STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395350	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Locust Grove Retirement Village	69 Cottage Road Mifflin, PA 17058

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19719 Based on clinical record review and staff interview, it was determined that the facility failed to establish clear and consistent resident's wishes regarding advance directives (written instruction, such as a living will or durable power of attorney, relating to the provision of healthcare, for a time when a resident may be incapacitated and not able to make decisions) for one of one resident reviewed (Resident 16). Findings include: Review of Resident 16's clinical record revealed that the facility admitted her on February 26, 2024. A physician's order dated February 26, 2024, indicated that Resident 16 was to be a full code, which would include CPR (cardiopulmonary resuscitation). Review of a POLST (Physician Orders for Life Sustaining Treatment, a document for specific medical orders to be honored by health care workers during a medical crisis) form signed by Resident 16's responsible party on [DATE], indicated that she wished for Resident 16 to be a DNR (Do Not Resuscitate, not to perform cardiopulmonary resuscitation if breathing stops). Resident 16 continued to have both a full code physician order and a DNR on her paper POLST until [DATE], when the surveyor brought it to the attention of the facility. Interview with the Administrator and Director of Nursing on [DATE], at 2:00 PM confirmed the above findings for Resident 16. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.29(a) Resident rights

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

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

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F 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. 20725 Based on review of select facility policies and procedures, clinical record review, and family and staff interview, it was determined that the facility failed to ensure reasonable care for the protection of the resident's property for one of 18 residents reviewed (Resident 228). Findings include: The facility policy entitled, Personal Items Inventory, last reviewed without changes on March 29, 2024, revealed that the facility's procedure included: Enter the resident's name, room number, medical record number, and the date of inventory on the Inventory of Personal Effects Identify articles as listed, indicating quantity and presence with a check (x) Describe items of specific value. Describe color and size. Do not indicate type of metal or stone Sign Inventory of Personal Effects sheet: signature of resident or responsible party/date; signature of nurse/date; If resident or responsible party is unable to sign, two facility personnel (one being a nurse) are to sign the inventory on admission Telephone interview with Resident 228's husband on April 30, 2024, at 12:13 PM revealed that he could not find Resident 228's wedding band or diamond ring. Resident 228's husband stated that he could not say if she was wearing the jewelry upon her admission to the hospital or to the facility. Clinical record review for Resident 228 revealed the facility admitted her on April 17, 2024. An Inventory of Personal Effects form (document the facility utilizes to account for resident's personal property on admission and upon discharge) had no property listed and had no signatures of either staff or the resident/resident's responsible party. Interview with Employee 10 (nurse aide) and Employee 11 (licensed practical nurse) on May 1, 2024, at 11:14 AM confirmed that Resident 228's Inventory of Personal Effects form was not completed since her admission to the facility. The surveyor reviewed the above findings with the Nursing Home Administrator and the Director of Nursing on May 1, 2024, at 2:00 PM. 28 Pa. Code 201.18(b)(2) Management 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.12(d)(1) Nursing services

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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. 38839 Based on observation, clinical record review, review of facility documents, and resident and staff interview, it was determined that the facility failed to protect the rights of a resident to be free from neglect by not providing the services necessary to avoid physical harm related to a sustained fracture on one of two nursing units, (Unit 100-300, Resident 33). This deficiency is cited as past noncompliance Findings include: Observation and interview with Resident 33 on May 1, 2024, at 9:49 AM revealed the resident was in bed. Resident 33 stated one person gave her a couple fractures and stated, She tried to get me into bed, she didn't use the lift. Resident 33 stated she hurt after that, and it was her fault, referencing the staff member. Resident 33 said her knee was broken. Clinical review for Resident 33 revealed an active physician's order dated November 8, 2023, for the resident to use a full mechanical lift as her transfer status. Review of Resident 33's plan of care revealed the resident requires a mechanical lift with two staff assistance for transfers initiated on the plan of care on October 13, 2022. A nursing note dated March 24, 2024, at 2:24 PM noted the resident began complaining of left knee pain that hurt after being bumped during transfer the day before. The note indicated there was no concern or swelling noted of the knee. An x-ray of Resident 33's left knee completed on March 25, 2024, revealed the resident had an acute fracture of the left lateral tibial plateau. The facility initiated an investigation on March 26, 2024, into Resident 33's acute knee fracture and upon resident interview dated March 26, 2024, the resident stated a staff member got her out of bed by herself and twisted her knee while lifting her. Review of staff statements obtained by the facility revealed the resident had mentioned several different staff members as individuals who transferred her independently. Based on a staff statement from Employee 15 (resident assistant) dated March 26, 2024, revealed that Employee 16 (nurse aide) was witnessed getting Resident 33 out of bed by just picking her up and putting her in the wheelchair to got to the dining area on March 23, 2024. Review of a telephone interview documented by facility staff dated March 26, 2024, with Employee 16 indicated the nurse aide indicated she did get Resident 33 out of bed, but indicated she used the Hoyer lift by herself to get the resident out of bed and indicated she knew two people were to be used with the lift. Employee 16 stated the resident did not express pain during the transfer but did hear a pop when she rolled her in bed when lunch was over. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review information submitted by the facility on March 28, 2024, indicated the facility had completed an investigation into Resident 33's reported knee pain and allegation of only being transferred with one person, and sustaining a fracture. The facility interviewed all staff working in the time frame surrounding the incident and determined Employee 16 did not follow Resident 33's plan of care regarding the mechanical lift for transfers with two people, and Employee 16 admitted there was not a second person present. Employee 16 was terminated from the facility on March 26, 2024. The facility provided staff education on using the correct transfer status when providing residents with care and transfers on March 26, 2024. Review of a facility implemented plan of correction, signed by facility administration during an Ad Hoc quality assurance (QA) meeting on March 26, 2024, revealed that the facility implemented the following: Random audits of transfers will be completed by the director of clinical services or their designee. The results will be reported at the April 18, 2024, QAPI meeting. Review of the audits dated March 26 and 27, 2024, revealed that staff were appropriately transferring residents utilizing the required staff. Review of the QAPI meeting dated April 25, 2024, revealed that the transfer audits were reviewed with no trends noted. Random audits on each shift will continue for another month. These results will be reviewed at the May QAPI meeting for further recommendation. The Ad Hoc meeting also indicated that staff continue to be educated on proper transfer status at orientation and as needed. The above findings were confirmed with the Nursing Home Administrator and Director of Nursing on May 3, 2024, at 11:30 AM. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a) Resident rights

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 20725 Based on a review of select facility policies and procedures, employee personnel record review, and staff interview, it was determined that the facility failed to obtain attestation of Pennsylvania residency as required for one of five personnel records reviewed (Employee 3). Findings include: In accordance with Act 13 Elder Abuse Mandatory Reporting and Act 169 Criminal Background Checks, nursing facilities are required to obtain a criminal background check on all newly hired employees. Facilities are required to obtain the Pennsylvania State Police (PSP) background check within 30 days of hire on all prospective employees. If the applicant has not been a Pennsylvania resident for the two years before application, they will need to have a PSP criminal history background check completed and an FBI Background Check. The facility policy entitled, Abuse, Neglect, Exploitation, and Misappropriation, last reviewed without changes on March 29, 2024, revealed that persons applying for employment will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. This includes, but is not limited to, criminal background checks. The policy did not include how the facility will have an employee attest to two consecutive years of Pennsylvania residency before application for employment. Review of Employee 3's (nurse aide) personnel file revealed that the facility hired her on January 7, 2024. Employee 3's personnel file included a document entitled, Statement of Two Year PA State Residency, signed and dated by Employee 3 on January 7, 2024, that did not include a response by Employee 3 for the questions if she was a resident of the State of Pennsylvania for the past two years or if she was a citizen of the United States. Interview with the Nursing Home Administrator and Employee 9 (human resources coordinator) on May 1, 2024, at 3:53 PM confirmed the above findings regarding Employee 3. 483.12(b)(1)-(3) Develop/implement Abuse/neglect Policies Previously cited deficiency 8/4/2023 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(1)(3)(e)(1) Management 28 Pa Code 201.19(8) Personnel policies and procedures

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 20725 Based on clinical record review and staff, resident, and family interview, it was determined that the facility failed to provide the resident and their representative a summary of the baseline care plan for two of 24 residents reviewed (Residents 228 and 231). Findings include: Interview with Resident 228's husband on April 30, 2024, at 12:27 PM revealed that he believed the facility's contracted hospice provider staff were organizing his wife's care. Resident 228's husband was not aware of the frequency of visits completed by hospice staff. Review of the facility's CMS-802 (form used to list all current residents and pertinent care categories) revealed that Resident 228 received hospice services. Clinical record review for Resident 228 revealed that the facility admitted her on April 17, 2024. Review of active physician orders for Resident 228 revealed no evidence that she was to receive services from a hospice provider. Interview with Employee 11 (licensed practical nurse) on May 1, 2024, at 11:14 AM revealed that a baseline care plan form in Resident 228's clinical record included her name, date of birth, and physician's name; however, otherwise, was completely blank. Employee 11 confirmed that the facility had not developed Resident 228's comprehensive plan of care as of this date. The facility failed to develop a baseline plan of care that included the minimum healthcare information necessary (e.g., hospice services) to care for Resident 228. The surveyor reviewed the above concerns regarding Resident 228 during an interview with the Director of Nursing and the Nursing Home Administrator on May 1, 2024, at 2:00 PM. The interview confirmed that the facility did not obtain a physician's order for Resident 228's hospice services until following the surveyor's review of her medical record on April 30, 2024. Interview with Resident 231 on April 30, 2024, at 3:40 PM revealed that she denied receiving a written summary of a care plan. Review of Resident 231's Baseline Care Plan and Summary available in her physical clinical record on the nursing unit revealed no signatures of staff, Resident 231, or Resident 231's representative. The document included a section on the last page labeled, Below are completion signatures and dates of those participating in the initial baseline care plan development and summary. The surveyor reviewed the above concerns regarding Resident 231 during an interview with the Director of Nursing and the Nursing Home Administrator on May 1, 2024, at 2:00 PM. Information provided by the facility on May 2, 2024, revealed that Resident 231 signed the Baseline Care Plan and Summary on May 1, 2024 (following the surveyor's questioning). (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38839 Based on clinical record review and resident and staff interview, it was determined that the facility failed to provide bathing assistance for a resident dependent on staff assistance for five of seven residents reviewed for activities of daily living (Residents 33, 39, 47, 52, and 63). Findings include: Interview with Resident 33 on May 1, 2024, at 9:52 AM revealed she is to get showered on Tuesdays and Fridays, during the day, and she doesn't refuse them, but stated she had a fracture and maybe that's why she wasn't getting them. Clinical record review for Resident 33 did reveal the resident had sustained a fracture in her leg in March 2024, and was scheduled to receive showers on Tuesdays and Fridays on the 2-10:00 PM shift and as needed. A review of Resident 33's bathing records for April 2024, revealed the resident was totally dependent on staff for bathing, and did receive a shower on April 2 and April 9, 2024, on her scheduled shower days after her fracture, but had only received a bed bath on April 5, 23, and 26; a partial bed bath on April 19 and 30; and April 16 was noted as response not required. There was no evidence Resident 33 could not receive a shower due to her fracture nor any documented showers on an as needed basis outside of her scheduled shower days. In a follow up interview with Resident 33 on May 3, 2024, at 10:45 AM regarding only receiving a partial bed bath on April 30, 2024, the resident stated she could not get a shower because there was only one. When the resident was asked one what? the resident stated, one girl, referencing the staff. Resident 33 again stated she would not refuse to be showered per her preference. There was no evidence Resident 33 received a shower since April 9, 2024. The above concerns regarding Resident 33's bathing being completed per the resident's bathing preference were reviewed with the Nursing Home Administrator and Director of Nursing on May 3, 2024, at 11:38 AM. Review of Resident 47's clinical record revealed a Minimum Data Set Assessment (MDS, an assessment tool completed at specific intervals to determine care needs) dated October 12, 2023, that the facility assessed her as being dependent on staff assistance for bathing. An MDS dated [DATE], determined that it was very important for Resident 47 to be able to decide on whether she gets a bed bath or shower. Review of Resident 47's bathing documentation dated April 2024, revealed that she has not received a shower since April 9, 2024. There was no documented evidence in Resident 47's clinical record to indicate that the facility determined her preferences for bathing. Review of Resident 52's clinical record revealed an MDS dated [DATE], that indicated the facility determined she was dependent on staff assistance for bathing. An MDS dated [DATE], determined that it was very important for Resident 52 to be able to decide on whether she gets a bed bath or shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident 52 on April 30, 2024, at 12:00 PM revealed that she is not getting her showers like she is supposed to. Resident 52 indicated that she is supposed to get a shower two times a week. Review of Resident 52's bathing documentation dated April 2024, revealed that she has not received a shower since April 18, 2024. Review of Resident 63's clinical record revealed an MDS assessment dated [DATE], that indicated the facility assessed him as being dependent on staff assistance for bathing. Review of Resident 63's bathing documentation dated April 2024, revealed that he has not received a shower since April 9, 2024. Resident 63 has only received partial bathing since April 16, 2024. There was no documented evidence in Resident 63's clinical record to indicate his preferences regarding receiving a bed bath or a shower. Interview with the Administrator and Director of Nursing on May 2, 2024, at 1:45 PM acknowledged the above findings for Residents 47, 52, and 63, and confirmed that the facility has not obtained any resident preferences for bathing. Review of Resident 39's clinical record revealed his most recent quarterly MDS dated [DATE], revealed that the facility assessed him as being dependent on staff assistance for bathing. Resident 39 was unable to be interviewed due to his current cognitive status. A review of Resident 39's task documentation (ADL, activities of daily living charting) revealed he preferred to receive a shower/bath/bed bath two times a week on the second shift. A review of Resident 39's task documentation revealed that he only received one shower in the last month, he received eight partial, or bed baths. There was no documented evidence in Resident 39's clinical record to indicate his preferences regarding the type of shower, tub bath, or bed bath he preferred to receive. Interview with the Administrator and Director of Nursing on May 2, 2024, at 1:45 PM acknowledged the above findings for Resident 39 and confirmed that the facility has not obtained any resident preferences for bathing. Refer to F725. 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 20725 Based on 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 and medication administration for one of two residents reviewed for intravenous access concerns (Resident 74); implementation of interventions for one of four residents reviewed for skin conditions (Resident 231); and bowel protocol medications for one of one resident reviewed for constipation concerns (Resident 231). Findings include: Clinical record review for Resident 74 revealed a plan of care initiated by the facility on April 25, 2024, to address antibiotic therapy related to an endocarditis infection (inflammation of the inner lining of the heart chambers and valves; usually caused by a bacterial infection). Interventions listed in the plan of care included: PICC line (PICC, 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) and flushes as ordered E-kit (emergency kit) at bedside No BP (blood pressure) in left arm Observation of Resident 74 on April 30, 2024, at 1:40 PM revealed a PICC line access site on the back of his left bicep. Observation of Resident 74 and Resident 74's room revealed no indication of any restrictions preventing use of his left arm for blood pressures or venipuncture (blood draws). There was no emergency equipment readily visible in Resident 74's room in the event of complications from the PICC line access (such as clamps or compression dressing kit in the event of bleeding). Interview with Employee 6 (registered nurse) on April 30, 2024, at 1:54 PM confirmed the above findings for Resident 74. Clinical record review for Resident 74 revealed active physician orders dated April 3, 2024, for the following: Cefazolin Sodium (antibiotic medication) 2000 mg (milligrams) intravenously every eight hours for endocarditis PICC or midline, measure upper arm circumference in centimeters and external catheter length in inches on admission, with each dressing change, and as needed. Flush PICC with 10 milliliters (ml) of normal sterile saline every shift and as needed Review of Resident 74's MAR (Medication Administration Record, electronic documentation of the administration of medications) and TAR (Treatment Administration Record, electronic documentation of the completion of treatments) dated April 2024 revealed 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	No staff documented a measurement of Resident 74's left upper arm as scheduled on April 21, 2024 No staff documented the administration of the Cefazolin Sodium intravenous medication on April 9, 18, and 26, 2024, at 6:00 AM. No staff documented the normal sterile saline flush as scheduled on April 18 and 26, 2024, at 6:00 AM. The surveyor reviewed the above concerns pertaining to Resident 74 during an interview with the Director of Nursing and the Nursing Home Administrator on May 1, 2024, at 2:00 PM. Clinical record review for Resident 231 revealed a physician's order dated April 23, 2024, for Resident 231 to wear a heel lift boot on her left foot when in bed. Observation and interview with Resident 231 on April 30, 2024, at 3:46 PM revealed she was in bed with her foot wrapped in white gauze. Observation of the gauze revealed two small circular areas of orange discoloration. Resident 231 stated that she was not sure if the areas were indicative of wound drainage or the color of the betadine (liquid antiseptic and disinfectant used for the treatment and prevention of infections in wounds and cuts) treatment used on her wounds. Resident 231 was not wearing a heel lift boot at the time of the observation. Interview with Resident 231 revealed that she had a doctor's appointment earlier that day; and that the doctor indicated that she would be starting an antibiotic. Clinical record review for Resident 231 revealed no evidence that a physician prescribed an antibiotic for Resident 231. The surveyor requested the progress note from the consulting surgical provider Resident 231 visited on April 30, 2024, during an interview with the Director of Nursing and the Nursing Home Administrator on May 1, 2024, at 2:00 PM, and May 2, 2024, at 10:50 AM. Nursing documentation dated May 1, 2024, at 11:35 PM revealed that the provider was in the facility that evening, reviewed wound care notes, and approved a physician's order for Clindamycin (antibiotic) and ciprofloxacin (Cipro, an antibiotic) based on recommendation from the clinic. Staff faxed the orders to the pharmacy at that time (at least 32 hours after Resident 231 returned from the wound clinic). Interview with the Nursing Home Administrator and the Director of Nursing on May 2, 2024, at 10:50 AM revealed that the facility could not provide the progress note documentation from the consulting wound care provider that evaluated Resident 231 on April 30, 2024. The surveyor called the wound and hyperbaric (oxygen therapy to strengthen natural wound healing) center provider on May 2, 2024, at 11:17 AM and left a voicemail message requesting a return call at the facility to discuss a resident's care that occurred on April 30, 2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nursing Home Administrator provided three of five pages of a progress note from the wound care provider dated April 30, 2024, on May 2, 2024, at 11:36 AM. Following the surveyor's request for page four and five of the document, the facility provided the fourth and fifth pages of the document that indicated medication changes to start the antibiotic, Cipro, 500 milligrams (mg) in the morning and at bedtime for 14 days; Clindamycin HCL 300 mg in the morning, noon and before bedtime for 14 days; and Florastor (probiotic, meant to maintain the normal bacteria in the gut to prevent secondary infections) in the morning and at bedtime for 14 days. A physician's order entered May 1, 2024, at 11:26 PM instructed staff to administer Clindamycin HCL 300 mg TID for cellulitis of amputation site for 14 days; Ciprofloxacin HCL 500 mg two times a day for cellulitis of amputation site for 14 days; and started Acidophilus (Lactobacillus) two times a day for14 days. Facility staff failed to refer wound center recommendations to Resident 231's physician timely, which delayed the implementation of the antibiotic and probiotic therapy. The facility failed to ensure the receipt and availability of wound consultant documentation following the treatment by outside resources. During an interview with Resident 231 on April 30, 2024, at 3:50 PM she stated, I keep thinking I should go (have a bowel movement), feels like I should soon go. Resident 231 denied that she is having a bowel movement at least every two to three days. Clinical record review of a physician's order dated April 20, 2024, revealed staff were instructed to administer 30 ml of MOM (Milk of Magnesia, liquid laxative) as needed for constipation or no bowel movement in three days. A Bowel and Bladder Report (electronic documentation used by the facility to record resident bowel movements) for Resident 231 revealed that she did not have a bowel movement on April 28, 29, and 30, 2024. Staff recorded a bowel movement for Resident 231 on May 1, 2024, at 11:53 AM. Review of Resident 231's MAR dated April 2024 revealed that staff did not administer the MOM medication when Resident 231 did not have a bowel movement in three days. The surveyor reviewed the findings regarding Resident 231's constipation during an interview with the Director of Nursing and the Nursing Home Administrator on May 2, 2024, at 10:50 AM. 483.25 Quality of Care Previously cited deficiency 8/4/23 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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Locust Grove Retirement Village	69 Cottage Road Mifflin, PA 17058

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 38839 Based on clinical record review, observation, and staff interview, it was determined that the facility failed to assess a blister for one of three residents reviewed (Resident 10). Findings include: Clinical record review for Resident 10 revealed a progress note dated April 10, 2024, at 10:57 AM noting the resident had a blister that opened on his left great lateral toe and the resident had stated he rubbed it on his footboard. It was also noted a longer bed was needed and bacitracin (antibacterial ointment) and a Band-Aid were applied. A follow up progress note dated April 10, 2024, at 3:27 PM noted the resident had a 0.5 cm (centimeter) x 0. 5 cm blister that opened on his left great lateral toe and Vaseline and a band aid were applied. A maintenance work order dated April 11, 2024, indicated a longer bed was provided for the resident, and a review of physician orders revealed a treatment order for the resident's toe on April 10, 2024, and changed on April 11, 2024, to apply Vaseline to the area and cover with a band aid. The order was discontinued on April 19, 2024. As of May 1, 2024, at 2:30 PM as confirmed with the Nursing Home Administrator and Director of Nursing, there was no evidence a weekly assessment to include measurements and wound status or any updated assessment of Resident 10's area to his left great toe since the nursing note dated April 10, 2024. Review of a nursing note dated May 1, 2024, at 6:52 PM after the above notification indicated Resident 10's area was healed. An observation of Resident 10's left lateral great toe on May 2, 2024, at 11:30 AM revealed a scabbed area. In an interview with the Nursing Home Administrator and Director of Nursing on May 2, 2024, at 2:15 PM it was confirmed there was no follow up assessment of Resident 10's blister area since April 10, 2024, until brought to the attention by the surveyor on May 1, 2024. 28 Pa. Code 211.10(d) Resident care policies 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18229 Based on clinical record review and staff interview, it was determined that the facility failed to provide services to maintain a resident's range of motion for one of three residents reviewed (Residents 39). Findings include: Clinical record review revealed a quarterly MDS (Minimum Data Set, an assessment completed at specific intervals to determine resident care needs) dated September 6, 2023, noting staff assessed Resident 39 as having no upper or lower extremity impairments. Further review of Resident 39's clinical record revealed a significant change MDS assessment dated [DATE], noting nursing staff assessed Resident 39 as having a limited range of motion (ROM, movement of the body to maintain a resident's ability) to his lower extremity. Nursing staff again assessed Resident 39 as having a limited range of motion to his lower extremity on his most recent quarterly MDS assessment dated [DATE]. Review of occupational therapy documentation revealed Resident 39 was discharged from occupational therapy on December 18, 2023. A review of Resident 39's occupational therapy discharge summary revealed his prognosis to maintain his current level of function would be good with consistent staff follow-through and a restorative nursing program. The occupational therapy discharge summary noted that skilled occupational therapy services were medically necessary to promote lower and upper extremity strength, range of motion, participation in activities of daily living, and to establish a restorative nursing program. Review of Resident 39's clinical record revealed staff did not initiate a restorative nursing program for Resident 39's lower extremity. A review of task documentation for Resident 39 from December 2023 to May 2024, confirmed these findings. The facility failed to ensure Resident 39 received appropriate treatment and services to maintain his range of motion or prevent further decline in his range of motion. The findings for Resident 39 were reviewed with the Director of Nursing on May 3, 2024, at 11:58 AM. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20725 Based on clinical record review and staff interview, it was determined that the facility failed to implement interventions to maintain acceptable parameters of nutritional status for one of six residents reviewed for nutritional concerns (Resident 233). Findings include: Clinical record review for Resident 233 revealed nursing documentation dated April 23, 2024, at 3:00 PM that indicated the facility admitted him from the hospital after multiple intensive care unit assignments, a history of necrotizing pancreatitis (severe inflammation that causes tissue death in the pancreas organ), and with treatment that had included TPN (total parenteral nutrition, medical intervention that provides all the nutrients and calories a person needs through a vein) since March 8, 2024. The documentation stipulated that Resident 233 was to have TPN from 6:00 PM to 6:00 AM. Nursing documentation dated April 23, 2024, at 7:32 PM, and April 24, 2024, at 8:13 PM revealed that the TPN was not available from the pharmacy for administration. Nursing documentation dated April 25, 2024, at 4:19 AM revealed that the TPN was on order and awaiting pharmacy delivery. Nursing documentation dated April 25, 2024, at 9:32 AM revealed that the physician was in to see Resident 233. The physician recommended a no fat, no dairy, diet and to consult the dietician. Staff sent an email to the dietician. The physician also recommended clear ensure (dietary supplement given by mouth) to be given; and to discontinue the house supplement. The documentation also indicated that the Vitamin A supplement ordered for Resident 233 was not available in the facility's pharmacy. Nursing staff made the physician aware of the missed Vitamin A dose and the physician requested that the facility obtain it from a second pharmacy to supply it at the facility. The documentation stipulated that the TPN did not arrive from the pharmacy. The physician indicated that if the facility did not have the TPN by noon, that staff were to transfer Resident 233 to the hospital. The writer indicated that the Director of Nursing was aware and was working on, getting it. Review of Resident 233's MAR and TAR (medication administration record and treatment administration record, electronic documentation of the administration of medications and treatments) dated April 2024, revealed that Resident 233 did not receive the TPN/electrolytes intravenous concentrate that was to start nightly at 6:00 PM on April 23, 24, and 25, 2024. A review of weight assessments obtained by staff for Resident 233 revealed the following weight assessments: April 24, 2024, 165 pounds April 25, 2024, 160.4 pounds (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Mini Nutritional assessment dated [DATE], at 10:15 AM indicated that Resident 233 was in the malnourished category and had a severe decrease in food intake. The assessment indicated that the writer did not know if Resident 233 had a weight loss in the last three months (although Resident 233 reflected a 4. 6 weight loss since his admission to the facility). The assessment stipulated that due to an assessed score of seven, Resident 233 was malnourished. An initial Nutritional Evaluation dated April 25, 2024, at 10:16 AM confirmed that the writer knew that Resident 233's most recent weight was 160.4 pounds (4.6 pounds less than his original weight assessment). The assessment reviewed the nutrients provided by the physician ordered TPN, and that Resident 233 was ordered a Vitamin A supplement; however, the assessment failed to include that Resident 233 had not received one administration of the TPN or Vitamin A supplement since his admission to the facility. The nutritional assessments failed to identify that Resident 233 reflected a 4.6-pound weight loss between the April 24, 2024, and April 25, 2024, assessments. The nutritional assessments failed to identify that Resident 233 had not received any TPN nutrition or Vitamin A supplements due to unavailability from the facility pharmacy. Nursing documentation dated April 25, 2024, at 11:30 AM revealed that the facility's physician was waiting for a prescription from the pharmacy for a signature, and the documentation indicated that the TPN would be in the evening delivery to the facility. The first indication that Resident 233 received any parenteral nutrition was nursing documentation dated April 26, 2024, at 12:31 PM that TPN would be infusing until 11:00 AM (indicative that the TPN would have been started on April 25, 2024, at 11:00 PM; more than two days after Resident 233's admission to the facility). Review of Resident 233's MAR and TAR dated May 2024, revealed that Resident 233 had not received one dose of his physician ordered Vitamin A supplement since residing in the facility. The surveyor reviewed the above concerns regarding Resident 233 during an interview with the Director of Nursing and the Nursing Home Administrator on May 1, 2024, at 2:00 PM, and May 2, 2024, at 10:50 AM. The interview confirmed that the facility had not obtained a supply of Vitamin A for Resident 233. 28 Pa. Code 211.2(d)(3) Medical director 28 Pa. Code 211.9(f)(4)(k) Pharmacy services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 18229 Based on clinical record review and staff and resident interview, it was determined that the facility failed to identify triggers related to a resident's diagnosis of Post-Traumatic Stress Disorder, to provide culturally, competent, trauma-informed care, and to eliminate or mitigate re-traumatization for one of five residents reviewed for mood/behavior (Resident 3). Findings include: Clinical record review for Resident 3 revealed a diagnosis of Chronic Post Traumatic Stress Disorder (PTSD, a mental and behavioral disorder that develops related to a terrifying event) since October 27, 2023. Review of a social service progress note dated April 7, 2023, 12:22 PM revealed Employee 13 (social worker) reviewed recent behaviors of increased agitation and yelling out, including some verbal abuse towards others. Documentation revealed Resident 3 continues to be significantly confused at baseline and continues medication management for mood and behavior concerns. Employee 13's documentation noted Resident 3 has expressed at times that he has just returned from the war and that he has a gunshot wound. Employee 13 noted that it is understood that Resident 3 is a veteran. She noted that it is possible that Resident 3 is recalling some memories from his military years and is unable to orient himself to the current reality due to dementia and confusion. Employee 13 noted to refrain from crowding or overstimulation of Resident 3 during efforts to de-escalate. She also noted to speak in a calm manner, level voice, and do not engage in an argumentative narrative with Resident 3. Employee 13 noted Resident 3's care plan was reviewed. Review of Resident 3's care plan revealed the facility did not label his diagnosis of PTSD. There were no identified triggers (everyday situations that cause a person to re-experience the traumatic event as if it was reoccurring). Interview with Employee 13 on May 2, 2024, at 11:10 AM confirmed these findings. She confirmed that the facility added Resident 3's PTSD diagnosis in October 2023, and did not identify triggers until April 2024. The identified triggers were never added to Resident 3's plan of care to help staff understand, recognize, and respond to the effects of Resident 3's previous trauma. These findings were reviewed with the Nursing Home Administrator and Director of Nursing on May 2, 2024, at 2:38 PM. 28 Pa Code 211.12 (d)(3)(5) Nursing services

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 38839 Based on clinical record review, review of facility documents, and resident, family member, and staff interview, it was determined that the facility failed to have sufficient nursing staff to meet resident's needs for four of 24 residents reviewed (Resident 28, 33, 52, and 64). Findings include: A review of a facility complaint/grievance form dated March 6, 2024, noted a resident concern regarding call bell response times. The investigation to the concern was noted as completed on March 25, 2024, by a registered nurse, and indicated, Call bell response times have increased due to staffing shortages, response times are monitored and while it is found to have increased response time, it is not because staff are choosing to not respond it is simply because that are extremely busy. The concern form had not yet been noted as resolved as of May 3, 2024. Facility nurse staffing was reviewed for the week of March 22 - March 28, 2024, which included the March 25, 2024, date the grievance investigation was completed and reflected the facility had an average staffing of 2.66 hours per patient day, below the state minimum of 2.87. The facility only met the minimum one day during the week and fell below on the dates indicated below: March 22, 2024, 2.48 March 23, 2024, 2.64 March 24, 2024, 2.74 March 25, 2024, 2.53 March 26, 2024, 2.78 March 28, 2024, 2.38 In an interview with Resident 13, on April 30, 2024, at 11:40 AM the resident indicated she will often wait when she rings her call bell for care to be completed but was patient and understood because the facility was short staffed, and the staff are really busy. Resident 13 did not wish to provide specifics on call bell wait times. In an interview with Resident 33 on May 1, 2024, at 9:52 AM the resident stated she is to get showered on Tuesdays and Fridays, during the day, and doesn't refuse them, but stated she had a fracture and, that's maybe why she wasn't getting them. Clinical record review for Resident 33 did reveal the resident had sustained a fracture in her leg in March 2024, and was scheduled to receive showers on Tuesdays and Fridays on the 2-10:00 PM shift and as needed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 33's bathing records for April 2024, revealed the resident was totally dependent on staff for bathing, and did receive a shower on April 2 and April 9, 2024, on her scheduled shower days after her fracture, but had only received a bed bath on April 5, 23, and 26; a partial bed bath on April 19 and 30; and April 16 was noted as response not required. There was no evidence Resident 33 could not receive a shower due to her fracture nor any documented showers on an as needed basis outside of her scheduled shower days. In a follow up interview with Resident 33 on May 3, 2024, at 10:45 AM regarding only receiving a partial bed bath on April 30, 2024, the resident stated she could not get a shower because there was only one. When the resident was asked one what? the resident stated, one girl, referencing the staff. Interview with Resident 28 on April 30, 2024, at 11:34 AM revealed that the facility is short-staffed. He stated it could take a long time for staff to respond to his call bell due to not having enough staff. Resident 28 stated that he has waited for 30 to 45 minutes for the staff to take him to the bathroom. A review of facility staffing for the resident's scheduled shower day of April 30, 2024, revealed the facility did not meet state minimum requirement for nurse staffing for the day as follows: Dayshift: 5.0 nurse aides, required 6.58. 2.0 licensed practical nurses, required 3.16. Evening shift: 1.5 nurse aides, required 6.58. The facility's nursing hours per patient day for April 30, 2024, was 2.13 below the state minimum of 2.87. Interview with Resident 52 on April 30, 2024, at 12:06 PM revealed that she is not getting her showers. Resident 52 indicated it might be because the facility never has enough staff. Interview with Resident 64's responsible part on April 30, 2024, at 12:45 PM revealed that his mother has to wait a long time for call bells because they don't have enough staff. Interview with the Director of Nursing on May 2, 2024, at 10:50 AM revealed that the facility accepted a new admission on May 1, 2024, despite not being able to meet the minimum number of staff required for the current census. The above concerns regarding grievance response and resident care completion with staffing was reviewed with the Nursing Home Administrator and Director of Nursing on May 3, 2024, at 11:38 AM. Refer to 677 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.18(e)(1)(6) Management 28 Pa. Code 211.12(d)(1)(3)(4)(5) (f)(f.1)(2)(3)(4) (i)(1) Nursing services

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 20725 Based on review of select facility policies and procedures, observation, and review of personnel records, it was determined that the facility failed to ensure specific competencies necessary to care for resident needs for one of two residents reviewed for intravenous access concerns (400 hall nursing unit, Resident 74, Employee 7). Findings include: The facility policy entitled, Peripheral Intravenous Catheter Flushing, last reviewed without changes on March 29, 2024, revealed that infusion therapy in the post-acute care facility is performed by licensed nurses according to state law and facility policy. The nurse is responsible and accountable for obtaining and maintaining competence with infusion therapy within his or her scope of practice. Competency validation is documented in accordance with organizational policy. According to, Pennsylvania Code, Title 49, Chapter 21, Functions of the LPN, an LPN (licensed practical nurse) may perform only the IV (intravenous) therapy functions for which the LPN possesses the knowledge, skill, and ability to perform in a safe manner. Observation of the 400-hall nursing unit on May 1, 2024, at 1:37 PM revealed Employee 7 (licensed practical nurse) preparing an intravenous solution of Cefazolin Sodium (liquid antibiotic), 2000 milligrams, for administration via Resident 74's PICC line (PICC, 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.). Continued observation of Employee 7 on May 1, 2024, at 1:43 PM revealed she administered 10 milliliters of normal sterile saline flush solution via Resident 74's PICC site before connecting the intravenous Cefazolin Sodium medication, which infused via an electrical pump. Employee 7 entered settings on the electrical pump to prompt administration of the medication over a one-hour period. The surveyor requested any intravenous or PICC line competencies or specialized trainings completed with Employee 7 during an interview with the Nursing Home Administrator and Director of Nursing on May 1, 2024, at 2:00 PM, and May 2, 2024, at 2:00 PM. Interview with the Director of Nursing and the Nursing Home Administrator on May 3, 2024, at 10:50 AM revealed that the facility had no evidence of any competencies or specialized trainings completed with Employee 7 pertaining to intravenous medication administration via a PICC line. 28 Pa. Code 201.19(7) Personnel policies and procedures 28 Pa. Code 201.20(a)(6)(d) Staff development 28 Pa. Code 211.12(d)(1) Nursing services

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 18229 Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement individualized person-centered care plans to address dementia and cognitive loss displayed by one of two residents reviewed (Resident 3). Findings include: Clinical record review for Resident 3 revealed the facility admitted him on September 17, 2021. A diagnosis of dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life) was added on November 29, 2022. A review of Resident 3's most recent annual Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated August 15, 2023, indicated that the facility assessed Resident 3 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed. A review of Resident 3's care plan revealed that there was no indication that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss. Interview with Employee 13 (social worker) on May 3, 2024, at 10:02 AM confirmed the facility had no further documentation that the facility developed and implemented an individualized person-centered care plan to address Resident 3's dementia and cognitive loss. 28 Pa Code 211.12 (d)(1)(3)(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. 18229 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 for medication regime review (Resident 3). Findings include: Clinical record review revealed that the facility admitted Resident 3 on September 17, 2021. Resident 3's clinical record revealed a physician's order for Seroquel (an antipsychotic medication) 25 milligrams (mg) every 24 hours as needed (PRN) for agitation on September 20, 2023. Review of the consultant pharmacist's recommendation dated September 22, 2023, revealed Resident 3 has a PRN order for Seroquel without a stop date. The consultant pharmacist requested the facility discontinue Resident 3's PRN Seroquel or add a stop date that does not exceed 14 days from initiation. If the PRN antipsychotic cannot be discontinued at this time, the prescriber should directly examine the resident to determine if the antipsychotic is still needed and document the specific condition being treated before issuing a new PRN order. The prescribing physician's response on September 28, 2023, was Seroquel indefinite per psych. Review of the consultant pharmacist recommendation dated January 29, 2024, revealed Resident 3 has a PRN order for Seroquel 25 mg every four hours as needed for agitation, with no stop date since November 10, 2023. Nursing staff only administered it one time in December 2023 and not at all in January 2024. The consultant pharmacist requested the facility discontinue Resident 3's PRN Seroquel or add a stop date that does not exceed 14 days from initiation. If the PRN antipsychotic cannot be discontinued at this time, the prescriber should directly examine the resident to determine if the antipsychotic is still needed and document the specific condition being treated before issuing a new PRN order. The prescribing physician's response on February 2, 2024, was Resident is finally stable, no change indicated. Review of the consultant pharmacist recommendation dated March 28, 2024, revealed Resident 3 has a PRN order for Seroquel without a stop date. The consultant pharmacist requested the facility discontinue Resident 3's PRN Seroquel or add a stop date that does not exceed 14 days from initiation. If the PRN antipsychotic cannot be discontinued at this time, the prescriber should directly examine the resident to determine if the antipsychotic is still needed and document the specific condition being treated before issuing a new PRN order. The prescribing physician's response on April 4, 2023, was stable on current regimen. An interview with the Nursing Home Administrator and Director of Nursing on May 3, 2024, at 11:02 AM confirmed these findings. The facility was unable to provide any documentation by the attending physician, or prescribing practitioner that showed Resident 3's PRN Seroquel was appropriate to be extended beyond 14 days. There was no documented rationale in Resident 3's clinical record or any indication of the duration of Resident 3's PRN Seroquel. (continued on next page)

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	395350	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Locust Grove Retirement Village	69 Cottage Road Mifflin, PA 17058

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(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 review of select facility policies and procedures, observation, and staff interview, it was determined that the facility failed to ensure a medication error rate below five percent (100/200/300 hall nursing unit, Residents 62 and 15). Findings include: The facility's medication error rate was 6.67 percent based on 30 medication opportunities with two medication errors. The facility policy entitled, Medication - Oral Administration Of, last reviewed without changes on March 29, 2024, revealed that staff should compare the medication unit/dose label against the MAR prior to returning the medication container or card to the medication cart or disposing of the empty container; and prior to supporting the resident to accept and ingest the medication. The policy did not include the expectation of nursing staff when there are specific instructions printed on the pharmacy label such as, give with food, or give with a meal. Review of the facility's mealtimes revealed that the 100 Hall receives the breakfast meal at 7:15 AM. Observation of a medication administration pass on the 100 Hall nursing unit on April 30, 2024, at 10:29 AM revealed Employee 8 (licensed practical nurse) prepared Metformin HCL (medication used to lower blood sugar) 1000 mg (milligrams) for administration to Resident 62. The pharmacy label on the medication instructed staff to administer the medication with a meal. Employee 8 did not provide any food to Resident 62 when she administered the medication to Resident 62 on April 30, 2024, at 10:35 AM. Interview with Employee 8 on April 30, 2024, at 10:35 AM revealed that Resident 62 likely finished her breakfast at approximately 7:45 AM. Employee 8 stated that Resident 62 may have received a snack during the morning activity that she was involved in at the time of the medication administration. Interview with Employee 4 (activities aide) on April 30, 2024, at 10:53 AM revealed that there was no food provided at the morning activity. The residents were given a beverage of either coffee or hot chocolate. Continued observation of a medication administration pass on the 100 Hall nursing unit on April 30, 2024, at 10:39 AM revealed Employee 8 prepared Celecoxib (a nonsteroidal anti-inflammatory drug that reduces hormones that cause inflammation and pain in the body) 100 mg for administration to Resident 15. The pharmacy label on the medication instructed staff to administer the medication with food. Employee 8 did not provide any food to Resident 15 when she administered the medication. Interview with Employee 8 on April 30, 2024, at 10:50 AM confirmed that she did not provide any food to either Residents 62 or 15 despite medications administered included instructions from the pharmacy to do so. (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 medication administration during an interview with the Nursing Home Administrator and the Director of Nursing on May 1, 2024, at 2:00 PM. The interview indicated that the facility was unable to provide a policy or procedure provided to staff who administer medications relating to the expectation to administer medications with food when the label on the medication or manufacturer's instructions stipulates to do so. 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.10(a)(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 19719 Based on observation, review of select policies and procedures, and staff interview, it was determined that the facility failed to secure medications and biologicals on one of two nursing units (One, Two, Three Hall nursing unit). Findings include: Review of the policy entitled Storage and Expiration of Medications, Biologicals, Syringes, and Needles, last reviewed on March 29, 2024, indicates that the facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or in a medication room that is inaccessible by residents and visitors. The policy indicates that the facility should ensure that medications and biologicals are stored at appropriate recommended temperatures. Observation of the One, Two, Three hall nursing unit on April 30, 2024, at 9:45 AM revealed medications laying on the counter to include Zofran (anti-nausea medication), Celexa (treats major depression), Buspar (treats anxiety), Incruse Ellipta inhaler (used to treat chronic lung conditions), and a bottle of liquid Keppra (used to treat seizures). The medications were available to non-licensed staff, visitors, and residents. Interview with the Director of Nursing on April 30, 2024, at 9:50 AM confirmed the above observations. Observation of the One, Two, Three hall nursing unit on May 2, 2024, at 12:45 PM revealed an unlocked room containing an unlocked treatment cart. Medications available to non-licensed staff, residents, and visitors included Lidocaine cream (used for pain), Diclofenac Sodium (used for pain), Hydrocortisone cream (topical steroid), Nystatin powder (used to treat fungal infections), Triamcinolone (treats skin conditions), Ketoconazole shampoo (an anti-fungal), and a combination cream containing Silvadene, Zinc, and Nystatin (used to treat skin conditions). Two of the creams had labels that indicated the facility should be storing them in the refrigerator. Interview with Employee 8, Licensed Practical Nurse, on May 2, 2024, at 12:50 PM confirmed the above findings and indicated that the treatment cart should have been locked, and that medications requiring refrigeration should have been in the refrigerator. 28 Pa. Code 211.9 (k) Pharmacy services 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38839 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 implement appropriate enhanced barrier transmission-based precautions on two of two nursing units (400, and 100/200/300 nursing unit; Residents 65, 74, 231, and 232). Findings include: Review of the memo entitled Enhanced Barrier Precautions (EBP, gown and glove use) in Nursing Homes to Prevent the Spread of Multi-drug Resistant Organisms released by the Center for Medicaid and Medicare Services (CMS) on March 20, 2024, with an implementation date of April 1, 2024, revealed that nursing care facilities are to use EBP for residents with chronic wounds or indwelling medical devices (i.e., indwelling urinary catheters) during high-contact resident care activities regardless of their multidrug-resistant organism status. High-contact activity would include things like dressing, transferring, changing linens, providing hygiene, changing briefs, wound care, or device care. Review of the CDC (Centers for Disease Control) informational poster entitled, Enhanced Barrier Precautions (EBP) Steps, revealed that the last step is to dispose of the gown and gloves in the room. An observation of Resident 65 on April 30, 2024, at 12:20 PM revealed the resident was in his room sitting in a wheelchair with a catheter in place. There was no evidence of any enhanced barrier precautions sign prior to or upon entering the resident room or additional personal protective equipment (PPE) such as gowns, in or around the room to care for the resident. Clinical record review for Resident 65 revealed a physician's order for the resident to have a foley catheter since the resident's admission to the facility on [DATE]. In a follow up observation and interview with Resident 65 on April 30, 2024, at 1:18 PM Resident 65 stated he has had a catheter since January, and the staff do not wear gowns when caring for him, just normal clothes. Further observation on May 1, 2024, at 9:22 AM and May 2, 2024, at 11:40 AM of Resident 65 revealed the resident still did not have any evidence of EBP in place (signage or additional PPE available in or near the room). In a concurrent interview on May 2, 2024, of a nurse aide (Employee 14) working in Resident 65's hallway, the nurse aide stated other than gloves, no additional PPE was needed to care for Resident 65. When asked if anything extra was needed besides the gloves due to the resident having a catheter, the nurse aide stated, she was not sure as some residents with catheters have signs and PPE bins in their room, but others do not. The nurse aide then stated when there is a sign for additional precautions, she follows the precautions listed, and since Resident 65 did not have a sign, she would not need to utilize additional PPE other than the gloves. The nurse aide confirmed Resident 65 has had a catheter and no EBP were implemented for the resident. The above findings were reviewed with the Nursing Home Administrator and Director of Nursing on May 2, 2024, at 2:30 PM. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy entitled, Enhanced Barrier Precautions, last reviewed without changes on March 29, 2024, revealed that signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. PPE is available outside of the resident rooms. Observation of Resident 231 on April 30, 2024, at 3:48 PM revealed she was in bed with her foot wrapped in white gauze. Observation of the gauze revealed two small circular areas of orange discoloration. Resident 231 stated that she was not sure if the areas were indicative of wound drainage or the color of the betadine (liquid antiseptic and disinfectant used for the treatment and prevention of infections in wounds and cuts) treatment used on her wounds. Observation of Resident 231's room revealed no evidence that the facility implemented EBP for her. Observation Resident 231's room on May 2, 2024, at 11:50 AM revealed no evidence of EBP measures. Interview with Resident 232 on April 30, 2024, at 2:23 PM revealed that she recently had brain surgery and had wounds on her head. Resident 232 removed a crocheted cap, which resulted in a gauze wrap falling from her head and exposing gauze stuck to an area of the right side of her head. Observation of Resident 232's room revealed no evidence that the facility implemented EBP for her. Observation of Resident 232's room on May 2, 2024, at 11:50 AM revealed no evidence of EBP measures. Interview with Employee 7 (licensed practical nurse, LPN) on May 2, 2024, at 11:55 AM confirmed that Residents 231 and 232 have wounds; however, neither resident have EBP measures in place. Observation of Resident 74's room on April 30, 2024, at 1:35 PM revealed an enhanced barrier precautions sign on the door and a plastic bin of PPE outside the door. Clinical record review for Resident 74 revealed a physician's order dated April 9, 2024, for staff to implement enhanced barrier precautions. Observation of Resident 74's room on May 1, 2024, at 1:40 PM revealed a sign indicating that EBP were required to enter and/or provide care to Resident 74. Observation of an administration of an intravenous medication for Resident 74 on May 1, 2024, at 1:40 PM revealed Employee 7 used hand sanitizer and donned an isolation gown and gloves to begin the medication administration via Resident 74's PICC line (PICC, 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.). Continued observation of Resident 74's treatment on May 1, 2024, at 1:46 PM revealed Employee 7 left Resident 74's room to the hallway outside his door to remove her isolation gown and gloves. Employee 7 held the isolation gown as a ball in her hands, walked to the other hallway on the nursing unit to the soiled utility room, used her hands to open the secured soiled utility room door, and discarded the isolation gown. Employee 7 confirmed that there were no receptacles in Resident 74's room or in the hallway to put the reusable isolation gown when removed. Employee 7 performed hand hygiene after disposing of the gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor reviewed the above findings regarding Residents 231, 232, and 74 during an interview with the Nursing Home Administrator and the Director of Nursing on May 2, 2024, at 1:45 PM. 28 Pa. Code 201.18(b)(3)(d)(e)(1) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services