STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395335	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
William Penn Healthcare and Rehabilitation Center	163 Summit Drive Lewistown, PA 17044

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 44738 Based on observation and interview, it was determined that the facility failed to provide a clean, comfortable environment in two shower rooms located on one of two nursing units (Nursing Unit 1, Windmill Hill). Findings include: Interview with Employee 3, nurse aide, on June 23, 2024, at 11:55 AM revealed that the staff utilize both shower rooms on Nursing Unit 1. The larger of the shower rooms is mainly utilized; however, the smaller shower room across the hall is used if the other shower is occupied. Observation of the larger shower room on June 23, 2024, at 11:56 AM revealed the following: A dislodged piece of tile on the floor that appeared to be from around the drain area in the floor. Two ceiling lights had debris that included dead insects in the protective coverings. The tiled floor in the shower had a build-up of grime and stains. The paint on the ceiling above the shower area was peeling in multiple areas. A ceiling light above the commode had debris and a dead insect in the protective covering. A metal hand hygiene product dispenser base was attached to the wall near the sink. There were six metal tabs sticking out from the base that were sharp and posed a potential hazard. A heater vent in the wall had an extensive build-up of dust on the vents. Observation of the second shower room across the hall on June 23, 2024, at 12:08 PM revealed the following: A ceiling light above the commode had debris in the protective covering. There was a baseball sized damaged and marred section of the wall behind the commode. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A shower curtain was stained with dried, darker colored stains especially near the bottom of the curtain. There were multiple spiders observed: one spider near the floor outside of a shower stall, three spiders inside of the shower stall in webs, and one spider near the base of a wall on the far side of a large tub. There was a build-up of debris on the base of the wheelchair scale located in the shower room. Observation on June 23, 2024, at 12:13 PM revealed a maroon chair located at Nurse Station 1 that had extensive wear to the cushions of the chair. The cushions were extensively peeling and cracked on both the back rest cushion and seat of the chair. The above information for Nursing Unit 1 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on June 24, 2024, at 2:15 PM. 28 Pa. Code 201.18(b)(3)(e)(2.1) Management

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 29512 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that a significant change MDS assessment was completed timely after election of hospice care for one of two residents reviewed (Resident 103). Findings include: Review of the Resident Assessment Instrument 3.0 User's Manual (RAI, reference used to complete an MDS) revealed that the facility must complete a significant change MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine care needs) no later than 14 days after the effective dated of the election of hospice. Clinical record review for Resident 103 revealed that on June 6, 2024, their physician ordered hospice care. There was no documentation indicating that the facility completed a significant change MDS as indicated by the RAI Manual until after identified by the surveyor. The surveyor reviewed the above findings during an interview with the Nursing Home Administrator and Director of Nursing on June 24, 2024, at 2:00 PM. 28 Pa. Code 211.5 (f) Clinical records

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20725 Based on clinical record review and resident and staff interview, it was determined that the facility failed to ensure assessments accurately reflected residents' status for 10 of 24 residents reviewed (Residents 9, 19, 32, 41, 55, 60, 63, 85, 97, and 109). Findings include: Interview with Resident 60 on June 23, 2024, at 10:38 AM revealed that she denied ever having a physical restraint. Resident 60 indicated that she is unable to transfer herself out of bed, and that a staff member utilizes a stand-up mechanical lift to transfer her out of bed to a chair. Clinical record review of an annual MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) assessment for Resident 60 dated May 4, 2024, revealed that staff assessed the daily use of a bed rail as a restraint. The CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument, MDS) Manual for Item P (Physical Restraint) instructs that if the resident is immobile and cannot voluntarily get out of bed because of a physical limitation or because proper assistive devices were not present, the bed rails do not meet the definition of a physical restraint. Clinical record review for Resident 60 revealed no evidence of the use of a physical restraint. Interview with the Director of Nursing and the Nursing Home Administrator on June 23, 2024, at 2:30 PM confirmed that the MDS coding for Resident 60's restraint was an error. They indicated that Resident 60 never had a restraint. Clinical record review for Resident 19 revealed the resident was admitted to the facility on [DATE]. A quarterly MDS for Resident 19 dated April 17, 2024, noted that the facility staff assessed the resident as being on an anticoagulant (blood thinner). Further clinical record review revealed no evidence that Resident 19 received an anticoagulant during the assessment period for the MDS. An interview with Employee 2, the Registered Nurse Assessment Coordinator, on June 25, 2024, at 11:50 AM confirmed that Resident 19 did not receive an anticoagulant and the data entered in the MDS was an error. Observation of Resident 109 on June 23, 2024, at 9:26 AM revealed the resident was in bed. There was an enabler bar attached to the resident's left side of the bed. There was no observed evidence of any restraints being utilized. Clinical record review of a quarterly MDS for Resident 109 dated May 14, 2024, revealed that staff assessed the daily use of a bed rail as a restraint. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further clinical record review for Resident 109 revealed no evidence of the use of a restraint. Interview with the Nursing Home Administrator and Director of Nursing on June 24, 2024, at 2:00 PM confirmed that restraints were not used on Resident 109. An interview with Employee 2 on June 25, 2024, at 11:50 AM confirmed that the MDS coding that indicated a restraint for Resident 109 was an error, and the resident never had a restraint. Clinical record review for Resident 9 revealed an MDS dated [DATE], that indicated she was taking an anticoagulant (a medication that thins the blood to reduce or prevent blood clotting). Further clinical record review of Resident 9's medication administration for March and April 2024, revealed no indication that she was taking an anticoagulant medication at that time. Interview with the Nursing Home Administrator and Director of Nursing on June 24, 2024, at 2:20 PM confirmed the above noted findings that Resident 9 was not on an anticoagulant medication and the MDS was coded in error. Interview with Resident 41 on June 23, 2024, at 12:00 PM revealed that she denied ever having a physical restraint. Resident 41 indicated that she is unable to transfer herself out of bed. Resident 41 indicated that a staff member utilizes a stand-up mechanical lift to transfer her out of bed to a chair. Clinical record review for Resident 41 revealed an MDS dated [DATE], that indicated staff assessed the daily use of a bed rail as a restraint. Clinical record review for Resident 41 revealed no evidence of the use of a physical restraint. Interview of Resident 97's wife on June 23, 2024, at 12:10 PM revealed that he never had a restraint. She also indicated that he is unable to transfer himself and that it takes two people to get him out of bed. Clinical record review for Resident 97 revealed an MDS dated [DATE], that indicated staff assessed the daily use of a bedrail as a restraint. Interview with the Director of Nursing and the Nursing Home Administrator on June 23, 2024, at 2:30 PM, confirmed that the MDS coding for Residents 41 and 97's restraints was an error, and that Residents 41 and 97 never had a restraint. Clinical record review for Resident 32 revealed that the facility completed a quarterly MDS on December 19, 2023, and March 15, 2024, and an annual MDS on June 4, 2024, which indicated that the resident was restrained by bed rails daily. Review of Resident 32's clinical record revealed a current physician's order and a care plan for two quarter side rales to assist with turning and repositioning due to weakness and deficits from a diagnosis of non-traumatic intracerebral hemorrhage (brain bleed). A facility assessment completed on April 29, 2024, revealed that Resident 32's bilateral siderails were for bed mobility and not a restraint. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clinical record review for Resident 55 revealed that the facility completed a quarterly MDS on May 31, 2024, that indicated the resident was restrained by bed rails daily. Review of Resident 55's clinical record revealed a current physician order and a care plan for two quarter side rails to assist with turning and repositioning due to weakness and hemiplegia (paralysis). A facility assessment completed on April 29, 2024, revealed that Resident 55's bilateral siderails were for bed mobility and not a restraint. Clinical record review for Resident 63 revealed that the facility completed a quarterly Minimum Data Set assessment on November 21, 2023, an annual MDS on February 21, 2024, and another quarterly MDS on May 21, 2024, that indicated the resident was restrained by bed rails daily. Review of Resident 63's clinical record revealed a current physician's order and a care plan for two quarter siderails to assist with turning and repositioning due to a diagnosis of morbid obesity. A facility assessment completed on April 29, 2024, revealed that Resident 63's bilateral siderails were for bed mobility and not a restraint. Clinical record review for Resident 85 revealed that the facility completed a quarterly MDS on March 19, 2024, that indicated the resident was restrained by bed rails daily. Review of Resident 85's clinical record revealed a current physician's order and a care plan for two quarter side rails to assist with turning and repositioning due to vertebral fracture, spinal stenosis (narrowing), and quadriplegia (paralyzed). A facility assessment completed on April 29, 2024, revealed that Resident 85's bilateral siderails were for bed mobility and not a restraint. The surveyor reviewed the above findings during an interview with the Nursing Home Administrator and Director of Nursing on June 23, 2024, at 2:15 PM. 28 Pa. Code 211.5(f)(ix) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 36798 Based on clinical record review and resident and staff interview, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan to maintain the highest practicable care for two of 26 residents reviewed (Residents 41 and 81). Findings Include: Interview with Resident 41 on June 22, 2024, at 2:00 PM revealed that she is legally blind from macular degeneration (an eye disease that causes a gradual breakdown of the cells in the part of the eye that is responsible for central vision). Clinical record review for Resident 41's plan of care revealed that there was no care plan related to her vision loss. This information was reviewed with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) during an interview on June 23, 2024, at 2:07 PM. A care plan for Resident 41 related to her impaired vision was provided to the surveyor on June 24, 2024, at 8:55 AM. The care plan indicated that it was initiated on September 14, 2020. Review of the care plan history in the facility's computerized documentation system, revealed that the care plan provided to the surveyor was resolved on September 16, 2020, and was originally created as impaired vision related to impaired peripheral vison (difficulty seeing things up or down or side to side without moving the head), and then revised on June 24, 2024, after the surveyor inquired about a care plan for impaired vision. Interview with Resident 81 on June 23, 2024, at 11:27 AM revealed that she had been going to a dentist outside of the facility because she needs a lot of dental work done and it could not be done by the dentist in the facility. She said she has receding gums and has several teeth that need pulled. Review of Resident 81's care plan revealed that there was no care plan related to her dental issues. These issues were discussed with the NHA and DON during an interview on June 23, 2024, at 2:13 PM. A care plan for Resident 81 related to her dental concerns was provided to the surveyor on June 24, 2024, at 8:55 AM. The care plan indicated that it was initiated on June 24, 2024, after the surveyor brought it to their attention on June 23, 2024. The facility failed to develop a comprehensive person-centered care plan to maintain the highest practicable care for Residents 41 and 81. 28 Pa. Code 211.12(d)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 20725 Based on review of select facility policies and procedures, observation, clinical record review, and resident and staff interview, it was determined that the facility failed to provide the highest practicable care related to intravenous access for one of one resident reviewed for intravenous access concerns (Resident 80). Findings include: The facility policy entitled, Midline Dressing Changes, last reviewed without changes on March 21, 2024, revealed that general guidelines include to change the midline catheter dressing every five to seven days or if wet, dirty, not intact, or compromised in any way. Label the dressing with initials, date, and time. The policy did not include interventions implemented into a resident's plan of care to prevent infection or other complications from the use of a midline. The policy did not include routine assessments needed to monitor the resident during the presence of a midline catheter. Clinical record review for Resident 80 revealed nursing documentation dated June 3, 2024, at 2:33 PM that Resident 80 presented on admission with a, PICC (Peripherally inserted central catheter, long, thin, tube that is inserted through a vein in the arm and passed through to a larger vein near the heart. The line requires careful care and monitoring for complications including bleeding, infection, and blood clots) lune (sic, line) present in RUA (right upper arm). Resident 80 had a foot ulcer and physician orders for wound care. Admission physician orders dated June 3, 2024, for Resident 80 included Meropenem (an antibiotic that is used to treat severe infections of the skin or stomach) one gram intravenously every eight hours until July 2, 2024, related to acute osteomyelitis (infection identified in the bone) of the right ankle and foot. Resident 80's physician orders dated June 3, 2024, that remained active until Resident 80's readmission from the hospital on June 11, 2024, pertaining to a midline (thin, soft tubing placed into a vein in the arm for intravenous access) venous access site, included the following: Midline, maintain emergency kit at bedside Change midline dressing and caps every seven days, day shift, every Monday, and as needed Monitor midline site every shift Resident 80's physician orders dated June 4, 2024, that remained active until Resident 80's readmission from the hospital on June 11, 2024, pertaining to a midline venous access site, included the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Midline/PICC IV (intravenous) dressing, extension set, and cap change every week and as needed one time a day every seven day(s) for IV therapy dressing change and as needed for leakage, blockage, soilage Midline, measure circumference in CM (centimeters) of upper arm insertion site every shift for midline every shift and as needed. Midline, measure length in CM of the external midline line access every day shift from insertion site to port, daily and as needed. A plan of care initiated by the facility on June 4, 2024, to address Resident 80's potential for complications at her intravenous insertion site (midline to RUA) included only one intervention, which was to change the intravenous tubing per the physician order or per protocol. There were no interventions regarding maintenance (e.g., changing the dressing and caps every seven days), assessment (e.g., measuring the circumference of the arm or length of the external tubing), prevention of complications (e.g., keeping site dry and restricting the use of the limb for blood pressures), or response for potential complications like bleeding (e.g., emergency kit at bedside). Resident 80's physician orders dated June 11, 2024, (upon her readmission from the hospital) included the following: Midline, measure length in CM of the external midline line access every day shift from insertion site to port, daily and as needed Midline, measure circumference in CM of upper arm insertion site every shift and as needed Midline/PICC IV dressing, extension set, and cap change every week and as needed one time a day every Wednesday for IV therapy dressing change and as needed for leakage, blockage, soilage Review of Resident 80's medication administration record (MAR, electronic system of documentation of medication administration) and treatment administration record (TAR, electronic system of documentation of treatment completions) dated June 2024 revealed that staff did not obtain a measurement of Resident 80's upper arm until June 11, 2024, night shift. Staff failed to obtain a measurement of the circumference of Resident 80's arm on night shift on June 17, 2024, and on day shift on June 19, 2024. Staff also failed to document any assessments of the external midline tubing length until June 22, 2024. Observation and interview with Resident 80 on June 22, 2024, at 12:46 PM confirmed that she had an open sore on her right foot and was receiving intravenous antibiotics through an intravenous site located in her right bicep area. Resident 80 stated that, .it is a midline. Observation of the clear dressing over the tubing in Resident 80's right arm revealed dated initials that indicated the dressing was applied on June 6, 2024. There was no emergency kit, or signs pertaining to restrictions for Resident 80's right arm visible in Resident 80's room. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident 80 with Employee 1 (registered nurse) on June 23, 2024, at 9:23 AM confirmed that the midline dressing to Resident 80's right arm was dated June 6, 2024, indicating that the same dressing had remained in place for 17 days although physician orders instructed that staff change it every seven days. Review of Resident 80's TAR dated June 2024, revealed that staff initialed completion of a midline dressing change on June 12, 2024, at 8:00 AM; however, observation and staff interview confirmed that the dressing applied on June 6, 2024, was unchanged. Following the surveyor's questioning, staff discontinued the physician order related to changing the midline catheter dressing and restarted it on June 23, 2024, at 10:15 AM. The surveyor reviewed the above concerns regarding Resident 80's midline catheter care with the Director of Nursing and the Nursing Home Administrator on June 23, 2024, at 2:00 PM and June 24, 2024, at 2:00 PM. The facility did not provide a policy, procedure, or staff competency outline, that evidenced what the administration's expectations were of staff planning care for a resident with a midline catheter. 28 Pa. Code 211.5(f)(viii) Medical records 28 Pa. Code 211.10(a)(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 20725 Based on clinical record review and resident and staff interview, it was determined that the facility failed to implement interventions to treat hearing loss for one of two residents reviewed for hearing concerns (Resident 31). Findings include: Interview with Resident 31 on June 22, 2024, at 11:56 AM revealed that she had difficulty hearing and required the use of a dry erase board to communicate. Clinical record review of documentation from the facility's contracted audiology professional dated August 18, 2023, indicated that the assessment/plan for Resident 80 confirmed that she had sensorineural hearing loss (hearing loss resulting from damaged hair cells in the inner ear) bilaterally. The documentation indicated that staff reported that they write notes when needed. The provider's recommendation was a trial of a pocket talker (personal sound amplifier) to aid in hearing for communication of needs. A plan of care developed by the facility to address Resident 31's hearing loss included no reference to the use of a pocket talker. Interview with the Director of Nursing and the Nursing Home Administrator on June 24, 2024, at 2:00 PM revealed no evidence that the facility implemented the audiology provider's recommendation for a pocket talker. The facility provided evidence on June 25, 2024, that staff revised Resident 31's plan of care related to her hearing loss on June 24, 2024, (following the surveyor's questioning), to include that Resident 31 will be provided with the use of a pocket talker to assist with communicating with staff and others. 28 Pa. Code 211.12(d)(1)(3)(5) 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. 29512 Based on clinical record review and staff interview, it was determined that the facility failed to provide physician ordered services to maintain a resident's range of motion for one of two residents reviewed (Resident 55). Findings include: Clinical record review for Resident 55 revealed a current physician's order for staff to provide a restorative program (range of motion, ROM, movement of the body in an attempt to maintain a resident's ability) to prevent contracture(s), which included left lower extremity (LLE) ROM passive stretching to left leg into knee extension times five repetitions and holding for 30 seconds, to be completed with AM (morning) and PM (evening) care. Review of task documentation for Resident 55 for April, May, and June 2024, revealed that staff did not document completion of the restorative task on the following dates: Day Shift: April 13 and 14, 2024 May 21, 28, and 29, 2024 (documented not applicable) May 24, 25, and 26, 2024 (no documentation) June 8 and 9, 2024 Evening Shift: April 1, 3, 4, 5, 7, 9, 10, 13, 24, 16, 18, 19, 23, 24, 27, and 28, 2024 May 1, 2, 3, 4, 5, 7, 8, 11, 13, 14, 17, 21, 22, 24, 25, 26, 27, and 29, 2024 June 1, 2, 3 8 9, 10, 12, 13, 14, 15, 16, 17, 18, 19, and 20, 2024 The surveyor reviewed the above information on June 24, 2024, at 2:00 PM with the Nursing Home Administrator and Director of Nursing. 28 Pa. Code 211.10(a)(c)(d) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 20725 Based on review of select facility policies and procedures, clinical record review, observation, and staff and resident interview, it was determined that the facility failed to implement supplemental oxygen per physician orders for one of one resident reviewed for oxygen concerns (Resident 80). Findings include: The facility policy entitled, Departmental (Respiratory Therapy) - Prevention of Infection, last reviewed March 21, 2024, revealed that the purpose of the procedure was to guide prevention of infection associated with respiratory therapy tasks and equipment among residents and staff. Preparation included a review of the resident's care plan to assess for any special circumstances or precautions related to the resident. Infection control considerations related to medication nebulizers/continuous aerosol equipment included to store the circuit in a plastic bag, marked with the date and resident's name, between uses. Interview with Resident 80 on June 22, 2024, at 12:45 PM, revealed that she was diagnosed with rhinovirus (virus that is the most frequent cause of the common cold), and that she was tested two weeks ago. Resident 80 stated that she wears supplemental oxygen all the time. Resident 80 coughed repeatedly during the interview. Observation of the room concentrator (medical machine that concentrates room air to administer an oxygen-rich supply to the resident) at Resident 80's bedside revealed the liter flow was at one and one-half liters per minute. Clinical record review for Resident 80 revealed an active physician's order dated June 11, 2024, for staff to administer supplemental oxygen at 0.5 liters per minute at hour of sleep via a nasal canula (flexible tubing with small prongs on one end, which are inserted into the nostrils for supplemental oxygen administration) or face mask every shift for a diagnosis of hypoxia (difficulty breathing and low blood oxygen levels) and to maintain a pulse ox (pulse oximeter, or pulse ox, is a non-invasive electronic device placed on a finger to estimate the blood's oxygen level) greater than 90 percent. Staff were to enter a pulse ox assessment and the liters of oxygen administered every shift for comfort requested by the resident related to dyspnea (shortness of breath). Observation of a medication administration pass on June 23, 2024, at 9:11 AM revealed Employee 1 (registered nurse) assessed Resident 80's oxygen saturation via pulse ox as 99 percent. The liter flow on Resident 80's room concentrator remained at one and one-half liters per minute. Resident 80 did not appear to be, or complain of, dyspnea. Employee 1 utilized nebulizer equipment (device that turns liquid medicine into a mist that is breathed into the lungs for administration of the medication) stored, unbagged, on Resident 80's bedside recliner to administer Resident 80's ipratropium/albuterol (medicine used to relax the airway muscles to dilate the passageways and increase air exchange) medication treatment. Interview with Employee 1 on June 23, 2024, at 9:17 AM confirmed that the bedside respiratory equipment that she utilized for Resident 80 was not bagged (to protect it from potential environmental contaminates between uses). (continued on next page)

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	395335	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
William Penn Healthcare and Rehabilitation Center	163 Summit Drive Lewistown, PA 17044

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Employee 1 on June 23, 2024, at 12:57 PM confirmed that her assessment of Resident 80's oxygen saturation more than three hours earlier was 99 percent, and that Resident 80's physician order was for 0.5 liters per minute. Employee 1 confirmed that Resident 80's supplemental oxygen dose remained at one and one-half liters per minute although there was no evidence that Resident 80 was dyspneic or needed the increased liter flow to maintain a pulse ox saturation greater than 90 percent. Employee 1 reduced the oxygen concentrator liter flow slowly to 0.5 liters per minute (to prevent the concentrator equipment alarm) and verified Resident 80's oxygen saturation was 97 percent. Review of Resident 80's TAR (treatment administration record, electronic documentation of the completion of treatments) dated June 11 to 23, 2024, revealed that staff errantly documented the oxygen liter flow administered to Resident 80 as between 93 and 99 liters per minute (which was not possible with the respiratory equipment available for use) on numerous occasions. Staff documented oxygen administration liter flows from 0.5 liters per minute to 1.5 liters per minute for oxygen saturation assessments that ranged from 93 to 99 percent. Review of a plan of care developed by the facility on June 4, 2024, to address Resident 80's risk for respiratory impairment revealed a list of interventions that included: Administer medications/treatments per physician orders Obtain labs/diagnostic tests as ordered and notify physician of results Oxygen at two liters per minute Resident 80's plan of care did not reflect the physician ordered liter flow of 0.5 liters per minute. The surveyor reviewed Resident 80's supplemental oxygen administration concerns during an interview with the Nursing Home Administrator and the Director of Nursing on June 23, 2024, at 2:00 PM. The surveyor requested any policies, procedures, or staff competency expectations regarding the use of supplemental oxygen and the storage of equipment. The facility did not provide a policy or procedure regarding the use of supplemental oxygen. The surveyor reviewed the concern regarding the nebulizer equipment used for Resident 80's medication administration during an interview with the Nursing Home Administrator and the Director of Nursing on June 24, 2024, at 2:00 PM. 28 Pa. Code 211.10(a)(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 36798 Based on clinical record review and staff interview, it was determined that the facility failed to ensure a resident's medication regime was free from potentially unnecessary medications for one of five residents reviewed (Resident 57). Findings include: Review of Resident 57's clinical record revealed a note from the pharmacist to the attending physician dated September 7, 2023, that requested a gradual dose reduction of her Escitalopram (Lexapro, a medication used to treat depression) 10 milligrams (mg) daily. The physician responded on September 13, 2023, by checking the box that read other and wrote, current dose beneficial, with no further explanation. Clinical record review of Resident 57's behavior documentation on the Medication Administration Record (MAR) for September 2023, related to the medication Escitalopram, revealed no behaviors documented related to her diagnosis of depression. Further review of Resident 57's clinical record revealed a pharmacist note to the attending physician dated February 12, 2024, that requested a trail dose reduction of her Ativan (a medication used to treat symptoms of anxiety) 0.25 mg twice a day. The physician responded on February 16, 2024, by checking the box that read disagree with no explanation provided. Clinical record review of Resident 57's behavior documentation on the MAR for February 2024, related to the medication, Ativan, revealed no behaviors documented related to her diagnosis of anxiety. The Nursing Home Administrator and Director of Nursing were made aware of concerns with Resident 57's physician's response to her pharmacy recommendation regarding the medications Escitalopram and Ativan, and the lack of episodic documentation related to her depression and anxiety to indicate the need for the medication during a meeting on June 24, 2024, at 2:15 PM. The facility failed to ensure that Resident 57's medication regime was free from potentially unnecessary medications. 483.45(d)(e)(1)-(2) Drug Regimen is Free From Unnecessary Drugs Previously cited deficiency 6/30/23 28 Pa. Code 211.9(a)(1)(k) Pharmacy services 28 Pa. Code 211.10(a) Resident care policies (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 20725 Based on clinical record review, observation, and staff interview, it was determined that the facility failed to have a medication error rate less than five percent (Residents 77 and 80). Findings include: The facility's medication error rate was 6.67 percent based on 30 medication opportunities with two medication errors. Observation of a medication administration pass on June 23, 2024, at 8:46 AM revealed Employee 1 (registered nurse) administered Omeprazole (medication used to reduce stomach acid) 20 milligrams (mg) to Resident 77. Resident 77 had finished her breakfast meal. Interview with Employee 1 on June 23, 2024, at 12:57 PM confirmed that Resident 77 received her Omeprazole medication after she had consumed her breakfast. Review of https://www.drugs.com revealed that it is usually best to take Omeprazole one hour before meals. When omeprazole is taken with food it reduces the amount of omeprazole that reaches the bloodstream. Clinical record review for Resident 80 revealed a physician's order for staff to administer Fluticasone Propionate (Flonase, a steroid nasal spray that prevents allergic inflammation) nasal suspension, 50 MCG (micrograms) per inhalation, one spray in both nostrils one time a day. Observation of a medication administration pass on June 23, 2024, at 8:55 AM revealed Employee 1 prepared medications for administration to Resident 80 that included Fluticasone Propionate. Observation on June 23, 2024, at 9:12 AM revealed Employee 1 handed Resident 80 her Fluticasone Propionate nasal spray. Resident 80 performed two nasal sprays into her right nostril followed by two nasal sprays into her left nostril. Employee 1 did not attempt to redirect Resident 80 from administering two sprays of the medication before she completed the administrations. Following the administration of the medication, Employee 1 informed Resident 80 that she was to have only one spray of the medication in each nostril. Employee 1 stated, We (nursing staff) should be doing it for you. Resident 80's clinical record contained no evidence that the facility assessed her for the capability of self-administering her medications. Interview with Employee 1 on June 23, 2024, at 9:17 AM confirmed that the physician's order for the nasal spray was for one spray in each nostril, but she permitted Resident 80 to do two sprays in both nares. Employee 1 could have redirected Resident 80 after she performed the procedure incorrectly in the right nostril and before she completed the administrations in the left nostril. Employee 1 confirmed that she did not have information to indicate that Resident 80 was assessed to self-administer her medications. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed the above concerns regarding the Omeprazole and Flonase medication errors during an interview with the Director of Nursing and the Nursing Home Administrator on June 24, 2024, at 2:00 PM. 483.25(f)(1) Free of Medication Error Rates Five Percent or More Previously cited 6/30/23 28 Pa. Code 211.12(d)(1)(5) Nursing services

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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. 20725 Based on a review of select facility policies and procedures, observation, clinical record review, and staff and resident interview, it was determined that the facility failed to implement enhanced barrier precautions for one of three residents reviewed for infection control concerns (Resident 80). Findings include: The facility policy entitled, Enhanced Barrier Precautions, last reviewed without changes on March 21, 2024, revealed that enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms to residents. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include wound care (any skin opening requiring a dressing) and/or device care or use (central line, urinary catheter, feeding tube, etc.). Staff are trained prior to caring for residents on EBPs. Interview with Resident 80 on June 22, 2024, at 12:46 PM revealed that she had an open sore on her right foot and was receiving intravenous antibiotics through a midline (thin, soft tubing placed into a vein in the arm for intravenous access) in her right upper arm. Observation of Resident 80's right arm during the interview confirmed that she had a clear dressing covering tubing in the area of her right bicep. Observation of Resident 80's doorway revealed a sign to indicate EBPs were necessary. Clinical record review for Resident 80 revealed infectious disease consultant documentation dated June 21, 2024, that indicated Resident 80 had diagnoses that included osteomyelitis (bone infection) of her right foot. A bone biopsy completed March 27, 2024, identified MSSA (Methicillin Susceptible Staphylococcus Aureus, bacteria that is susceptible to the methicillin antibiotic). Consultation/Clinical Referral form documentation dated June 21, 2024, indicated that a culture of Resident 80's right heel wound identified the bacteria, pseudomonas, for which she would receive six weeks of Meropenem (an antibiotic that is used to treat severe infections of the skin or stomach). Observation of Employee 1 (registered nurse) on June 23, 2024, at 1:37 PM revealed she entered Resident 80's room to perform wound care to her open right foot wound without an isolation gown. Continued observation of Resident 80's wound care from 1:37 PM to 2:04 PM revealed Employee 1 performed all the procedures of the wound care (including removal of soiled dressings, wound cleansing, application of new dressings, and removal of items from the room) without donning an isolation gown. Observation of Resident 80 during the procedure confirmed that she had an open wound to the bottom of her right foot that drained a small amount of beige-colored drainage. Interview with Employee 1 on June 23, 2024, at 2:04 PM confirmed that although Resident 80 had a sign for enhanced barrier precautions (that noted a gown and gloves were required for wound care) on her door, she did not wear a gown. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services