STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395356	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guy and Mary Felt Manor, Inc	110 East Fourth Street Emporium, PA 15834

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** Based on clinical record review and staff interview, it was determined that the facility failed to establish clear and consistent resident wishes regarding advance directives for two of four residents reviewed for advance directive concerns (Residents 11 and 22). Findings include: Clinical record review of Resident 11's physical chart revealed a POLST (Physician Orders for Life-Sustaining Treatment, portable medical order form that records residents' treatment wishes so that emergency personnel know what treatment the resident wants in the event of a medical emergency) signed by a physician on [DATE], and signed by Resident 11 that indicated Resident 11 desired CPR (Full Code, cardiopulmonary resuscitation, chest compressions and artificial breathing assistance upon a medical emergency and/or death); however, limited other interventions such as refusing intubation (DNI, do not insert a tube into the airway to help with breathing). Review of active physician orders in Resident 11's electronic medical record instructed staff to implement Full Code treatment. Interview with Employee 1 (licensed practical nurse/infection prevention control preventionist) and Employee 2 (registered nurse) on [DATE], at 2:22 PM revealed that in the event of a medical emergency for Resident 11, both employees would refer to her electronic medical record physician's order that did not include a prohibition for intubation. Employees 1 and 2 confirmed that current physician orders for Resident 11 instructed staff to implement Full Code treatment. Employees 1 and 2 reviewed the POLST included in Resident 11's physical chart and confirmed Resident 11's wishes were to restrict intubation. Clinical record review of Resident 22's physical chart revealed social services documentation dated [DATE], at 4:31 PM that revealed that Resident 22 completed admission paperwork, and Resident 22 stated that her son is one person designated as her power-of-attorney. The documentation indicated that a POLST was completed with Resident 22 for Full Code, limited interventions. The writer indicated that the form would be forwarded to the physician for signature and filed. Social services documentation dated [DATE], at 4:17 PM revealed that Resident 22's son was present to discuss Resident 22's code status. Resident 22's son completed the POLST with Resident 22 and selected CPR with limited interventions. The writer indicated that the form would be forwarded to the physician for signature and filed in Resident 22's medical record. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A POLST signed by a physician on [DATE], and signed by Resident 22's responsible party (son) indicated Resident 22 was to receive CPR; however, was not to receive intubation (DNI) as stipulated in the limited interventions. Review of active physician orders in Resident 22's electronic medical record (EMR) instructed staff to implement Full Code treatment. Interview with Employees 1 and 2 on [DATE], at 2:22 PM revealed that because Resident 22's active EMR (electronic medical record) physician orders instructed Full Code and there was no sticker on the outside of Resident 22's physical medical record, staff would determine that they were to implement Full Code CPR treatment without any restriction to intubation. The surveyor reviewed the DNI omission from Resident 11's and Resident 22's electronic physician orders during an interview with the Director of Nursing and the Nursing Home Administrator on [DATE], at 2:30 PM. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on clinical record review, review of select policies and procedures, and staff and resident interview, it was determined that the facility failed to thoroughly investigate and notify the appropriate agencies of an identified incident of potential resident misappropriation of property (money) for one of one resident reviewed (Resident 130). Findings include: Review of the facility's active policy entitled Abuse Policy, last reviewed without changes on January 29, 2025, revealed that each resident will be free and protected from abuse, including misappropriation of resident property. Reports of misappropriation of resident property are promptly and thoroughly investigation. The administrator or designee will direct completion of an active search for missing item(s), immediately protect the resident, and coordinate delivery of appropriated medical and/or psychological care and attention. The investigation will consist of at least the following: Review of the completed complaint report Interview with the person or persons reporting the incident Interview with any witnesses Review of the resident record A search of the resident room (with resident permission) Interview with staff members having contact with the resident during the relevant periods or shifts of the alleged incident Interview with the resident's roommate, family members, and visitors Root-cause analysis of all circumstances surrounding the incident Results of the investigation will be documented and attached to the report. The resident and/or family will be notified of the completion of the investigation and whether the incident was substantiated. During an interview with Resident 130 on June 16, 2025, at 12:21 PM the resident indicated that their spouse had given them $100.00 for use at the beauticians to receive a perm. They had placed the money in their purse. One week prior to this interview, the resident checked the purse and noticed $80.00 of the $100.00 was missing. Resident 130 sent the purse home with her spouse upon identification of the missing funds. Resident 130 notified the facility on June 13, 2025. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clinical record review for Resident 130 revealed that on May 30, 2025, Resident 130's spouse indicated that they would not like to set up a resident fund account and did not wish to have a key to their locked drawer. On June 13, 2025, at 2:39 PM the facility's social worker re-educated Resident 130 and their spouse regarding the facility's petty cash fund and a key lock for the side table drawer. Both continued to deny a petty cash account or a key for the side drawer. Social services indicated to notify them should that wish to utilize either and requested the spouse notify staff when leaving funds for the resident's use. There was no documentation of any incidents regarding missing funds or reported misappropriation of any property for Resident 130. During interviews with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on June 16, 2025, at 3:05 PM and June 17, 2025, at 2:50 PM, and with the Director of Nursing on June 18, 2025, at 8:49 AM information regarding the facility's investigation of Resident 130's allegation of missing money was requested. On June 18, 2025, at 12:15 PM, the facility provided copies of the Pennsylvania Department of Health's (PA DOH) Electronic Reporting System (ERS) dated June 18, 2025, the Pennsylvania Department of Aging and Pennsylvania Department of Human Services' Mandatory Abuse Report dated June 18, 2025, and two witness statements dated June 13, 2025. There was no documentation provided that indicated they initiated and/or thoroughly investigated Resident 130's allegation of misappropriation of resident funds prior to June 18, 2025. The surveyor reviewed this information during an interview the NHA on June 18, 2025, at 11:53 AM. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (e)(1) Management

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on review of select policies and procedures, resident and staff interview, and clinical record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for one of one resident reviewed (Resident 130). Findings include: The policy entitled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property last reviewed without changes on January 29, 2025, revealed that all alleged violations involving misappropriation of resident property are reported immediately to the administrator. All owners, operators, employees, managers, agents, or contractors must report to the State Agency and law enforcement entities any reasonable suspicion of a crime against an individual who is a resident of or is receiving care from the facility no later than 24-hours if the events did not result in serious bodily injury. During an interview with Resident 130 on June 16, 2025, at 12:21 PM the resident indicated that their spouse had given them $100.00 for use at the facility's beautician to receive a perm. They had placed the money in their purse. One week prior to this interview, the resident checked the purse and noticed $80.00 of the $100. 00 was missing. Resident 130 sent the purse home with her spouse upon identification of the missing funds. Resident 130 indicated they notified the facility on June 13, 2025. Clinical record review for Resident 130 revealed that on May 30, 2025, Resident 130's spouse indicated that they would not like to set up a resident fund account and did not wish to have a key to their locked drawer. On June 13, 2025, at 2:39 PM the facility's social worker re-educated Resident 130 and their spouse regarding the facility's petty cash fund and a key lock for side table drawer. Both continued to deny needing a petty cash account or a key for the side drawer. Social services indicated to notify them should they wish to utilize either and requested the spouse to notify staff when leaving funds for the resident's use. There was no documentation of any incidents regarding missing funds or reported misappropriation of property for Resident 130 in their clinical record. During interviews with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on June 16, 2025, at 3:05 PM information regarding the facility's investigation of Resident 130's allegation of missing money was requested. The DON confirmed that the facility was aware of the need to timely investigate resident concerns of misappropriation and reporting reasonable suspicions of crime to the appropriate identified authorities. On June 18, 2025, at 12:15 PM the facility provided copies of the Pennsylvania Department of Health's (PA DOH) Electronic Reporting System (ERS) dated June 18, 2025, the Pennsylvania Department of Aging and Pennsylvania Department of Human Services Mandatory Abuse Report dated June 18, 2025, and two witness statements dated June 13, 2025. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the PA DOH ERS on June 18, 2025, revealed that the NHA submitted an electronic report regarding Resident 130's misappropriation allegations on June 18, 2025, at 10:06 AM, almost 5 days after Resident 130 notified the facility of potential misappropriation. Further review of the facility's ERS report dated June 18, 2025, revealed that the facility acknowledged Resident 130's notification and indicated that the surveyor was notified of the concern by Resident 130 on June 16, 2025. The surveyor informed the facility of the resident's concern on June 16, 2025. Further review revealed that the required agencies were not notified of the reasonable suspicion of crime until June 18, 2025. There was no documentation provided that indicated that they reported Resident 130's allegation of misappropriation of resident funds to the Department of Heath, Department of Aging, or any law enforcement entity prior to June 18, 2025. The surveyor reviewed this information during an interview with the NHA and DON on June 16, 2025, at 3:05 PM. 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 201.19 Personnel policies and procedures 28 Pa. Code 201.29(a) Resident rights 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to develop a comprehensive care plan for two of 12 residents reviewed (Residents 11 and 22). Findings include: Clinical record review for Resident 11 revealed nursing documentation dated March 20, 2025, at 3:32 AM that staff found Resident 11 on the floor beside her wheelchair. Resident 11 stated that she fell asleep in her wheelchair. Staff assessed redness on the upper left corner of Resident 11's forehead. Review of the facility's investigation of Resident 11's fall on March 20, 2025, revealed that the new intervention to prevent fall recurrence was to remind staff to attempt to get Resident 11 to lay in bed when she appears sleepy in her wheelchair. Nursing documentation dated April 19, 2025, at 9:54 PM revealed that staff heard yelling and found Resident 11 on the floor beside her wheelchair. Resident 11 stated that she fell asleep, had a dream, and fell out of her wheelchair. Review of the facility's investigation of Resident 11's fall on April 19, 2025, revealed that the new intervention to prevent fall recurrence was for staff to attempt to offer Resident 11 to lay down in bed if sleepy at 10:00 PM. Review of Resident 11's plan of care developed by the facility on May 5, 2023, to address Resident 11's risk for falls revealed a list of interventions; however, the instruction for staff to attempt to get Resident 11 to lay in bed when she appears sleepy in her wheelchair (before or at 10:00 PM) was not included in the interventions. Review of Resident 11's medication regime revealed the use of Apixaban (Eliquis, an anticoagulant to thin blood and prevent blood clots) two times a day related to a history of thrombosis (stationary blood clot) and embolism (blood clot that has traveled from its original location). An annual MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated March 6, 2025, revealed that Resident 11's medications included the use of an anticoagulant. A physician's progress note dated June 11, 2025, at 7:26 AM revealed a list of diagnoses that included the presence of a pacemaker (medical device surgically implanted in the chest that helps regulate the heart's rhythm by delivering electrical impulses to the heart as needed). Appointment documentation dated June 16, 2025, at 3:29 PM revealed that the facility received instructions from Resident 11's cardiologist (physician that specializes in diseases of the heart) to schedule a pacemaker check in the office on June 24, 2025, at 9:45 AM. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 11's plans of care revealed no entries related to her use of an anticoagulant or the presence of a cardiac pacemaker. The surveyor reviewed the above concerns regarding Resident 11's plan of care during an interview with the Director of Nursing and the Nursing Home Administrator on June 17, 2025, at 2:00 PM. Interview with Resident 22 on June 16, 2025, at 1:46 PM revealed that she required antibiotics for a urinary tract infection with MRSA (Methicillin-resistant Staphylococcus aureus, bacteria that is resistant to many antibiotics and can cause serious infections) when first admitted to the facility. Clinical record review for Resident 22 revealed an admission MDS dated [DATE], that did not indicate that Resident 22 had a urinary tract infection in the last 30 days or that she presented with a multi-drug-resistant organism (MDRO). Nursing documentation dated November 26, 2024, at 10:17 AM revealed that the certified registered nurse practitioner requested Resident 22 have a urinalysis with culture and sensitivity test. Lab results documentation dated November 28, 2024, at 1:18 PM revealed that the facility was made aware that Resident 22's urine had greater than 100,000 cfu (colony-forming units of viable bacteria) of Staphylococcus present. A laboratory report dated as collected November 27, 2024, revealed that Resident 22 had a urinary tract infection with MRSA. Nursing documentation dated November 30, 2024, at 10:36 AM revealed that Resident 22 received Doxycycline (antibiotic) for a urinary tract infection with MRSA, and she was on contact isolation (interventions implemented to prevent the spread of infection that include the use of handwashing, isolation gowns, and gloves for all resident care). Nursing documentation dated January 1, 2025, at 6:57 AM revealed that Resident 22 was not responding well, was pale, and exhibited nonsensical conversation. Staff arranged for her transport to the hospital emergency room for evaluation, and Resident 22 left the facility. Nursing documentation dated January 1, 2025, at 2:09 PM revealed that Resident 22 returned to the facility with a diagnosis of a urinary tract infection and would receive Macrobid (antibiotic) for seven days. A physician's order dated January 1, 2025, instructed staff to administer Macrobid 100 mg (milligrams) twice daily for seven days for a urinary tract infection. Observation of Resident 22's room on June 16, 2025, at 1:08 PM revealed a sign to stop and see nursing staff before entering, and a sign to use contact precautions (clean hands before entering and when leaving the room, staff to don gloves and a gown before entering the room, and staff to use dedicated or disposable equipment for care). Interview with Employee 10 (nurse aide) on the date and time of the observation revealed that Resident 22 had MRSA in her urine, that she was incontinent of urine, and that she wears incontinent briefs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of a medication administration pass for Resident 22 with Employee 7 (licensed practical nurse) on June 16, 2025, at 4:12 PM confirmed that the signage on Resident 22's room entry area indicated that she required contact isolation precautions. Review of Resident 22's plans of care revealed no evidence that the facility developed a plan of care to address Resident 22's history of urinary tract infections with an MDRO or that she required the implementation of contact precaution isolation. The surveyor reviewed the above concerns regarding Resident 22's plans of care during an interview with the Director of Nursing and Employee 1 (licensed practical nurse/infection control prevention coordinator) on June 18, 2025, at 9:00 AM. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 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 two of three residents reviewed for ROM concerns (Residents 12 and 14). Findings include: Clinical record review revealed the facility admitted Resident 12 on January 6, 2025. Review of Resident 12's admission MDS (Minimum Data Set, an assessment completed at specific intervals to determine care needs) dated January 13, 2025, noted staff assessed Resident 12 as having no impairment to her range of motion (ROM, movement of the body to maintain a resident's ability) of her bilateral upper and lower extremities. Review of 12's next quarterly MDS dated [DATE], noted staff assessed Resident 12 as having declined, with bilateral impairments to her upper and lower extremities. Review of Resident 12's physical therapy documentation revealed that she was discharged from therapy on April 10, 2025. There was no evidence that the facility addressed Resident 12's decline in range of motion. Interview with Employee 11 (registered nurse assessment coordinator) and Employee 12 (physical therapist assistant) on June 18, 2025, at 10:02 AM confirmed these findings for Resident 12. Clinical record review revealed the facility admitted Resident 14 on January 17, 2024. Review of Resident 14's annual MDS dated [DATE], noted staff assessed Resident 14 as having no impairment to her range of motion. Review of Resident 14's quarterly MDS assessment dated [DATE], noted staff assessed Resident 12 as having declined, with bilateral impairments to her upper and lower extremities. Review of Resident 14's physical therapy documentation revealed that she was discharged from therapy on April 10, 2025. Physical therapy discharge recommendations included a recommendation of a walk to dine program for Resident 14 with nursing. There was no evidence that the facility addressed Resident 14's decline in range of motion or implemented the recommended walk to dine program for Resident 14. Interview with Employees 11 and 12 on June 18, 2025, at 10:02 AM confirmed these findings for Resident 14. Further interview with Employee 12 on June 18, 2025, at 11:56 AM confirmed the nursing staff never implemented Resident 14's recommended walk to dine program. The above findings for Residents 12 and 14 were reviewed with the Director of Nursing and Nursing Home Administrator on June 17, 2025, at 2:00 PM. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident's attending physician addressed pharmacy recommendations for two of five residents reviewed for unnecessary medications (Residents 11 and 7). Findings include: Clinical record review for Resident 11 revealed a consultant pharmacist review note dated January 13, 2025, at 12:00 PM that indicated Resident 11 had physician orders to receive Vitamin D daily and oyster shell calcium daily for dietary supplements. The pharmacist reported that the supplements may be deemed unnecessary and asked the physician to consider discontinuing them. The consultant pharmacist report to the physician dated January 13, 2025, had no physician/prescriber response. Clinical record review for Resident 11 revealed a consultant pharmacist review note dated March 18, 2025, at 1:32 PM that current orders for Prozac (an antidepressant) daily in combination with Zyprexa (antipsychotic medication used to balance chemicals in the brain) daily was indicated for Treatment-Resistant Major Depressive Disorder (diagnosis used when a person with major depressive disorder does not respond adequately to at least two different antidepressant medications). The pharmacist requested that the physician update Resident 11's diagnosis to reflect the indication for use. The consultant pharmacist report to the physician dated March 18, 2025, noted the physician/prescriber response as, Orders Updated, on March 31, 2025. Resident 11's active physician orders for Resident 11's Prozac medication continued to list the indication for use diagnosis as major depressive disorder, recurrent severe without psychotic features since November 1, 2023. Resident 11's active physician orders for Resident 11's Zyprexa medication continued to list the indication for use diagnosis as major depressive disorder, recurrent unspecified since April 11, 2024. There was no indication that physician orders were updated regarding the indication for the combination use of Zyprexa and Prozac medications for Resident 11. Interview with the Director of Nursing on June 18, 2025, at 12:11 PM confirmed the above findings for Resident 11. Clinical record review for Resident 7 revealed current physician orders dated January 8, 2025, for Risperidone (an anti-psychotic) 0.25 mg (milligram) BID (twice daily) for therapeutic (dosage) related to unspecified Dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's consultant pharmacist completed a medication review on March 20, 2025. The pharmacist identified that Resident 7's Risperidone diagnosis was for Dementia, indicated that this was not an approved diagnosis, and requested that the physician address and provide an appropriate diagnosis for the medication. On March 31, 2025, Resident 7's physician addressed the pharmacist's recommendation and indicated that the Risperidone diagnosis was for depression. There was no documentation that the facility addressed the physician's response to the medication recommendation. The surveyor reviewed the above information during an interview with Nursing Home Administrator and the Director of Nursing on June 17, 2025, at 2:57 PM. 28 Pa. Code 211.9 (k) Pharmacy services 28 Pa. Code 211.12(d)(3)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation and staff interview, it was determined that the facility failed to secure treatment biologicals during wound care for one of two residents observed (Resident 10). Findings include: Observation of wound care with Employee 2 (registered nurse) on June 17, 2025, at 9:07 AM revealed Employee 2 gathered all wound care supplies from a treatment supply cart in the hallway and entered Resident 10's room, shut the door, and began her wound care. Employee 2 failed to secure (lock) the treatment supply cart before entering Resident 10's room. Interview with Employee 2 after completion of the dressing change and return to the treatment cart confirmed that he did not lock the treatment cart while the cart was unattended in the hallway. 28 Pa. Code 211.12(d)(1) Nursing services

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guy and Mary Felt Manor, Inc	110 East Fourth Street Emporium, PA 15834

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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. Based on a review of select facility policies and procedures, Centers for Disease Control (CDC) standards, clinical record review, review of personnel payroll records, observation, and resident and staff interview, it was determined that the facility failed to ensure an environment free from the potential spread of infection related to COVID-19 work exclusions for two of two employees reviewed (Employees 3 and 4), COVID-19 outbreak testing for three of three episodes of facility COVID-19 outbreaks (July 29, 2024, to August 3, 2024; September 16, 2024; and February 9, 2025); transmission based precautions for one of one resident identified on transmission based precautions (Resident 22); enhanced barrier precautions for one of two residents observed for wound care (Resident 10); a process to obtain pertinent information following acute care hospital treatment for one of one resident reviewed for urinary tract infections (Resident 22); and resident personal laundry processing (Residents 11, 17, 15, 13, and 23). Findings include: Centers for Disease Control criteria for staff to return to work following COVID-19 infection (https://www.cdc.gov/covid/hcp/infection-control/guidance-risk-assesment-hcp.html?CDC_AAref_Val=https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html) revealed that health care personnel (HCP) with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met: At least seven days have passed since symptoms first appeared if a negative viral test is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7). At least 24 hours have passed since last fever without the use of fever-reducing medications. Symptoms (e.g., cough, shortness of breath) have improved. If using an antigen test (can give results in as little as 15 minutes, do not require laboratory testing for the results), HCP should have a negative test obtained on day 5 and again 48 hours later. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Current CDC Infection Control Guidance for SARS-CoV-2 (COVID-19), at https://www.cdc.gov/covid/hcp/infection-control/index.html, revealed that asymptomatic residents with close contact with someone with COVID-19 infection should have a series of three viral tests for COVID-19 infection. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day one (where day of exposure is day zero), day three, and day five. Healthcare facilities should have a plan for how COVID-19 exposures in a healthcare facility will be investigated and managed and how contact tracing will be performed. If healthcare-associated transmission is suspected or identified, facilities might consider expanded testing of HCP (health care personnel), and residents as determined by the distribution and number of cases throughout the facility and ability to identify close contacts. When performing an outbreak response to a known case, facilities should always defer to the recommendations of the jurisdiction's public health authority. A single new case of COVID-19 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed. The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day one (where day of exposure is day zero), day three, and day five. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every three to seven days until there are no new cases for 14 days. Review of the facility's submissions to the Department of Health Event Reporting System (ERS, online system established for facilities to comply with required notification to the Department of the facility's reportable events) revealed that Employee 3 tested positive for COVD-19 on July 29, 2024 (day zero). Interview with Employee 3 (receptionist) on June 17, 2025, at 3:32 PM confirmed that she tested positive for COVID-19 while working on July 29, 2024. Employee 3 stated that she began to have sinus symptoms (congestion), so she followed the facility protocol and performed a rapid (antigen) test at the facility that confirmed COVID-19 infection. Employee 3 stated that she stayed to work while wearing a mask until leaving early at 1:30 PM that day, stayed home while sick the next two days, but that she returned to work the following day (day three after her positive test). Employee 3 stated that she believed that if she did not show symptoms, she could work. Employee 3 stated that she felt sick again on day four, so she did not come to work at the facility; however, she did not take any additional sick days after the fourth day. Employee 3 denied COVID-19 testing on days five or seven to ensure negative findings before returning to work. Review of Employee 3's timecard confirmed that she did not have regular work hours paid on days one, two, and four after her positive COVID-19 test; however, Employee 3 worked regular hours on days three, five, six, seven, eight, and nine. Review of the facility's submissions to the Department of Health Event Reporting System revealed that Employee 4, nurse aide, tested positive for COVD-19 on July 29, 2024 (day zero). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Employee 4's timecard revealed that she worked regular hours on the following dates: August 3, 2024, 3:00 PM to 11:00 PM (day five) August 5, 2024, 3:00 PM to 11:00 PM (day seven) August 6, 2024, 3:00 PM to 11:00 PM (day eight) August 7, 2024, 3:00 PM to 11:00 PM (day nine) August 8, 2024, 3:00 PM to 11:00 PM (day 10) Review of the facility's submissions to the Department of Health Event Reporting System revealed that the facility continued to report positive COVID-19 cases for both residents and staff until August 3, 2024. The facility reported two new staff COVID-19 positive tests on September 16, 2024. The facility reported a new resident COVID-19 positive test on February 9, 2025. Interview with Employee 1 (licensed practical nurse/infection control prevention coordinator) on June 18, 2025, at 9:00 AM confirmed that the facility had no evidence of testing staff (Employees 3 and 4) returning to work before CDC guidelines for HCP with known COVID-19 infection. The interview with Employee 1 indicated that the facility had no evidence of COVID-19 testing of staff during the August 2024, September 2024, or February 2025 COVID-19 outbreaks via either contract tracing or the broad-based approach. Employee 1 provided COVID-19 staff testing logs dated November 4 through 25, 2024; and December 2 through 30, 2024 (although the facility reported no new COVID-19 cases during that time). The logs provided indicated that testing occurred on a weekly basis; and did not follow any schedule established by CDC guidelines (on day one, day three, and day five and continued every three to seven days until there are no new cases for 14 days). The logs also indicated that no testing was performed on those staff that were recorded as vaccines up to date (despite CDC guidelines that stipulate testing is done regardless of vaccination status). Interview with Resident 22 on June 16, 2025, at 1:46 PM revealed that she required antibiotics for a urinary tract infection with MRSA (Methicillin-resistant Staphylococcus aureus, bacteria that is resistant to many antibiotics and can cause serious infections) when first admitted to the facility. Clinical record review for Resident 22 revealed a laboratory report dated as collected November 27, 2024, that indicated that Resident 22 had a urinary tract infection with MRSA. Observation of Resident 22's room on June 16, 2025, at 1:08 PM revealed a sign to stop and see nursing staff before entering; and a sign to use contact precautions (clean hands before entering and when leaving the room, staff to don gloves and a gown before entering the room, and staff to use dedicated or disposable equipment for care). Interview with Employee 10 (nurse aide) on the date and time of the observation revealed that Resident 22 had MRSA in her urine, that she was incontinent of urine, and that she wears incontinence briefs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of medication administration for Resident 22 with Employee 7 (licensed practical nurse) on June 16, 2025, at 3:36 PM revealed that Employee 7 did not don a gown before entering Resident 22's room. Employee 7's clothing contacted Resident 22's bed several times as she leaned over Resident 22 to administer eye drops to both of Resident 22's eyes; and during the procedure to obtain a blood pressure assessment. Employee 7 returned to the medication cart and placed the blood pressure cuff and stethoscope used to obtain Resident 22's blood pressure assessment directly on the top of the medication cart. Employee 7 then used a sanitizing cloth to clean the stethoscope and cuff; however, Employee 7 did not clean the top of the medication cart. Employee 7 then continued medication administrations to five other residents. Interview with Employee 7 on June 16, 2025, at 4:12 PM confirmed that the signage on Resident 22's room entry area indicated that she required contact isolation precautions, and that those precautions were required due to a MRSA infection in her urine; however, the interview confirmed that no gown was donned before entering her room to administer her medications and obtain a blood pressure assessment. The interview also confirmed that Employee 7 had to clean the blood pressure cuff and stethoscope because those items were not dedicated equipment for Resident 22, but that she potentially contaminated the top of the medication cart when the equipment was placed there before cleaning. The surveyor reviewed the above concerns regarding Resident 22's isolation precautions during an interview with the Director of Nursing and the Nursing Home Administrator on June 17, 2025, at 2:40 PM. Observation of Resident 22's room on June 18, 2025, at 10:20 AM revealed continued use of contact isolation precaution signage. Nursing documentation dated January 1, 2025, at 6:57 AM revealed that Resident 22 was not responding well, was pale, and exhibited nonsensical conversation. Staff arranged for her transport to the hospital emergency room for evaluation, and Resident 22 left the facility. Nursing documentation dated January 1, 2025, at 2:09 PM revealed that Resident 22 returned to the facility with a diagnosis of a urinary tract infection and would receive Macrobid (antibiotic) for seven days. A physician's order dated January 1, 2025, instructed staff to administer Macrobid 100 mg (milligrams) twice daily for seven days for a urinary tract infection. Review of an MAR (medication administration record, electronic documentation of the administration of medications) dated January 2025 revealed that Resident 22 received Macrobid two times a day for her urinary tract infection from January 1, 2025, at 10:30 PM to January 8, 2025, at 10:30 AM. A laboratory report dated January 3, 2025, indicated that the bacteria in Resident 22's urine (Enterobacter cloacae complex) was only intermediately susceptible to Macrobid. The laboratory report indicated that the organism was susceptible to the antibiotic Bactrim. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Employee 1 on June 17, 2025, at 1:04 PM indicated that laboratory culture and sensitivity reports are received by the licensed nurses who will notify a physician if an ordered antibiotic is not effective to treat a condition. Employee 1 stated that he was unaware if or when the facility staff received the urine culture and sensitivity report completed by the acute hospital emergency room on January 1, 2025. The facility had no evidence that staff notified Resident 22's physician with the report that a different antibiotic presented a better treatment response to Resident 22's infecting organism. Review of the Centers for Medicare and Medicaid Services (CMS) memo entitled, Enhanced Barrier Precautions in Nursing Homes, dated March 20, 2024, revealed that nursing care facilities are to use enhanced barrier precautions (EBP, gown and glove use) 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 facility policy entitled, Isolation Precautions, last reviewed January 29, 2025, revealed Enhanced Barrier Precautions are in response to the detection of serious antibiotic resistance threats in nursing homes guided by the CDC in December 2019. EBP prevent transmission with residents known or suspected to be infected of novel or targeted MDROs. EBP are indicated for residents with indwelling medical devices and wounds who are at high risk for acquiring and being colonized with MDROs when they reside on the same unit as a resident colonized or infected with a novel or targeted MDRO. High-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include wound care (any skin opening requiring a dressing). Implementation of EBP include to ensure access to alcohol-based hand rub. Review of the facility policy entitled, Clean Dressing Change, last reviewed January 29, 2025, revealed that procedural steps include the following sequence: Perform hand hygiene Put on (don) clean gloves Remove dressing and place in trash can Remove (doff) gloves and perform hand hygiene Put on clean gloves Cleanse wound Remove gloves and perform hand hygiene Put on clean gloves Apply clean dressings as ordered Remove gloves and perform hand hygiene (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy entitled, Hand Hygiene Policy and Procedure, last reviewed January 29, 2025, revealed that indications for the use of alcohol-based hand rub (ABHR) include for routine decontaminating hands in clinical situations such as moving from a contaminated body site to a clean body site during resident care and after removing gloves. Clinical record review for Resident 10 revealed nursing documentation dated May 27, 2025, at 10:07 PM that Resident 10 had an open area to her coccyx (tailbone). Observation of Resident 10's room on June 16, 2025, at 12:43 PM revealed Enhanced Barrier signs on her doorway and a cart outside her doorway with reusable gowns and disposable gloves. Observation of Resident 10's wound care with Employee 2 (registered nurse) on June 17, 2025, at 9:10 AM revealed that Employee 2 did not don a gown before performing the procedure (despite the signage on Resident 10's doorway). Employee 2 donned gloves, removed the soiled dressing from Resident 10's buttocks, removed his gloves, donned new gloves (without performing hand hygiene), cleansed Resident 10's wounds with gauze, and reapplied the new dressings to Resident 10's buttocks. Interview with Employee 2 after completion of the dressing change and his return to the treatment cart in the hallway confirmed that he did not take any hand sanitizer into Resident 10's room or wash his hands between doffing the soiled gloves and donning new gloves. Review of the facility policy entitled, Laundry and Infection Control, last reviewed January 29, 2025, revealed that staff handle all used laundry as potentially contaminated and utilize standard precautions (i.e., gloves, gowns). Contaminated laundry is bagged at the point of collection (i.e., location where it was used). The facility follows manufacturer's instructions for all materials involved in the laundry process (i.e., washing machines, dryers, laundry detergents, and rinse aids). Review of the facility policy entitled, Laundry Policy and Procedure, last reviewed January 29, 2025, revealed that picking up personal clothing includes remove and tie laundry bags from the basket, and the laundry bag must be sealed before exiting the resident's room. Use 33-gallon black bags and/or laundry bags to replace the existing one. Do not place dirty laundry in linen storerooms, linen closets, or any room that contains clean linens. Steps for washing residents' laundry included to use proper PPE (personal protective equipment) and to not over fill washing machines. Interview with Employee 5 (director housekeeping/laundry) on June 18, 2025, at 9:50 AM revealed that resident personal laundry is collected from their rooms once or twice a week. A laundry employee collects the resident's soiled laundry from their closet. The interview indicated that each resident is to have a vented laundry hamper in their closet that is lined with either a plastic or linen bag that staff are to keep tied as the resident hampers do not have lids. Employee 5 stated that she was unaware of any concerns regarding staff not securing the soiled laundry bags between collections. Observation of the room used to process resident personal laundry revealed no isolation gowns. Interview with Employee 5 on the date and time of the observation confirmed that laundry staff do not don an isolation gown when transferring resident's soiled laundry into the washing machines. Employee 5 confirmed that there was no measure to protect staff clothing when transferring the soiled laundry. Employee 5 was unaware of the capacity limit of each washing machine in the laundry room (e.g., limit of how many pounds of laundry may be processed at one time to ensure appropriate agitation of clothing in the water and detergent to hygienically clean the laundry). Employee 5 confirmed that laundry staff do not weigh residents personal laundry loads before processing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Resident 11's room with Employee 6 (nurse aide) on June 18, 2025, at 10:45 AM revealed that Resident 11's closet hamper used for her soiled personal laundry had no lid, was lined with an open bag, and clothing was visible from the top of the hamper. Other clothing items hung on hangers from a bar above the open clothing hamper. Observation of Resident 17's closet hamper (tall, vented, white hamper) used for her soiled personal laundry with Employee 6 on June 18, 2025, at 10:46 AM revealed the hamper had no lid, was lined with an open black plastic bag, and clothing was visible from the top of the hamper. Other clothing items hung on hangers from a bar above the open clothing hamper. Observation of Resident 15's closet vented hamper used for her soiled personal laundry with Employee 6 on June 18, 2025, at 10:46 AM revealed the hamper had no lid, was lined with an open linen bag, and clothing was visible from the top of the hamper. Other clothing items hung on hangers from a bar above the open clothing hamper. Observation of Resident 13's closet with Employee 6 on June 18, 2025, at 10:47 AM revealed that an open black bag that lined a tall, vented, white hamper was falling inside the hamper. Clothing was visible from the top of the hamper. Other clothing items hung on hangers from a bar above the open clothing hamper. Observation of Resident 23's closet with Employee 6 on June 18, 2025, at 10:47 AM revealed that there was soiled clothing hanging over the top rim of a hamper, and the bag used to line the hamper was open. Other clothing items hung on hangers from a bar above the open clothing hamper. Observation of a soiled utility room with Employee 6 on June 18, 2025, at 10:50 AM revealed a hopper used by nurse aide staff to rinse excessively soiled resident clothing. Employee 6 confirmed that the room did not have any isolation gowns used by nursing staff for this procedure. One isolation gown was observed hanging on the wall; however, Employee 6 stated that was for the linen person (laundry personnel who collect linens such as sheets and towels). The facility failed to handle, store, or launder resident personal laundry in a manner to prevent the potential spread of infection. The surveyor reviewed the concerns regarding the facility's process for containing and laundering residents' personal soiled clothing during an interview with the Nursing Home Administrator on June 18, 2025, at 11:58 AM. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to offer pneumococcal vaccines to three of five residents reviewed for immunizations (Residents 20, 2, and 11). Findings include: The facility policy entitled, Pneumococcal Vaccines (PCV13, PCV20, and PPSV23) of Residents, last reviewed January 29, 2025, revealed that the purpose of the policy is to reduce morbidity and mortality from pneumococcal disease by vaccinating all residents who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. All residents of the facility should receive the pneumococcal vaccine (PCV13, PCV20, and/or PPSV23), unless there is a documented contraindication or right of refusal. The infection preventionist/designee will be responsible to monitor the facility's pneumococcal immunization program. Residents will have their immunization status determined at the time of admission and vaccine offered if not immunized. Each resident's immunization status will be documented in the resident's PCC (Point Click Care, electronic medical record system) immunization tab and on their consent form. Consent or declination is obtained upon admission. The facility distributes a consent/declination form annually to the resident/responsible party to update as needed as per regulatory guidelines. The infection preventionist is responsible for coordinating the administration of resident vaccines. The facility's active policy did not refer to the available pneumococcal vaccines PCV15 or PCV21. Clinical record review for Resident 20 revealed that the facility admitted her on December 27, 2021, at the age of 83. Resident 20's immunization tab indicated that she received a Pneumovax (PPSV23) immunization (on November 12, 2011) at the age of 73 before her admission to the facility. There were no other pneumococcal immunizations recorded in Resident 20's medical record. Current CDC recommendations (at https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/index.html) note that the CDC offers PneumoRecs VaxAdvisor as a free application to quickly and easily provide patient-specific pneumococcal vaccine guidance. Per the PneumoRecs VaxAdvisor application, someone greater than [AGE] years old, who had the PPSV23 vaccine, should receive one dose of PCV15, PCV20, or PCV21 at least one year after the last dose of PPSV23. Interview with Employee 1 (licensed practical nurse/infection control prevention coordinator) on June 17, 2025, at 1:15 PM and June 18, 2025, at 9:00 AM confirmed that the facility had no additional evidence of pneumococcal immunizations for Resident 20. Clinical record review for Resident 2 revealed that the facility admitted her on June 5, 2019. Review of Resident 2's immunization tab revealed that Resident 2 received the PCV13 vaccine (before her admission to the facility) on May 20, 2016 (at [AGE] years old), and the PPSV23 vaccine (before her admission to the facility) on December 1, 2018 (at [AGE] years old). (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per the PneumoRecs VaxAdvisor application, someone greater than [AGE] years old, who never received the PCV15, PCV20, or PCV21 immunizations, but received the PPSV23 and PCV13 immunizations at/after age [AGE] years old, should discuss with their clinical decision-making providers whether to administer one dose of PCV20 or PCV21 at least five years after the last pneumococcal vaccine dose to complete their pneumococcal vaccinations. Interview with Employee 1 on June 17, 2025, at 1:15 PM and June 18, 2025, at 9:00 AM confirmed that the facility had no additional evidence of offering Resident 2 either the PCV20 or PCV21 immunizations. Clinical record review for Resident 11 revealed that the facility admitted her on May 5, 2023. Review of Resident 11's immunization tab revealed that Resident 11 received the PCV13 vaccine (before her admission to the facility) on February 26, 2016 (at [AGE] years old), and the PPSV23 vaccine (before her admission to the facility) on November 7, 2016 (at [AGE] years old). Resident 11's clinical record contained no evidence that the facility offered the PCV20 or PCV21 vaccines. Interview with Employee 1 on June 17, 2025, at 1:15 PM and June 18, 2025, at 9:00 AM confirmed that the facility had no additional evidence of offering Resident 11 either the PCV20 or PCV21 immunizations per current CDC guidance. 28 Pa. Code 211.5(f)(i)-(xi) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of employee education records and staff interview, it was determined that the facility failed to ensure that nurse aides received 12 hours of in-service training annually for two of three nurse aides reviewed (Employees 8 and 9). Findings include: During a meeting with the Nursing Home Administrator and Director of Nursing on June 16, 2025, at 2:30 PM the surveyor asked for training records to indicate that nurse aides had received at least 12 hours of in-service training in the last year for Employees 8 and 9 (nurse aides). Review of Employee 8's training records revealed that she only received 9.50 hours in the last year. Review of Employee 9's training records revealed that she only received 11.00 hours in the last year. Interview with the Director of Nursing on June 18, 2025, at 9:10 AM confirmed there was no further evidence that Employees 8 and 9 received the required 12 hours of annual in-service training in the last year. 28 Pa. Code 201.19(7) Personnel policies and procedures 28 Pa. Code 201.20(a)(6)(d) Staff development