STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395364	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook North	300 Leader Drive Williamsport, PA 17701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 29512 Based on observation and staff and resident interview, it was determined that the facility failed to assist a resident to retain and use personal possessions on three of three nursing units (First, Second, and Third Floor Nursing Units; Residents 2, 19, 22, 64, 88, 92, 106, and 121). Findings include: Interview with Resident 22 on April 1, 2025, at 12:49 PM revealed that she could not locate a few pairs of pants and three shirts. Observation of the facility laundry on April 4, 2025, at 11:05 AM revealed that there was a large plastic laundry bin in the dirty laundry area that was stacked full of bagged dirty personal laundry and extended/overflowed 3.5 feet above the top of the plastic laundry bin. Further observation revealed that there were nine large bins identified for the first, second, and third floor nursing units in the clean laundry area that were stacked full of clean laundry that belonged to Residents 2, 19, 22, 64, 88, 92, 106, and 121. The clean bin of clothes was sitting for at least four days and the clothes were not distributed to the residents for their use. The facility failed to ensure that residents had access to their personal clothing timely after laundering by the facility. Interview with Employee 3, housekeeping supervisor, on April 4, 2025, at 11:05 AM, and the Nursing Home Administrator on April 4, 2025, at 12:13 PM confirmed the observation. 28 Pa. Code 201.18(f) Management 28 Pa. Code 201.29(c.3)(4) Resident rights

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 29512 Based on observation and staff interview, it was determined that the facility failed to provide adequate housekeeping and maintenance services to ensure a clean, safe, and orderly environment on one of three nursing units (200 Nursing Unit; Residents 19, 67, 84, 97, 108). Findings include: Observation of the 200 Nursing Unit on the following dates and times revealed: Observation on April 1, 2025, at 10:51 AM, revealed Resident 67's handrail on the left side of toilet was ripped off the wall with six open holes noted in the drywall where the handrail was located. Observation on April 1, 2025, at 10:57 AM revealed there was a strong urine odor on the 2 East hallway of the 200 Nursing Unit. Observation on April 1, 2025, at 11:06 AM revealed Resident 108's privacy curtain had a 3-foot by 2-foot yellow dried stain along the bottom of the curtain. Observation on April 1, 2025, at 11:14 AM revealed the drywall by Residents 97 and 84's closet and the drywall between Resident 84's bed and the bathroom was marred and gouged. Observation on April 3, 2025, at 3:15 PM revealed Resident 19's fan shroud was full off dust and debris. The above information was reviewed during an interview with the Nursing Home Administrator and Director of Nursing on April 3, 2025, at 3:30 PM. 483.10(i)(1)-(7) Safe/clean/comfortable/homelike Environment Previously cited 5/23/24 28 Pa. Code 201.18(b)(3) Management

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 18229 Based on review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to thoroughly investigate and report to the appropriate agencies an allegation of misappropriation of resident property for one of 24 records reviewed (Resident 38). Findings include: The policy entitled Vulnerable Adult Abuse and Neglect Prevention, last reviewed without changes on March 27, 2025, revealed upon receiving a complaint of alleged maltreatment, the Nursing Home Administrator must be notified immediately. The Director of Nursing or assigned designee and the Nursing Home Administrator will coordinate an investigation, which will include completion of witness statements. All parties involved including, staff, residents, or visitors who were potentially involved, or observed the alleged incident are to be interviewed by the Director of Nursing, Director of Social Services, or their designees. The facility must report to the State agency immediately, but no later than 2 hours after serious bodily injury, or not later than 24 hours if the alleged violation involves not serious bodily injury. Staff are required to call law enforcement officials if suspected concern is criminal in nature. Clinical record review for Resident 38 revealed nursing documentation dated December 10, 2024, at 10:41 PM revealing Resident 38 asked the licensed practical nurse why someone stole her 40 dollars. Interview with the Nursing Home Administrator on April 4, 2025, at 9:15 AM revealed that she completed a resident concern form regarding Resident 38's allegation of her missing 40 dollars. The Nursing Home Administrator confirmed that the facility did not complete an investigation, obtain witness statements, notify law enforcement, or notify the Department of Health related to Resident 38's allegation of missing money. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(1)(3)(e)(1) Management 28 Pa Code 201.19(8) Personnel policies and procedures

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F 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. 18229 Based on clinical record review and staff interview, it was determined that the facility failed to implement a comprehensive person-centered care plan regarding a pacemaker for one of 24 residents reviewed (Resident 78). Findings Include: Clinical record review for Resident 78 revealed a medical history that included the presence of a cardiac pacemaker (surgically implanted device used to control the electrical activity of the heart and regulate the heartbeat). A physician's order dated July 2, 2021, noted the presence of a cardiac pacemaker. Review of Resident 78's clinical record on April 1, 2025, at 2:05 PM revealed no care plan was developed related to the resident's pacemaker or associated resident monitoring/assessment. The above information for Resident 78 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on April 2, 2025, at 2:30 PM. The Director of Nursing confirmed these findings on April 3, 2025, at 8:54 AM. 28 Pa. Code 211.10 (a)(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36798 Based on observation, clinical record review, and resident and staff interview, it was determined that the facility failed to assist dependent residents with bathing and/or personal hygiene for 7 of 14 residents reviewed (Residents 2, 21, 88, 92, 96, 117, and 121). Findings include: Interview with Resident 2 on April 1, 2025, at 1:30 PM revealed that she did not receive her shower four times in February 2025, and two times in March 2025. She also indicated that she had missed showers in January but did not provide the number of showers she missed. Clinical record review for Resident 2 revealed that she did not receive her scheduled showers on January 19, 26, and 31, 2025. Review of Resident 2's clinical documentation for February 2025, revealed that she did not receive her scheduled showers on February 25, 2025. Review of Resident 2's clinical documentation for March 2025, revealed that she did not receive her scheduled showers on March 4 or 11, 2025. Review of Resident 2's current MDS (Minimum Data Set, an assessment completed at intervals by the facility to determine care needs of the resident) dated February 10, 2025, revealed that she required substantial/maximal assistance (the person helping lifts or holds trunk or limbs and provides more than half the effort with bathing/showers) with bathing. Observation of Resident 21 on April 1, 2025, at 11:51 AM revealed he entered the community room for lunch. His hair was disheveled and appeared greasy. Clinical record review for Resident 21 revealed that his scheduled shower days were Monday and Thursdays on dayshift. Review of Resident 21's task documentation for February 2025, revealed that he only had his hair washed two times, February 11 and 20, 2025. Review of Resident 21's task documentation for March 2025, revealed that he only had his hair washed on March 3, 2025. Observation of Resident 96 on April 1, 2025, at 11:46 AM revealed she was sleeping in a chair in the community room. Her hair appeared disheveled and greasy. Clinical record review for Resident 96 revealed task documentation for February and March 2025, that indicated she only had her hair washed on February 25, 2025, and March 5, and 8, 2025. Further clinical record review for Resident 96 revealed task documentation that indicated she did not have a bath or shower on February 12, 15, 19, or 22, 2025, and March 12, 15, 19, 22, and 26, 2025. Resident 96's scheduled bath days were Wednesday and Saturday dayshift. Resident 96's most recent MDS dated [DATE], revealed that she was coded as dependent (staff does all the effort. Resident does none of the effort to complete the activity) for bathing. The above noted bathing concerns for Residents 2, 21, and 96 were addressed with the Nursing Home Administrator on April 3, 2025, at 12:45 PM. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident 121's family voiced concerns that sometimes upon visiting, the resident's hair seems dirty and the family was unsure if the resident was getting bathed. A review of the census for Resident 121 revealed that the resident was admitted to the facility on [DATE]. Clinical record review for Resident 121 revealed an admission MDS that noted facility staff assessed the resident as having a BIMS (Brief Interview for Mental Status) of 4, which indicated cognitive impairment. Further review of Resident 121's MDS revealed the resident required substantial maximal assistance to shower and bathe self. Clinical record review for Resident 121 revealed a task list (located in the electronic health record where staff document specific care related events for a resident) that noted bathing on Monday and Thursday 3 PM to 11 PM. Further review of the bathing task for Resident 121 for March and April 2025, revealed staff documented one bed bath (basin or sink bath) as completed on March 8, 2025. The staff documented the resident as refusing bathing on March 20, 2025. The following dates were marked NA to note non-applicable: March 17, 24, 27, and 31, 2025. Further review of the clinical record revealed no evidence was documented to indicate Resident 121 refused a bath, there was a wound or injury preventing a bathing, or any other rationale other than the refusal on March 20, 2025. There was no evidence that staff reapproached Resident 121 after he refused bathing on March 20, 2025. The information on Resident 121 was reviewed with the Nursing Home Administrator on April 3, 2025, at 12:37 PM. Clinical record review revealed the facility admitted Resident 88 on May 19, 2022. A review of Resident 88's most recent MDS dated [DATE], indicated nursing staff assessed Resident 88 as requiring substantial to maximum staff assistance with bathing. A review of Resident 88's task documentation for the last three months revealed Resident 88 only received seven showers. There were eight days that the staff documented NA (not applicable), and Resident 88 did not receive his shower. Further review of Resident 88's clinical record revealed that Resident 88's bathing preference was identified as showers twice a week. Clinical record review revealed the facility admitted Resident 92 on December 13, 2023. A review of Resident 92's most recent quarterly MDS dated [DATE], indicated nursing staff assessed Resident 92 as dependent on staff for bathing. A review of Resident 92's task documentation for the last three months revealed Resident 92 only received four showers and staff documented that Resident 92 refused her shower four times. There was no evidence that staff reapproached Resident 92 after they refused bathing to re-attempt. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident 92's clinical record revealed that Resident 92's bathing preference was identified as showers twice a week. Clinical record review revealed the facility admitted Resident 117 on February 6, 2025. A review of Resident 117's admission MDS dated [DATE], indicated nursing staff assessed Resident 117 as requiring partial to moderate staff assistance (staff lifts, holds, or supports trunk or limbs, but provides less than half the effort). A review of Resident 117's task documentation since admission revealed Resident 117 only received four showers, and staff documented that Resident 117 refused his shower four times. There was no evidence that staff reapproached Resident 117 after they refused bathing to re-attempt. Further review of Resident 117's clinical record revealed that Resident 117's bathing preference was identified as showers twice a week. The above information for Residents 88, 92, and 117 was reviewed during an interview with the Nursing Home Administrator and the Director of Nursing on April 3, 2025, at 2:30 PM. The facility failed to provide assistance for bathing assistance for residents' dependent on staff assistance. 483.24(a)(2) ADL Care Provide for Dependent Residents Previously cited deficiency 9/19/24 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36798 Based on clinical record review and resident and staff interview, it was determined that the facility failed to complete restorative range of motion programs to maintain a resident's range of motion for one of seven residents reviewed (Residents 64). Findings include: Interview with Resident 64 on April 1, 2025, at 11:35 AM revealed that her goal was to go home but the problem is her legs don't work right. She said that she can use her arms and do most things needed with them but that she can't use her legs, and she does not want them to get worse. She indicated that she has not had any therapy for about a week. Clinical record review for Resident 64 revealed an MDS (Minimum Data Set, an assessment completed at intervals by the facility to determine the care needs of the resident) assessment dated [DATE], that indicated she currently had no impairment of her upper or lower extremities. Further clinical record review for Resident 64 revealed that she was discontinued from both occupational and physical therapy on March 8, 2025, related to limited progress and non-compliance. Clinical record review of the occupational therapy discharge summary dated March 8, 2025, indicated that Resident 64's active range of motion (moving a joint through its full [NAME] of motion using your own muscles and no external assistance) was limited due to general weakness. The summary also noted that no restorative program was indicated, and Resident 64's prognosis to maintain her current level of functioning was excellent with consistent staff support. Review of Resident 64's physical therapy discharge summary dated March 10, 2025, revealed that her current bilateral extremity strength was two minus out of five, indicating that she had a slight weakness and may have trouble moving the limb without gravity being eliminated (lying down with the leg supported). The summary indicated that restorative programs were not indicated at this time and that her prognosis to maintain her current level of functioning was excelled with consistent staff support. There was no indication in Resident 64's clinical record that restorative programs were initiated. Interview with the Nursing Home Administrator on April 4, 2025, at 1:45 PM confirmed the above noted findings for Residents 64. The facility failed to implement a range of motion program to maintain a resident's range of motion for Resident 64. 28 Pa. Code 211.10(a)(c)(d) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 18229 Based on review of select policy and procedures, clinical record review, and staff interview, it was determined that the facility failed to provide timely assessments and implement interventions to promote acceptable parameters of nutritional status for two of eight residents reviewed for nutritional concerns (Residents 88 and 112). Findings include: Review of the facility policy and procedure entitled, Resident height and weight, last reviewed without changes on March 27, 2025, revealed that all residents will be weighed upon admission and subsequently as the policy directs to provide a baseline and ongoing record for monitoring stability of weight as an indicator of nutritional status and medical condition over a period of time. The nursing department staff and dietary staff will cooperate to prevent, monitor, and provide intervention for undesirable weight variances for the residents. The purpose of the policy is to provide guidelines for physician notification and documentation of significant weight changes. Any weight change of five pounds or greater within 30 days will be retaken within 72 hours for verification and re-weight will be documented in the electronic medical record. If the re-weight verifies a significant, unplanned weight change, this is communicated to the resident's physician, responsible party, dietitian, and any others deemed necessary by the interdisciplinary team. This weight change will be assessed and reviewed by the dietitian in cooperation with the interdisciplinary team and appropriate interventions will be implemented. The dietitian will review individual weights recorded in the electronic medical record monthly and as needed to identify trends overtime. Unplanned weight trends will be assessed and addressed by the dietitian and MD notifications will be made by nursing staff if applicable. Clinical record review for Resident 112 revealed a weight loss of 24.5 pounds, from November 27, 2024, at 174.7 pounds to January 14, 2025, at 150.2 pounds. Further documentation of her weights revealed that there was no weight obtained in December 2024. There was no reweight obtained when the significant weight loss occurred on January 14, 2025. A weight change progress note dated January 15, 2025, at 2:39 PM revealed that Resident 112 had a significant weight loss noted. The note indicated that Resident 112 was not receiving supplements, and she was not receiving extra food or snacks. The note also indicated that Resident 112's diet was upgraded on December 30, 2024, from a pureed level four diet to a minced and moist diet (a texture-modified diet designed for individuals with difficulty chewing or swallowing). Further clinical record review revealed that there was no further monitoring of Resident 112's weight loss from January 15, 2025, until February 11, 2025, at 4:30 PM when a dietitian summary note revealed that Resident 112's cause of weight loss is uncertain, although her food and fluid intake was down from last review. Resident 112's weight was noted as 150 pounds. She also indicated that Resident 112 had a 14.1 percent significant weight loss in 3 months and 19.6 percent weight loss in 6 months, and that Resident 112 met the criteria for being at risk for malnutrition, but no new interventions were initiated. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A weight change note dated February 27, 2025, at 1:35 PM revealed that Resident 112 had gained two pounds, and her weight was 152 pounds on February 19, 2025. The note also indicated that she met the criteria for being at risk for malnutrition. Clinical documentation for Resident 112 revealed her weight was 155 pounds on March 19, 2025, and 141.6 pounds on April 1, 2025, with no reweight obtained as of April 4, 2024, at 9:40 AM. Interview with Employee 2 (registered dietician) on April 4, 2025, at 9:45 AM confirmed the above noted findings related to Resident 112. The Nursing Home Administrator was made aware on April 4, 2025, at 9:50 AM of concerns that the facility failed to obtain reweights and failed to implement interventions to promote acceptable parameters of nutritional status for Resident 112. Clinical record review revealed the facility admitted Resident 88 on May 19, 2022. Further review of Resident 88's clinical record revealed the following weight assessments: January 2, 2025, 158.2 pounds February 9, 2025, 158.6 pounds March 1, 2025, 144.6 pounds (a 14-pound, 8.83 percent severe weight loss in a month) Further review of Resident 88's clinical record revealed a quarterly dietitian summary on February 28, 2025. The next dietary assessment isn't until April 1, 2025, noting Resident 88's weight loss. Interview with Employee 2 on April 4, 2025, at 8:50 AM revealed that there was no assessment of Resident 88's severe weight loss identified on March 1, 2025, until she completed a weight change note on April 1, 2025 (four weeks after the severe weight loss). Employee 2 stated the facility does not have a system to notify her of significant or severe weight losses and gains. The facility failed to assess Resident 88's severe weight loss in a timely manner. 483.25(g)(1) Maintain acceptable parameters of nutrition Previously cited 5/23/24 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 29512 Based on observation and staff interview, it was determined that the facility failed to provide appropriate respiratory care and services for one of one resident reviewed (Resident 19). Findings include: According to the American Association for Respiratory Care proper cleansing of respiratory (nebulizer) equipment reduces infection risk. The longer a dirty nebulizer sits and is allowed to dry, the harder it is to clean thoroughly. Parts of the aerosol drug delivery device should be rinsed and then washed with soap and hot water after each treatment. Once completely dry, store the nebulizer cup and mouthpiece in a zip lock bag. On April 1, 2025, at 10:46 AM and April 3, 2025, at 3:15 PM, Resident 19's oxygen NC (nasal canula, tubing to deliver oxygen to the nose) was lying on their bed unbagged and their oxygen concentrator was running. On April 1, 2025, at 10:46 AM and 2:48 PM, April 2, 2025, at 2:28 PM, and April 3, 2025, at 8:41 AM and 3:15 PM, Resident 19's nebulizer machine was sitting on the floor in front of their oxygen concentrator and their nebulizer tubing was lying on the floor unbagged. The above information was reviewed with the Director of Nursing during an interview on April 3, 2025, at 3:15 PM. 28 Pa. Code 211.10 (c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. 29512 Based on clinical record review and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician ordered pain medications for one of one resident reviewed (Resident 108) Findings include: Review of Physiopedia's and Wikipedia's definition of the numeric pain rating scale (parameters) from zero to 10 indicated that no pain was identified as zero, mild pain was identified as one to three, moderate pain was identified as four to six, and severe pain was identified as seven to 10. Clinical record review for Resident 108 revealed physician's orders for the following pain medications: Ordered on February 14, 2025, and discontinued on March 11, 2025, Oxycodone 5 mg (milligrams) 2 tablets PO (by mouth) every 4 hours PRN (as needed) for severe pain 7-10. Review of Resident 108's February and March 2025 MAR (medication administration record, a form to document medication administration) revealed that staff did not document a level of pain on the following dates and times: Oxycodone (for moderate to severe pain) 5 mg 2 tablets PO every 4 hours PRN for severe pain 7-10. February 21, 2025, at 8:05 AM, 1:19 PM, and 4:00 PM, no pain level February 22, 2025, at 2:41 AM, no pain level February 23, 2025, at 4:33 PM and 9:03 PM, no pain level February 24, 2025, at 4:00 PM, no pain level February 28, 2025, at 8:30 PM, no pain level March 2, 2025, at 8:11 PM, no pain level March 3, 2025, at 8:24 PM, no pain level March 8, 2025, at 12:42 AM and 5:28 PM, no pain level March 9, 2025, at 9:00 PM, no pain level March 10, 2025, at 10:51 AM and 7:47 PM, no pain level Staff did not administer Resident 108's pain medications according to the physician ordered pain scale level(s). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edenbrook North	300 Leader Drive Williamsport, PA 17701

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The above information was reviewed during an interview with the Director of Nursing on April 3, 2025, at 9:20 AM. 483.25(k) Pain Management Previously cited 5/23/24 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 36798 Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement an individualized person-centered care plan to address dementia and cognitive loss displayed by one of three residents reviewed (Resident 63). Findings include: Clinical record review for Resident 63 revealed that the facility admitted her on April 1, 2024, with diagnosis of Dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life). A review of Resident 63's significant change Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated December 18, 2024, indicated that the facility assessed Resident 63 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed. A review of Resident 63's care plan entitled, impaired cognitive function/dementia and impaired thought processes related to dementia initiated on April 5, 2024, failed to identify individualized person-centered interventions to address Resident 63's dementia and cognitive loss. The findings were reviewed with the Nursing Home Administrator on April 3, 2025, at 2:45 PM. 483.40(b)(3) Dementia Treatment and Services Previously cited 5/23/24 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services

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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. 44738 Based on observation and staff interview, it was determined that the facility failed to store food items in a safe and sanitary manner and maintain the environment in a safe and sanitary condition in the facility's main kitchen. Findings included: Observation of the facility's main kitchen with Employee 2, dietitian, on April 1, 2025, at 8:30 AM revealed the following: A mobile rack holding bowls had various debris on the base and felt greasy to touch. Two floor drains had an extensive amount of debris in them. The perimeter of the grease trap in the floor of the dishwasher area had an extensive build-up of debris, including food debris. A windowsill had a build-up of dust, a dead bug, and a discarded potato chip. A storage room adjacent to the main kitchen contained a refrigerator and freezer that held resident food items. The facility was unable to provide a history of temperature monitoring on these units. An interview with the Nursing Home Administrator on April 2, 2025, at 2:43 PM confirmed that facility staff are unable to find documented temperature monitoring for these units. A review of tray line food temperatures provided revealed no documented temperatures for the following dates: March 2, 8, 9, 15, 29, 2025 (breakfast) March 2, 7, 8, 15, 29, 2025 (lunch) March 2-22; March 24-29, 2025 (dinner) The facility failed to provide any additional documentation that the food temperatures were documented by staff for the dates reviewed. The above information was reviewed in a meeting with the Nursing Home Administrator on March 3, 2025, at 3:00 PM. 483.60 (i) Food prepare, distribute, and serve -sanitary/safety Previously cited 5/23/24 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 29512 Based on observation and staff interview, it was determined that the facility failed to ensure safe and sanitary storage and handling of personal food products brought in from outside sources for one of three nursing units (200 Nursing Unit, Resident 22). Findings Include: Observation of Resident 22's room on April 1, 2025, at 10:46 AM revealed that they had a personal refrigerator. There was no temperature monitoring log for Resident 22's refrigerator. Inside Resident 22's refrigerator there were the following items: A container of cottage cheese with a best by date of January 13, 2025 A gallon of sweet tea with a sell by date of January 24, 2025 Two undated Styrofoam containers Continued observation of Resident 22's refrigerator on April 2, 2025, at 2:16 PM revealed no temperature log. The above noted items continued to be in the refrigerator with the following items added: An undated Styrofoam container Two applesauce containers with a use by date of March 14, 2025. The above information was reviewed during an interview with the Nursing Home Administrator on April 4, 2025, at 9:18 AM. The Nursing Home Administrator revealed that resident refrigerators should be monitored for foodborne concerns. 28 Pa. Code 201.18(b)(1) Management

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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. 44738 Based on observation, clinical record review, and resident and staff interview, it was determined that the facility failed to implement appropriate enhanced barrier transmission-based precautions for three of 24 residents reviewed (Residents 2, 67, and 106) Findings include: Review of the memo entitled Enhanced Barrier Precautions (EBP, gown and glove use) in Nursing Homes to Prevent the Spread of Multi-drug Resistant Organisms (MDRO, bacteria that are resistant to some antibiotics) released by the Center for Medicaid and Medicare Services (CMS) on March 20, 2024, with an implementation date of April 1, 2024, revealed that nursing care facilities are to use EBP for residents with chronic wounds or indwelling medical devices 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 titled, Enhanced Barrier Precautions, reviewed without changes on March 27, 2025, revealed that it is the policy of the facility that EBP, in addition to standard contact precautions (refer to the infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status), will be implemented during high-contact resident care activities when caring for residents that have an increased risk for acquiring MDROs such as a resident with chronic wounds requiring a dressing, indwelling medical devices, or residents with infection or colonization (when a germ or microbe is found on or in the body but does not cause symptoms or disease) with an MDRO. Further review of the policy revealed that EBP refers to an infection control intervention designed to reduce transmission of MDROs that employs targeted gown and glove use during high contact resident care activities (dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting, device care, wound care). The policy noted that EBP will not only focus on residents with an infection or colonization with an MDRO, but it will also address residents at risk for developing or becoming colonized. EBP require gown and glove use for residents with a novel or targeted MDRO or any resident with a wound or indwelling medical device during specific high-contact care activities. Clinical record review for Resident 106 revealed the resident has bilateral heel pressure ulcers. The resident has current orders for wound care and antibiotic treatment related to the pressure ulcers. There was no evidence in the clinical record to indicate that Resident 106 was on any type of enhanced barrier precautions or any type of isolation for the wound. (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 106's room on April 3, 2025, at 1:10 PM revealed no evidence that the resident was on EBP (no sign indicating EBP precautions, no personal protective equipment (PPE) in the room or at the doorway to don (put on and use), or any sign placed that instructed to see the nurse prior to care Observation of Resident 106's wound care on April 3, 2025, at 1:10 PM revealed Employee 4, licensed practical nurse, and Employee 5, registered nurse, entered the resident's room and performed wound care to the resident's bilateral heels, which included a dressing change. There was dark colored wound drainage noted on the bed sheet of the resident's bed under the resident's heels. The staff did not wear gowns during the high contact activity of wound care with noted drainage. The above information for Resident 106 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on April 3, 2025, at 2:15 PM. Clinical record review for Resident 2 revealed a urinalysis dated March 18, 2025, that indicated she had ESBL (extended-spectrum beta-lactamase an enzyme found in some strains of bacteria that can't be killed by many of the antibiotics doctors use to treat infections) in her urine. Resident 2 was then hospitalized from March 19 to 25, 2025. There was no evidence in her clinical record that EBP was initiated upon her return from the hospital. Observation of Resident 2's room on April 1, 2025, at 1:30 PM revealed no evidence that EBP was initiated. The above information for Resident 2 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on April 3, 2025, at 2:00 PM. Clinical record review for Resident 67 revealed current physician orders for a Foley (urinary) catheter to straight drainage every shift for a diagnosis of bilateral obstructive uropathy (blockage of the urinary system). Observation on April 1, 2025, at 10:41 AM and 12:48 PM, April 2, 2025, at 12:47 PM and 12:53 PM, and April 3, 2025, at 8:41 AM of the hallway outside Resident 67's room revealed that there was no enhanced barrier precaution signage to indicate the need to utilize PPE (personal protective equipment, to prevent infectious disease transmission) and /or the necessary PPE available outside Resident 67's room though they had an indwelling medical device (Foley urinary catheter). The above information was reviewed during an interview on April 3, 2025, at 3:11 PM with the Nursing Home Administrator and the Director of Nursing. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 44738 Based on observation and staff interview, it was determined that the facility failed to ensure a safe and sanitary environment at an outside designated employee break area located on the facility grounds. Findings include: Observation of an outside employee break area located near the facility's dumpsters at the front of the building on April 1, 2025, at 9:10 AM with Employee 2, dietitian, revealed the following: Various plastic and paper products, a hairnet, wet pieces of cardboard, and several balled up medical gloves discarded on the ground. Multiple discarded cigarette butts, especially around the perimeter of the area. A significant build-up of dead leaves. An overflowing garbage can that contained a brief. A metal bucket with brown-colored water and discarded cigarette butts in it. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on April 2, 2025, at 2:43 PM. 483.90(i) Other Environmental Conditions Previously cited deficiency 5/23/24 28 Pa. Code 201.18 (b)(1)(3) Management