STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395359	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jersey Shore Skilled Nursing and Rehabilitation Ce	1008 Thompson Street Jersey Shore, PA 17740

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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. 36798 Based on clinical record review and staff interview, it was determined that the facility failed to determine a resident's wishes regarding an advance directive for one of 10 residents reviewed (Resident 27). Findings include: Clinical record review for Resident 27 revealed that the facility admitted her on March 6, 2024, with a diagnosis of a left femoral fracture and end stage renal disease. Clinical record review revealed her advance directive to be DNR (Do Not Resuscitate, a medical order that instructs health care providers not to intervene if a patient stops breathing or if their heart stops beating). A Medical Practitioner Note (Physician/ Nurse practitioner) dated March 7, 2024, at 10:28 PM revealed that Resident 27 was severely lethargic and fatigued. Her neurological assessment revealed that she was alert, awake, and oriented to person only. The note further indicated that Resident 27 desired to be a DNR based on her advance directive. Interview with the Nursing Home Administrator and Director of Nursing (DON) on April 9, 2024, at 2:12 PM revealed that they obtained Resident 27's DNR information from her discharge records that were brought with her from the hospital. Interview with the DON on April 10, 2024, at 12:32 PM revealed that there was no advance directive located in Resident 27's chart and that she was unsure where the physician obtained the DNR information. The facility failed to determine a resident's wishes related to her code status prior to obtaining a physician's order for her code status. 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 19719 Based on clinical record review and staff interview, it was determined that the facility failed to provide the correct required notification to a resident whose payment coverage changed for two of five residents reviewed (Residents 34 and 89). Findings include: A review of the Form Instructions Skilled Nursing Facility (SNF) Advanced Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055 revealed that examples of the common reasons why an extended care stay, or services may not be covered under Medicare might include the beneficiary no longer requires daily skilled care for a medical condition but wants to continue residing in the skilled nursing facility (SNF). The SNF enters a good faith estimate of the cost of the corresponding care that may not be covered by Medicare. In the blank that follows Beginning on ., the skilled nursing facility enters the date on which the beneficiary may be responsible for paying for care that Medicare is not expected to cover. The beneficiary selects an option box to indicate a desire to continue to receive the care or not to continue to receive the care and if there is a desire to have the bill submitted to Medicare for consideration. The beneficiary or their authorized representative must sign the signature box to acknowledge that they read and understood the notice. The SNF must issue this notice when there is a termination of all Medicare Part A services for coverage reasons. If after issuing the NOMNC, the SNF expects the beneficiary to remain in the facility in a non-covered stay, the SNFABN must be issued to inform the beneficiary of potential liability for the non-covered stay. Clinical record review of census information for Resident 34 revealed that the facility provided services primarily paid for by Medicare starting September 7, 2023. Resident 34's Medicare payment for services ended October 3, 2023. Resident 34 began to privately pay for his care on October 4, 2023. Resident 34 still resides in the facility. There was no documented evidence to indicate that the facility provided a CMS-10055 form to Resident 34 and/or his responsible party. Clinical record review of census information for Resident 89 revealed that the facility provided services primarily paid for by Medicare starting January 4, 2024. Resident 89's Medicare payment for services ended February 14, 2024. Resident 89 began to privately pay for his care on February 14, 2024. Resident 89 still resides in the facility. There was no documented evidence to indicate that the facility provided a CMS-10055 form to Resident 89 and/or his responsible party. The surveyor confirmed the above findings regarding Resident 34's and Resident 89's Medicare notices during an interview with Employee 1, medical records, on April 8, 2024, at 1:06 PM. Employee 1 indicated that she was not aware that the CMS-10055 form was to be used. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a) Resident rights

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 19719 Based on observations and staff and resident interview, it was determined that the facility failed to provide adequate housekeeping and maintenance services to maintain a clean and orderly environment on three of three nursing units (A and B Nursing Unit, D and E Nursing Unit, C Nursing Unit; Residents 7, 27, 43, 44, 79, 84, 89, 91, 97, and 153). Findings include: Observation of the facility's B hall nursing unit on April 8, 2024, at 8:58 AM revealed the following environmental concerns: At the end of the B hall nursing unit, the wallpaper was stained to the right of the heating and air conditioning unit. The wall outside Resident 84's room had peeling, stained, and cut wallpaper. Resident 84's room was missing a closet door. Resident 89's room was missing one of the closet doors. One handle fixture of the closet door was loose. The plastic protective cover on the lower half of the room doorway was broken and jagged. Observation of the facility's E hall nursing unit on April 8, 2024, at 11:30 AM, revealed the following environmental concerns: The closet door bottom brackets were broken in Resident 7's room causing the doors to swing back and forth. Resident 7 indicated that they have been broken and don't work right. Resident 7's bathroom door was difficult to open and shut as the bottom portion of the door was dragging on the floor. Resident 43's room had a large marring outside the bathroom on the wall. The marring had multiple colors inside, such as black, brown, and tan. Resident 43 indicated she was told it was mold. The wall in front of Resident 43's bed in between dressers was marred and scraped. A ceiling tile to the right of her window was stained. The wooden faceplate on the bottom drawer of Resident 43's dresser was broken. The bottom bracket of the closet doors was broken causing the doors to swing back and forth. One door of Resident 97's closet was broken and propped up against a shelf on the inside of her closet. The wall in front of Resident 153's bed by his dresser was marred and scraped. Resident 153's top dresser drawer was missing the handle. The above concerns regarding B and E halls were reviewed with the Administrator and Director of Nursing on April 8, 2024, at 2:15 PM. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Resident 91's room on the D unit on April 8, 2024, at 10:50 AM revealed the door to enter the room was all marred on the side that faces the hallway. The left corner inside the door had a buildup of dirt in it. In front of the closet there was dirt noted on the floor. There was a small plastic medicine cup noted on the floor to the left of the dresser that had the television on it. The bathroom door frame was all marred, there was used tissue on the floor of the bathroom, the toilet seat was dirty, the back of the toilet was splattered with a brown substance, and there was a small amount of brown substance on the floor to the left of the toilet. Observation of Resident 27's room on D unit on April 8, 2024, at 11:33 AM revealed that the door to the room was all marred, the frame to the bathroom door was all marred and chipped, the bathroom floor was dirty with a build-up of dirt around the toilet, and behind the head of the bed was a buildup of dirt and dust on the floor along the cove base. The above noted concerns regarding Resident 27's and 91's rooms were reviewed with the Nursing Home Administrator and Director of Nursing on April 8, 2024, at 2:22 PM. Observation of the C unit on April 7, 2024, at 10:39 AM revealed a dark blue armchair in the lounge area attached to the dining room with dried smeared food and crumbs on the interior and exterior sides of the arms on the chair and the seating area. Glass doors at the end of the hallway of the C unit, which exit to a foyer with another set of doors to an outdoor patio area, were observed with curtains on the exterior of the first set of doors to the foyer. The curtains were visibly dirty and dead bugs and cobwebs were collected at the base of the curtains. The foyer area was covered in dirt and debris, dead bugs, and cobwebs. A card table was observed folded up along the wall in the foyer area and was covered in cobwebs and dead bugs. The above findings on C unit were reviewed with the Nursing Home Administrator and Director of Nursing on April 8, 2024, at 2:20 PM. Observation of Resident 79's room on April 7, 2024, at 11:00 AM revealed that there were two medication cups lying on the floor by the door side of the bed near the trash can. There was red liquid in the shape of a medication cup dried on the floor beside one of the medication cups. On April 7, 2024, at 2:18 PM, the two medication cups were now placed in the Resident 79's trash can, however the dried red liquid remained on the floor. On April 8, 2024, at 9:46 AM the dried red liquid remained on Resident 79's floor. A six inch brown stain was now identified between Resident 79's bed and the bedside stand near the trash can. Observation of Resident 44's bathroom on April 7, 2024, at 2:14 PM revealed that the molding around the bottom of Resident 44's bathroom door was marred and scuffed. Observation of the A Wing Nursing Unit on April 7, 2024, at 2:15 PM revealed that the corner protector to the right of the A wing's double entry door was falling off the protector backing with 2 inches of the protector's backing exposed at the top. The surveyor reviewed the above information during an interview with the Nursing Home Administrator and Director of Nursing on April 8, 2024, at 1:30 PM and April 9, 2024, at 2:00 PM. 28 Pa. Code 207.2(a) Administrators Responsibility

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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** 36798 Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan to maintain the highest practicable care for one of three residents reviewed (Resident 81). Findings Include: Clinical record review for Resident 81 revealed that he was admitted to the facility on [DATE], and his primary language was Spanish. He was also able to speak in broken English (you speak English with difficulty or with a lot of mistakes). Interview with the Nursing Home Administrator and Director of Nursing on April 9, 2024, at 2:10 PM revealed that staff communicate with Resident 81 through one employee, a licensed practical nurse, that speaks Spanish, and some staff have interpreter applications on their phones. A Medical Practitioner (Physician or Nurse Practitioner) progress note dated March 4, 2023, at 2:33 PM revealed that Resident 81 solely speaks Spanish, but can communicate through movements such as head nods. A Social Determinant of Health (conditions in the environment that affect a wide range of health, functioning, and quality of life outcomes and risks) progress note dated March 18, 2024, at 9:39 AM by social services revealed that Resident 81 did not need or want an interpreter to communicate with a doctor or health care staff. A Medical Practitioner note date December 20, 2023, at 2:19 PM revealed that a discussion was held with Resident 81, and the nurse, who speaks Spanish and she communicated with him in detail regarding his code status (the type of emergent treatment a person would or would not receive if their heart or breathing stops). Review of Resident 81's care plan revealed no care plan related to his communication deficit or interventions for the staff to utilize to improve communication with him. Interview with the Director of Nursing on April 9, 2024, at 2:14 PM confirmed that there is not always a staff member present that speaks Spanish, and that there was no care plan in Resident 81's clinical record addressing his communication concerns or interventions for staff to utilize to communicate with him. The facility failed to implement a person center care plan to maintain the highest practicable care for Resident 81. 28 Pa. Code 211.12(d)(5) Nursing services

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 36798 Based on clinical record review and staff interview, it was determined that the facility failed to provide treatment to improve hearing for one of three residents reviewed (Resident 81). Findings include: Clinical record review for Resident 81 revealed an audiologist (a health care professional that assesses and manages disorders of hearing) progress note from an outside provider dated March 21, 2024, at 12:20 PM that indicated his left ear was impacted with cerumen (ear wax). The note further indicated that it should be removed as soon as possible by the facility if the resident allows. The facility should follow their protocol for cerumen removal with Debrox (a medication used to treat wax build-up) as ordered by the facility physician. Resident 81 should return for a hearing exam following cerumen removal. Clinical record review for Resident 81 revealed no evidence that the Debrox treatment to his ear was ordered or done. Interview with the Nursing Home Administrator on April 9, 2024, at 2:10 PM confirmed that the audiologist recommendations for Resident 81, were never reviewed by his physician and the treatment was never completed. The facility failed to implement recommended interventions to potentially improve Resident 81's hearing. 28 Pa. Code 211.10(a)(d) Resident care policies 28 Pa. Code 211.11(d) Resident care plan 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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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. 36798 Based on clinical record review and staff interview, it was determined that the facility failed to evaluate a pressure ulcer to prevent decline and promote healing for one of two residents reviewed (Residents 27). Findings include: Clinical record review for Resident 27 revealed that the facility admitted her on March 6, 2024, with a closed wound to her left heel. Review of Resident 27's skin and wound evaluation dated March 7, 2024, revealed that she had an abrasion that was present on admission and measured 2.5 centimeters (cm) x 2.0 cm with no depth. The wound bed was 100 percent covered with epithelial (a type of tissue that covers many surfaces on the inside and outside of your body). There was no slough (yellowish/white material noted on a wound bed) or eschar (dead tissue) present, and there was no drainage. It was a foam dressing and there was no additional care noted on the evaluation. An admission MDS (Minimum Data Set, an assessment completed at intervals by the facility to determine care needs) date March 13, 2024, revealed that Resident 27 did not have any pressure ulcers. Review of Resident 27's next skin and wound evaluation dated April 6, 2024, revealed that the wound was an abrasion on the left heel, that was present on her admission to the facility, 1.9 cm x 2.6 cm with no depth. The wound bed was now eschar but did not identify the percentage. No drainage was noted. No dressing was identified, and no additional care was noted on the evaluation form. Review of Resident 27's care plan that was initiated on March 7, 2024, and resolved on April 9, 2024, revealed the left heel wound was identified as a deep tissue injury (DTI, persistent non-blanchable deep red, maroon or purple discoloration with intact skin due to damage of underlying soft tissue). Interview with the Nursing Home Administrator and Director of Nursing on April 9, 2024, at 2:21 PM related to whether the wound on Resident 27's left heel was an abrasion or a pressure ulcer, revealed that they were going to have the wound specialist look at it on this same date. On April 10, 2024, at 9:13 AM the Nursing Home Administrator provided an initial wound evaluation and management summary that was completed by the wound clinic physician that indicated the wound on Resident 27's left heel was a pressure ulcer unstageable DTI with intact skin. The wound was 1.5 cm x 2.5 cm and depth was not measurable. They also provided a skin and wound evaluation form dated April 9, 2024, that indicated the wound was a pressure ulcer on the left heel, unstageable, and 100 percent, eschar was present, indicating the pressure ulcer declined. Review of Resident 27's treatment administration record (TAR) for March and April 2024, revealed that the staff were completing a body audit on the evening shift daily for skin observation. Review of Resident 27's clinical record revealed no documented evidence that the left heel was being assessed during the body audit. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no evidence that the facility completed an evaluation at least weekly on Resident 27's left heel pressure ulcer that included the location and staging, the size, drainage to include type, of odor present, and amount, pain, the color and type of tissue present, and a description of the wound bed and edges, to promote healing. The Director of Nursing confirmed the above noted findings during a meeting on April 10, 2024, at 12:30 PM. The facility failed to conduct an evaluation, at least weekly, to promote healing and prevent decline, of Resident 27's left heel pressure ulcer that worsened. 483.25(b)(1)(i)(ii) Treatment/svcs to Prevent/heal Pressure Ulcer Previously cited deficiency 5/11/23 and 12/4/23 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.10(a)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing care services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. 36798 Based on clinical record review and staff interview, it was determined that the facility failed to provide timely assessment and implement interventions to promote acceptable parameters of nutritional status for four of seven residents reviewed for nutritional concerns (Residents 46, 59, 86, and 91). Findings include: Review of Resident 46's clinical record revealed that the facility admitted him on March 18, 2024. Resident 46 was admitted to the facility with a diagnosis of malnutrition and needing a feeding tube for nutrition. There was no documented evidence in Resident 46's clinical record to indicate that an initial comprehensive dietary assessment was completed. A Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated March 25, 2024, indicated that the facility assessed him as being at nutritional risk and that the facility would proceed to develop a care plan regarding his risk for weight loss. There was no documented evidence in Resident 46's clinical record to indicate that the facility developed a potential for weight loss care plan or implemented interventions. Resident 46 was weighed by nursing staff on March 20, 2024, at 120 pounds. On April 3, 2024, nursing staff weighed Resident 46 at 110 pounds, which would be an 8.3 percent loss in less than three weeks. There was no documented evidence in Resident 46's clinical record to indicate that Resident 46's nutritional needs were assessed to determine if his caloric needs were being met. Interview with the Administrator on April 7, 2024, at 2:00 PM revealed that the facility has been without a qualified dietitian since March 8, 2024. Once the surveyor brought up the weight loss concerns regarding Resident 46, a dietary assessment was completed on April 10, 2024, at 7:12 AM. The assessment indicated that Resident 46 only eats 0-50 percent of his meals, and he has not been getting enough calories with his current order of nutrition by feeding tube. Interview with the Administrator on April 9, 2024, at 12:28 PM confirmed the above findings for Resident 46. Clinical record review for Resident 59 revealed the resident was admitted from another nursing facility on January 31, 2024, with a history of significant weight loss and dementia. A nutrition note by the registered dietitian dated February 14, 2024, at 1:30 PM indicated Resident 59 had variable weights since her admission with an initial weight on February 1, 2024, of 117.2 pounds, then 128 pounds on February 6, 104.5 pounds on February 7, and 109 pounds on February 12, 2024. The dietitian acknowledged a variance of scales utilized to obtain the weights may have a contributed to the variance in the weights, but due to the resident's history of weight loss and malnutrition, nutritional supplements were increased for the resident. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 59's weight record revealed the resident's weight continued to decline after the registered dietitian's note on February 14, 2024, with a weight of 100 pounds on February 26, 2024, 99.9 pounds on March 4, 2024, 97 pounds on March 18, 2024, 99 pounds on March 25, 2024, and 84.5 pounds on April 3, 2024. There was no evidence of a reweight after the April 3, 2024, weight and it was noted as last weight, refused. Resident 59 continued to lose weight since last noted by the registered dietitian on February 14, 2024, with a 12 pound (11 percent) severe weight loss from 109 pounds on February 12 to 97 pounds on March 11, 2024, and a 15.4 pound (15.4 percent) severe weight loss from 99.9 pounds on March 4, 2024, to April 3, 2024, residents last known weight. Resident 59's weights revealed a 32.7-pound weight loss since her admission to the facility from the weight first obtained on February 1, 2024, to the April 3, 2024, weight. There was no evidence Resident 59 was further assessed by the dietitian or physician regarding the resident's continued weight loss since the nutrition note on February 14, 2024. In an interview with the Nursing Home Administrator on April 9, 2024, at 2:19 PM the administrator indicated the facility has not employed a registered dietitian/nutrition professional since March 8, 2024, was currently in the recruitment phase and confirmed there was no additional information regarding nutrition interventions for Resident 59 after the resident continued to lose weight. Clinical record review for Resident 86 revealed the following weights: December 18, 2023, 138.0 pounds January 5, 2024, 129.0 pounds (9 pounds, 6.5 percent weight loss in 18 days) February 1, 2024, 131.2 pounds (6.8 pounds, 5.03 percent weight loss since December 18, 2023) March 1, 2024, 132.0 pounds (6 pounds, 4.3 percent weight loss in 2.5 months) Review of Resident 86's meal intakes revealed that between December 15, 2024, and March 5, 2024, staff documented he ate 25 percent of his meal 16 times, ate 0 percent of his meal twice, and refused his meal seven times. There were several meals where Resident 86 was out of the facility visiting with his family. Review of Resident 86's physician documentation dated December 15, 2023, revealed that the resident had a poor prognosis due to stage four lung cancer with metastasis, with recent hospitalization for a pulmonary embolism. The physician's goal was to ensure that Resident 86 was supported nutritionally and identified nutritional support was of significant importance. The physician indicated that though (Resident 86)'s prognosis was very poor with limited survival (our) goal was to make sure that as long as (Resident 86) was alive he remains comfortable and safe. Resident 86's physician ordered the following: On December 15, 2023, for staff to provide a regular diet with regular texture. On December 19, 2023, admitted Resident 86 to hospice for terminal illness of lung cancer. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On December 20, 2023, provided a house shake twice daily for inadequate oral intake. On December 31, 2023, administer Zofran 4 milligrams every 8 hours as needed for nausea/vomiting. On February 21, 2024, discontinue hospice services per resident request. Review of Resident 86's registered dietitian documentation on December 19, 2023, the dietitian identified that Resident 86 had an advanced cancer diagnosis with hospice services, their intake was 78 percent, they had an elevated nutritional need, and recommended a house shake twice daily. The dietician deferred Resident 86's weekly weight monitoring secondary to their hospice status with weight loss expected, noting the dietitian was available for consultation as needed. The facility completed Resident 86's care plan conference on December 28, 2023, and indicated that his meal intakes were 25 to 50 percent, accepted nutritional supplements, and noted no eating difficulties. Review of Resident 86's nursing documentation revealed the following: On December 30, 2023, Resident 86 complained of an upset stomach at 2:10 AM with ginger ale accepted. On December 31, 2023, at 12:00 AM the facility notified the on-call physician regarding Resident 86 complaining of nausea and they ordered Zofran. At 6:05 AM, Resident 86 again complained of nausea. The facility notified hospice staff. At 5:00 PM, staff indicated that Resident 86 complained of intermittent nausea throughout the day. On January 12, 2024, Resident 86's physician indicated that the resident reported weight loss since his cancer diagnosis and requested staff keep the resident as comfortable and pain free as possible. On January 17, 2024, Resident 86's physician revealed that the resident complained of chest discomfort (mid-sternal regions) with swallowing liquids and solids for several months during almost every meal and had a diminished appetite. He ordered staff to start Omeprozole (for acid reflux) 40 milligrams by mouth daily and complete a barium swallow study for chest pain due to swallowing. Review of Resident 86's clinical record revealed neither the Omeprozole or barium study were ordered for Resident 86 between January 17, 2024, and March 5, 2024. On February 12, 2024, at 4:28 AM, Resident 86 complained of feeling like something was stuck in (his) throat and was irritating. Resident 86 was able to speak with no redness or irritation noted. He had eaten ice cream earlier with no concerns. On March 3, 2024, 3:35 PM, Resident 86 complained of a sore throat and felt he had trouble swallowing. His physician ordered throat lozenges/cough drops and his family requested Resident 86 receive hot soup or broth, ice cream, and mashed potatoes with every meal. The kitchen was notified. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On March 5, 2024, a different dietitian noted a significant change with Resident 86 and the first time that the dietitian assessed this resident. The dietitian noted the 6 pound (4.3 percent) weight loss in 2.5 months with malnutrition included in the diagnoses since admission. The dietitian noted ongoing swallowing concerns since January 17, 2024, with the resident informing the dietitian concerns with eating most food items, particularly meats. Resident 86 also indicated that the chocolate shakes being sent are too rich at times with noted creaminess. The dietitian changed the shakes to vanilla and the timing for the shakes to be delivered with the breakfast and dinner meals. Resident 86 was also agreeable to try Gelatin plus supplements, noting he would be open to try anything. Resident 86 indicated that he used to weight 149 to 155 pounds prior to admission with weight loss noted due to significant loss of muscle, fat, and grip strength and continued to lose weight despite eating. The dietitian informed Resident 86 that these were signs of malnutrition. The dietician identified that the facility had not ordered the Omeprozole and/or barium swallow study per the physician directive/documentation on January 17, 2024 (1.5 months prior). The dietitian indicated to monitor meal and supplement intakes/acceptance, weights, lab orders, medications, and diet texture tolerance. He also recommended a speech evaluation. On March 5, 2024, at 4:44 PM, nursing staff approached Resident 86 regarding the physician ordered Omeprozole and barium swallow study from January 17, 2024. Resident 86 determined that he did not wish to have the Omeprozole medication and did not want the barium swallow study completed. There was no documentation that indicated the facility's two dietitians identified, monitored, and implemented dietary interventions for Resident 86's weight loss and swallowing and intake concerns between December 19, 2023, and March 5, 2024. This surveyor reviewed the above information during an interview with the Nursing Home Administrator and Director of Nursing on April 9, 2024, at 1:37 PM and April 9, 2024, at 2:19 PM Clinical record review for Resident 91 revealed that the facility admitted him on January 11, 2024, with an admission weight of 185 pounds. He was on a regular diet with regular texture. A dietary progress note dated January 12, 2024, at 2:47 PM indicated that Resident 91's intakes have been variable with increased nutritional needs for healing related to a fracture. The note indicated that a request would be made to the food service director to offer resident high protein food options. It also indicated that the registered dietician would follow Resident 91. Review of Resident 91's documented weights revealed that he had a significant weight loss of 10 percent from January 11, 2024, when he weighed 185 pounds to March 7, 2024, where he weighed 165 pounds, and a 5 percent weight loss from January 11, 2024, where he weighed 185 pounds to February 22, 2024, where he weighed 175 pounds. Review of Resident 91's physician orders and care plan revealed that no new interventions were initiated related to his significant weight loss. There was no documentation that indicated the facility identified, monitored, and implemented dietary interventions for Resident 91's significant weight loss that was noted on February 22, 2024, and March 7, 2024. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This surveyor reviewed the above information related to Resident 91's weight loss during an interview with the Nursing Home Administrator and Director of Nursing on April 9, 2024, at 2:15 PM. 483.25(g)(1) Maintain acceptable parameters of nutrition Previously cited 5/11/23 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 211.12(d)(1)(3)(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. 38839 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 timely and implemented accepted recommendations timely for two of five residents reviewed (Residents 50 and 80). Findings include: Clinical record review for Resident 50 revealed a consultant pharmacist recommendation dated February 6, 2024, for the initiation of Vitamin D3 for the resident. The recommendation was noted as accepted by the physician and signed on February 25, 2024, by the physician. Further record review for Resident 50 revealed the resident did not receive a physician's order for the Vitamin D3 until March 6, 2024, 10 days later. Clinical record review for Resident 80 revealed a consultant pharmacist recommendation dated October 13, 2023, to check a serum Vitamin D level on the resident due to a recent fall. The recommendation was reviewed by the physician until November 27, 2023, greater than 30 days from the date of the recommendation. The physician did accept the recommendation for Resident 80 to obtain a serum Vitamin D level when signed on November 27, 2023, although there was no evidence the serum Vitamin D level was obtained until February 5, 2024, even though the resident had other blood lab work completed in the time frame. A consultant pharmacy recommendation dated February 6, 2024, for Resident 80 noted the serum Vitamin D level that was obtained on February 5, 2024, with a concentration of 11 ng/mL (nanograms/milliliter) and now recommended the addition of a Vitamin D3 supplement. Review of Resident 80's lab report dated February 5, 2024, revealed Resident 80's serum Vitamin D level was identified as deficient with a level less than 20 ng/mL. Resident 80 was ordered Vitamin D3 on February 6, 2024. The above information regarding Resident 50 and 80 was reviewed with the Nursing Home Administrator and Director of Nursing on April 9, 2024, at 2:00 PM. 28 Pa. Code 211.9 (d)(k) Pharmacy services 28 Pa. Code 211.12(d)(3)(5) Nursing services

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 29512 Based on clinical record review and staff interview, it was determined that the facility failed to ensure a resident's medication regime was free from potentially unnecessary medications for one of five residents reviewed (Resident 13). Findings include: Clinical record review for Resident 13 revealed a physician's order dated November 1, 2023, and discontinued on March 6, 2024, for Ativan (for anxiety) 1 milligram (mg) by mouth (PO) twice daily (BID) as needed (PRN) for 60 days. On March 16, 2024, Resident 13's physician reordered the Ativan 1 mg PO BID PRN for anxiety for another 60 days. Review of Resident 13's February, March, and April 2024 MARs (medication administration record, a form to document medication administration) revealed that there was no documentation that staff attempted non-medicinal interventions prior to administration of her PRN Ativan for 24 of the 25 administrations in February 2024, for 29 of the 36 administrations in March 2024, and for 9 of the 10 administrations in April 2024. The surveyor reviewed the above information for Resident 13 during an interview with the Nursing Home Administrator and Director Nursing on April 8, 2024, at 2:14 PM. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services 28 Pa. Code 211.10(a) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 19719 Based on staff interview, it was determined that the facility failed to employ a qualified registered dietitian, in the absence of a full time certified dietary manager. Findings include: Interview with the Administrator on April 7, 2024, at 2:00 PM revealed that the facility has not had a qualified dietitian either full time, part time, or on a consultant basis since March 8, 2024. It was also confirmed that the facility does not have a certified dietary manager. 28 Pa Code 201.18(e)(6) Management

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38839 Based on observation and staff interview, it was determined that the facility failed to store food in accordance with professional standards for food service safety and sanitation in the facility's main kitchen. Findings include: An observation of the facility's main kitchen on [DATE], at 8:38 AM revealed the following: A coffee station was observed with cabinets below the coffee maker with sliding doors. The tracks of the doors were filled with dried food, debris, and ground coffee. A household refrigerator located in the preparation area was observed with a dried white substance covering the lower interior shelf of the refrigerator and dried liquid spills on the interior door. A sliding window and wall behind a preparation table located beside the refrigerator noted above was covered with dried food splatter. A piece of equipment on a cart beside the table covered in a garbage bag was also observed with dried food splatter on the exterior of the garbage bag. A cart the piece of equipment was sitting on was covered in dust and debris as well as a [NAME] the cart sat on top of. A large round garbage can in the same area was uncovered with the lid leaning against the wall behind it. The flooring area around the garbage can extending behind the oven was observed with dried food and debris. Concurrent interview with Employee 5, cook, indicated the equipment under the garbage bag was an industrial mixer, which had not been used in several years. The lower shelves of preparation tables located near the food serving line contained a buildup of dust and debris. The wall area behind a preparation table holding the food processor was observed with dried food splatter covering the tiles on the wall, and the cabinets above the area. A sliding door cabinet under the area contained a buildup of dust and debris in the tracks of the sliding doors. A carboard box of sheet pan liners in the cabinet was observed open with the carboard box soiled with grease spots and dried food. A large round gray garbage can was sitting beside the mixer/cart the lid was off the garbage can and sitting propped up against the wall. The floor surrounding the garbage can and extending behind the oven had significant dried debris. Lower shelves of the preparation table area, which contains a sink, was soiled with dried spills and debris. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Several packages of bread products were observed on a rack in the dry storage area including multiple loaves of white bread, hot dog rolls, and hamburger rolls. The bread products were in clear plastic bags and there was no visible indication as to when they were placed there or when they needed to be used by. Employee 5 indicated the bread products came into the facility fresh but was not sure when they expired. Employee 5 found a carboard box from bread in the area and indicated the bread came delivered in the box, which also did not have a use by date on it but did indicate to keep the product frozen until ready to use. Employee 5 then indicated she was not sure if the bread came in fresh or frozen. There was no evidence to indicate when the bread products were pulled from the frozen state as indicated on the box, or when they needed to be used by. Shelving units throughout the dry storage area with food products stored on them were observed with dust, debris, and dried spills on several of the shelves. In an interview with the Nursing Home Administrator and Director of Nursing on [DATE], at 2:25 PM the above findings were reviewed. 28 Pa. Code 201.14 (a) Responsibility of licensee

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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. 29512 Based on review of facility staff education records and staff interview, it was determined that the facility failed to ensure that all nurse aide staff completed a minimum of 12 hours of in-service education training each year for two of four nurse aides reviewed (Employees 2 and 3). Findings include: During an interview with the Nursing Home Administrator (NHA) and Employee 6, human resources director, scheduler, and payroll, on April 10, 2024, at 9:30 AM the surveyor requested evidence of annual in-service education for Employee 2, nurse aide, hired January 25, 2022, and Employee 3, nurse aide, hired February 2, 2016. Interview with the NHA and Employee 6 on April 10, 2024, at 10:00 AM confirmed that Employee 2 only completed 6.26 hours and Employee 3 only completed 3.01 hours of the required 12 hours of annual in-service education, which included dementia training, abuse prevention training, and any areas of weakness or resident special care needs in the past year. 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 201.20(a)(d) Staff development 28 Pa. Code 211.12(c) Nursing services