cerebrovascular Accident-stroke) Hemiplegia/Hemiparesis (paralysis/weakness of one side of the body), Muscle weakness, Contracture of unspecified joint. Review of OT (Occupational Therapy) discharge summary dated December 2, 2024, revealed a recommendation for: Restorative Splint and Brace Program. Resume prior RNP (Restorative Nursing Program) for daily management with skin checks pre and post. Review of Resident R37's clinical record revealed the following previously established restorative nursing program: Nursing Maintenance Program Ambulation with Hemi walker with +1 contact guard assistance/min for 20-30 feet with wheelchair follow as tolerated to be completed daily. Ensure resident wears appropriate footwear or nonskid sock, allow to take time or breaks as needed. Dated November 30, 2023 Nursing Maintenance Program-Apply left hand splint during the nighttime hours as tolerated to decrease stiffness. Inspect skin before and after application. Review of Resident R37's care plan initiated on November 20, 2023, revealed the following: Resident R37 will wear a left-hand splint for 6 hours a day, Splint to be applied at 10 p.m. and removed at 4 a.m, Nursing to assess residents' skin at the time of application and removal of the brace for alterations in skin integrity and provide hygiene-Dated December 3, 2023 Nursing Maintenance Program-Left resting hand splint don in am and doff in pm (at least 4 hours) with skin checks before and after application. refer to PT/OT as needed-Dated December 3, 2024 Further review of Resident R37's clinical record revealed that there was no documented evidence that the previously established Restorative Nursing Program or Nursing Maintenance Program was reinstated and provided to Resident R37. Interview with ADON (Assistant Director of Nursing) conducted on December 29, 2024, at 10:58 am confirmed that there was no documented evidence that Restorative nursing/splinting was provided to Resident R37 Observation conducted during the tour of the second-floor unit on December 17, 2024, at 11:05 am revealed that Resident R37 was in bed with her left arm on her side. Follow-up observation on Resident R37 conducted with Director of Rehab, Employee E10 on December 18, 2024, at 1:36 pm revealed that Resident R37 was in the hall way of the second floor unit, sitting on a wheelchair. Further, Resident R37's left upper and lower extremities were limp. Interview with Employee E10 confirmed that Resident R7 had a left sided hemiplegia. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident R37 in the presence of Employee E10 conducted at the time of the observation revealed that no one puts her and that she is not able to put it in on on her own. Upon further interview with Resident R37, she revealed that sometimes one of the staff will put it on her at night. Observation of Resident R37's room together with Employee E10 revealed that there were no splints in her drawers, bed side table or anywhere in her room. Employee E10 stated that she will get Resident R37 a new pair of splints. 28 Pa Code 211.10(d) Resident care policies 28 Pa. Code 211.12 (d)(1)(3) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347 Based on the review of clinical records, observation, facility documentation and interviews with staff, it was determined that the facility failed to ensure that the residents' environment was free of accident hazards, and failed to ensure that hazardous material were not accessible to a resident in one nursing unit of one of three nursing units. (Third floor) Findings include: Review of Resident R575's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnosis' including opioid dependence with withdraw, other psychoactive substance dependence, homicidal ideations, nicotine dependence with withdrawal, homelessness, and suicide attempt. Review of MDS (minimum data set, assessment of resident care needs) for Resident R575 dated December 11, 2024, revealed that the Resident R 575 had a BIMS (brief interview for mental status) score of 15 which indicated the cognitive status of the resident was intact. Review of hospital record for Resident R 575 dated November 7, 2024, revealed the Resident reports that he had head injury in 1995 and report significant anger issues. The resident has a history of suicide ideation, homicide ideation, opioid use disorder spent most of his life in prison. Review of care plan for Resident R 575 dated December 5, 2024, revealed the resident was noted with a history of suicide attempt. Interventions included to allow the resident to express feelings and offer support, consult psychology, the door to residence room to be left open, items with resident could harm self to be removed from resident's room, residents be maintained on every hour check, and resident will use plastic utensils during meals. Also included in the intervention is a tap bell (no cords attached) given in place of call bell light for safety. Observation of Resident R575 on December 18, 2024, at 11:50 a.m. revealed Resident R575 standing in the doorway of the resident's room with 2 razors in hand. Interview with Resident R575 at time of above observation revealed that razors were found in the bathroom, set on the sick, they were left by Employee E4 nursing assistant. Interview with Employee E4, nursing assistant on December 18, 2024 confirmed that this employee accidently left the razors in the bathroom. Interview with Director of Nursing (DON), Employee E2 and administrator and Employee E1 on December 18, 2024, at 2:10 p.m. confirmed Resident 575 has history of behaviors and has care intervention in place for prevention of harm. DON confirmed that the resident should not have had access to razors. 28 Pa. Code 211.10(d) resident care policies (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.14(a) responsibility of licensee 28 Pa. Code 211.18(b)(1) management

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 06525 Based on clinical record review, interviews with staff and reviews of policies and procedures, it was determined the facility failed to ensure a medication were administered with adequate indications for use and monitoring for two of 33 resident clinical records reviewed (Resident R46 and R83). Findings include: A review of the policy titled antipsychotic medication use dated December 2016 revealed that the antipsychotic medications would be prescribed by the physican at the lowest possible dosage for the shorest period of time. The policy also indicated that psychotropic medications were to be evaluated by the physician for gradual dose reduction routinely. The policy said that residents would only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated. The policy indicated that the need to continue as needed orders for psychotropic medications beyond 14 days required that the physician document the rationale for the extended order. Review of Resident R46's quarterly MDS (Minimum Data Set, an assessment tool used to evaluate the functional abilities and cognitive status of a resident) dated July 16, 2024, revealed the resident was alert and oriented capable of making independent decisions, diagnosed with epilepsy, (a chronic brain disorder that causes seizures) and hemiplegia (one sided weakness) affecting the right dominate side. The resident was assessed as independent in all activities of daily living (ADL), including walking, and transferring and was continent of bowel and bladder. Review of Resident R46's physician orders instructed to give 3 milligrams (mg) of Melatonin dated August 13, 2024, and 50 mg of Trazodone dated October 24, 2023, to be given at night for insomnia. Further review of Resident R46's clinical record revealed the resident did not have a diagnosis of insomnia. Clinical record review revealed a quarterly MDS assessement dated September 22, 2024 that indicated Resident R83 had severe cognitive impairment and diagnoses of anxiety disorder, psychotic disorder and schizophrenia. The assessment also indicated that this resident was receiving antianxiety medication and antipsychotic medication. Clinical record review for Resident R83 revealed a psychiatrist's note dated December 5, 2024 that indicated that Resident R83 had diagnoses of schizophrenia, anxiety disorder and psychosis. Clinical record review revealed the physician had an order dated May 2, 2024 for Lorazepam (antianxiety agent) .5 mg orally every four hours as needed for anxiety disorder. Clinical record review revealed that there was no documentation to indicate the rationale for the continued use of an as needed psychotropic medication, Lorazepam, beyond 14 days for Resident R83. There was no clinical record documentation to indicate the duration that the antianxiety medication was to be used. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Licensed nurse, Employee E17, at 9:30 a.m., on December 19, 2024 confirmed that there was no clinical record documentation, as required for the rationale and extended use of the psychotropic medication, Lorazepam for Resident R83. Clinical record review for Resident R83 revealed that the physician had an order dated Setember 4, 2024 for Depakote sprinkles (anticonvulsant medication) 125 mg twice a day for behavior for Resident R83. Clinical record review also revealed that a valporic acid blood level (used to determine that effectiveness of therapy of the drug depakote) had been obtained and documented as below normal range of 50 to 100 micrograms per milliliter at 16.2 micrograms per milliliter for Resident R83 on October 29, 2024. There was no clinical record documentation to indicate that the laboratory study had been reviewed with the physician to ensure adequate monitoring of the drug use and that an acceptable blood range was acheived for Resident R83. Clinical record review for Resident R83 revealed that the physician had an order dated Setember 4, 2024 for depakote sprinkles (anticonvulsant medication) 125 mg twice a day for behavior for Resident R83. There was no clinical record documentation to indicate the physican had prescribed the medication depakote with adequate indication for its' use. The drug depakote was used pharmacologically for the treatment of bipolar polar disorder, epilepsey or migraine headaches. Interview with licensed practical nurse, Employee E17, at 9:45 a.m., on December 19, 2024 confirmed that there was no clinical record documentation to indicate that depakote (an anticonvulsant medication) was being used with adequate monitoring or with an adequate indication for use for Resident R83. 28 Pa. Code 211.12(d)(1) Nursing services

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F 0772 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have an agreement with an approved laboratory to obtain services, if on-site laboratory services aren't provided. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06525 Based on clinical records review and staff interview, it was determined that the facility failed to obtain a laboratory study as ordered by the physician for one of 33 clinical records reviewed. (Resident R158) Findings include: Clinical record review for Resident R158 revealed a diagnosis of obesity (overweight with excess body fat). Resident R158 was 68 inches in height and weighed 231 pounds indicating a weight of 25% above the ideal body weight of 154 +/- 10%. Clinical record review for Resident R158 revealed a quarterly MDS dated [DATE] that indicated that this resident was at high risk for pressure sore development and had moisture associated skin damage. Clinical record review for November 13 and 15, 2024 revealed that the physician had ordered laboratory studies of the blood to review the metabolism of albumin (a blood test to determine nutritional deficiencies and measure liver and kidney function) and thyroid (a gland that controls metabolism which effects how your body uses energy, regulates body temperature, blood pressure and heart rate) function for Resident R158. There was no clinical record documentation to indicate that these tests were completed as ordered by the physician for Resident R158. Interview with the Licensed nurse, Employee E17, at 10:00 a.m., on December 19, 2024 confirmed the lack of following the physician's orders for laboratory testing on November 13 and 15, 2024 for Resident R158. 28 Pa Code 211.12(d)(1) Nursing services

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 06525 Based on clinical record reviews, interviews with residents and staff, reviews of policies and procedures and food committee meeting minutes, it was determined that for eight of nine residents reviewed, the facility failed to ensure that suitable and nourishing snacks were provided for the residents who wanted to eat at non-traditional times, outside of the scheduled meal service schedule. (Residents R111, R23, R476, R95, R145, R133, R162 and R167). Findings include: A review of the facility policy titled the serving of between meal and bedtime snacks dated September, 2010 revealed that it was the facility's responsibility to provide each resident with adequate nutrition. The policy indicated that bedtime snacks were to be placed on the overbed table or serving area for each resident. Nursing staff were responsible for positioning all residents so that the bedtime snack was easily reachable. Each resident was to be placed in upright position. All residents were to receive assistance with eating their bedtime snacks (foods and beverages) as necessary, by the nursing staff. A group meeting held at 10:30 a.m., on December 17, 2024 with alert and oriented Residents (R111, R23, R476, R95, R145, R133, R162 and R167) revealed that these residents were able to verbally express their nutritional preferences and needs. During the meeting it was the residents consensus that they were not being routinely offered nourishing snacks (foods or beverages) at bedtime. Clinical record review for Residents (R111, R23, R476, R95, R145, R133, R162 and R167) confirmed that all of these residents were all alert and oriented and able to express their nutritional needs to staff. Clinical record review for resident R111 revealed an annual comprehensive assessment MDS (an assessment of care needs) dated September 16, 2024 that indicated this resident was cognitively intact. Clinical record review for Resident R23 revealed a quarterly comprehensive assessment MDS (an assessment of care needs) dated October 28, 2024 that indicated this resident was cognitively intact. Clinical record review for Resident R476 revealed an admission comprehensive assessment MDS (an assessment of care needs) dated December 9, 2024 that indicated this resident was cognitively intact. Clinical record review for Resident R95 revealed a quarterly comprehensive assessment MDS (an assessment of care needs) dated November 15, 2024 that indicated this resident was cognitively intact. Clinical record review for Resident R145 revealed a quarterly comprehensive assessment MDS (an assessment of care needs) dated October 9, 2024 that indicated this resident was cognitively intact. Clinical record review for Resident R133 revealed a quarterly comprehensive assessment MDS (an assessment of care needs) dated September 6, 2024 that indicated this resident was cognitively intact. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clinical record review for Resident R162 revealed an annual comprehensive assessment MDS (an assessment of care needs) dated October 8, 2024 that indicated this resident was cognitively intact. Clinical record review for Resident R167 revealed a quarterly comprehensive assessment MDS (an assessment of care needs) dated September 24, 2024 that indicated this resident was moderately cognitively impaired. Observations at 9:00 a.m., on December 18, 2024 of the medication rooms on the first floor nursing units revealed that the dietary department had provided bulk snacks at 6:00 a.m., for the residents. Licensed nursing staff, Employees E16 and E17 reported at 10:00 a.m., on December 18, 2024 that they would use the bulk snacks in the medication rooms for the residents during the 7-3 shift, if the residents requested a snack. The licensed nurses also reported that they were unaware if the 3-11 nursing staff were offering all the residents a bedtime snack routinely. Clinical record review for Residents (R111, R23, R476, R95, R145, R133, R162 and R167) revealed a lack on consistent and complete documentation to indicate that staff members responsible for offering and assisting residents with bedtime snacks (food and beverages) were completing this task. A review of the food committee meeting minutes for November 14, 2024 revealed that a resident that was in attendance at this meeting had voiced concerns about the between meals and bedtime snacks. The resident said that she was not offered between meals and bedtime snacks frequently, as care planned. 28 Pa. Code 201.18(b)(3) Management

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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. 47973 Based on observations, interviews with staff, and a review of facility procedures, it was determined that the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Findings include: Review of facility policy, Ware washing, revised February 2023 indicated that the dining services staff will be knowledgeable in the proper technique for processing dirty dishware through the dish machine, and proper handling of sanitized dishware. An initial tour of the main kitchen was conducted on December 16, 2024, at 9:38 a.m. with the Food Service Director (FSD), Employee E11. Interview with Employee E11, revealed that the facility dish machine is operating as a low temperature machine, primarily relying on chemical sanitation. Observations at 8:45 a.m. revealed dietary staff, Employee E13 and Employee E14, were starting the dishwasher to clean dirty dishware. Employee 13 and Employee 14 completed two loads of dirty dishes and stored them to dry. Further observations revealed that a test load of dishes was not conducted and the sanitizer testing strip to test the concentration of the final rinse waster was not utilized. Review of facility documentation, Dish machine log for the month of December 2024 revealed that the machine was tested at breakfast, lunch, and dinner on December 13th through the 15th by the Dietary Assistant, Employee E12. Observations of Dietary Assistant, Employee E12 testing the chemical dish machine revealed that Employee E12 utilized incorrect test strips, QAC QR test strip, which are used to measure the concentration of Quaternary Ammonium Compounds in a solution. Observations revealed that the strip did not change color and remained light green, indicating 0 parts per million (ppm). Follow up interview with Dietary Assistant, Employee E12 revealed that Employee E12 utilized the QAC QR test strips each time when completing the Dish Machine Log, and that she is unsure if this is the proper sanitation procedure. Interview with the FSD at 10:00 a.m. revealed that chlorine test strips are to be used to measure the concentration of chlorine in the sanitizing dishwasher solution and confirmed that Employee E12 did not use the correct test strips during observations. Further interview confirmed that proper sanitation practices for food safety were not followed. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(3) Management

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347 Based upon observations, staff interviews, and review of clinical records, it was determined this facility failed to establish and maintain enhanced barrier precautions for one resident of eight resident reviewed (Resident R15). Findings include: Review of the CDC Center for Disease Control and Prevention title enhanced barrier precaution and skilled nursing facilities dated November of 2022, revealed that enhanced barrier precautions (EBPS) in addition to standard precautions, are utilized to prevent the spread of multi drug resistant organisms to residents. Enhanced barrier precautions employees targeted gown and gloves use during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gowns are applied prior to performing the high contact resident care activity as opposed to before entering the room. All protective equipment is changed before caring for another resident. Example of high contact resident care activities requiring the use of gown and gloves for enhanced barrier precautions include dressing, bathing, transferring, providing hygiene, changing linen, changing briefs, device care (urinary catheter, feeding tube, ventilator, tracheotomy), and wound care. Signs are posted on the door or wall outside the resident's room indicating high contact resident care activities that require the use of gowns and gloves. Review of quarterly MDS (minimum data set assessment of resident care needs) for Resident R15 revealed Resident R15 was admitted into the facility November 13, 2012, then again readmitted [DATE] with diagnoses including Parkinson's disease (progressive disease of the central nervous system), dyskinesia (difficulty with voluntary movement), anxiety, bipolar disorder (condition in which a person has periods of depression and period of being extremely happy), muscle wasting, and dysphasia (difficulty swallowing). Further review of this MDS revealed that Resident R15 require enteral nutrition (food delivered through tube feeding). Review of Resident R15's care plan dated November 4, 2024, revealed Resident R15 requires tube feeding related to gastrostomy status with goals including tube insertion site will be free of signs and symptoms of an infection. Further review of the care plan revealed interventions that include to monitor, document, and report any signs or symptoms of aspiration or fever. Observation of Resident R15, door entering the resident room revealed a sign that stated, STOP, Enhanced Barrier Precautions, Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and gown for the following high contact resident care activities dressing, bathing, transferring, changing linens, providing hygiene, changing briefs, to voice care such as central line urinary catheter, feeding tube, tracheotomy, and wound care. Observation of Resident R15 on December 18, 2024, at 11:51 a.m. revealed that nurse aide, Employee E6 was providing incontinence care to Resident R15. Employee E6 was viewed as only wearing gloves, no gown was seen. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with nursing aide, Employee E6 on December 18, 2024, at 12:00 p.m. confirmed that this employee was aware of the enhanced barrier precaution instructed and did not follow the proper procedure of wearing a gown. 28. Pa Code 211.12(d)(1)(5) Nursing services 28 Pa. Code 201.14(a) Responsibility of licensee