STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395371	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quality Life Services - Apollo	151 Goodview Drive Apollo, PA 15613

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on a review of facility admission documents and staff interview, it was determined that the facility failed to ensure resident rights to make informed decisions and choices about important aspects of residents' health, safety and welfare by making certain residents understand the Notice of Medicare Non-Coverage (NOMNC) form and failed to ensure the agreement is explained to the resident and his or her representative in a form and manner that he or she understands for one of three residents (Closed Record (CR) Resident R1). Findings include: Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019 indicated that a Brief Interview for Mental Status (BIMS), is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of CR Resident R1's admission record indicated the resident was admitted to the facility on [DATE]. Review of physician's note dated 4/15/24, indicated that CR Resident R1 is not oriented to time or location. Review of Resident R110's demographic information available in the electronic medical record indicated that CR Resident R1's son was designated as the responsible party. Review of the Minimum Data Set (MDS - periodic assessment of care needs) dated 4/18/24, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), high blood pressure, and muscle weakness. Review of Section C: Cognitive Patterns, Questions C0500 BIMS Summary Score revealed CR Resident R1's score to be 4, severe impairment. Review of the NOMNC form dated 4/30/24, revealed that it was signed by CR Resident R1. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/21/24, at 2:07 p.m. Discharge Nurse Employee E12 stated that she is responsible for issuing NOMNC and obtaining the appropriate signatures. Discharge Nurse Employee E12 stated she has the resident sign if they have a BIMS of 13 or above, and if it is lower she would have the resident's responsible party sign, unless the doctor states that they have decisional capacity to do so themselves. During an interview on 8/22/24, at 2:18 p.m. the Nursing Home Administrator and the Assistant Nursing Home Administrator confirmed that the facility failed to ensure the NOMNC is explained to the resident and his or her representative in a form and manner that he or she understands for one of three residents. 28 Pa. Code 201.24 (b) Admission Policy. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(2) Management. 28 Pa. Code 201.29(a)(j) Resident Rights.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, observation, and staff interview it was determined that the facility failed to maintain the confidentiality of residents' medical information on one of four three units (Pleasant Valley Back Medication Cart). Findings include: Review of facility policy HIPAA/HITECH Administrative Policy dated 6/3/24, indicated the facility is to protect residents' privacy rights and their individually identifiable health information as required by the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information, 45 CRF Parts 160 and 164, the Health Information Technology for Economic and Clinical Health Act (HITECH) and all Federal regulations and interpretive guidelines promulgated thereunder. During an observation on 8/20/24, at 9:09: a.m. the Pleasant Valley Back Medication Cart outside of room [ROOM NUMBER] was left unattended with the computer screen open with identifiable information any passerby could see resident personal and confidential information. During an interview on 8/20/24, at 9:18 a.m. Licensed Practical Nurse Employee E4 confirmed the above observation. During an interview on 8/20/24, at 2:50 p.m. the Nursing Home Administrator confirmed that the facility failed to maintain the confidentiality of residents' medical information as required. 28 Pa. code: 211.5(b) Clinical records. 28 Pa. Code: 201.29(i) Resident Rights. 28 Pa. Code: 211.12(d)(3) Nursing Services.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on review of facility policies and clinical records, and staff interviews it was determined that the facility failed to assess the functional status of one of two resident (Resident R99) to determine if the use of a seatbelt is a restraint, and failed to develop a care plan for a seatbelt for one of two residents (Resident R2) Findings include: The facility Physical Restraint policy last reviewed 6/3/24, indicated that physical restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restrict freedom of movement or normal access to one's body. The resident must be physically and cognitively able to self-release devices such as Velcro lap trays or tables, seat belts with Velcro, or easy snap seat belts. If a resident cannot mentally and physically self-release, then the device is considered a restraint. The elimination potential of a physical restraint will be re-assessed at least quarterly and any time the elder experiences a significant change in condition by the interdisciplinary team. Review of the clinical record revealed that Resident R2 was admitted to the facility on [DATE]. Review of Resident 2's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 8/3/24, indicated diagnoses of traumatic brain injury (brain dysfunction caused by an outside force, such as a violet blow to the head), difficulty swallowing, and muscle wasting. Section P0100 indicated that resident has a trunk restraint when in chair or out of bed, and is used less than daily. Review of Resident R2's clinical record revealed a physician's order dated 9/15/23, for a seatbelt in place for security while transport and position changing. Review of Resident R2's plan of care failed to include the use of a seatbelt. Review of the clinical record revealed that Resident R99 was admitted to the facility on [DATE]. Review of Resident 99's MDS dated [DATE], indicated diagnoses of multiple rib fractures, repeated falls, and malnutrition (lack of nutrients to the body) Section P0100 indicated that resident has a trunk restraint when in chair or out of bed, and is used daily. Review of Resident R99's clinical record revealed a physician's order dated 6/19/24, for an alarming seatbelt at all times while out of bed to chair. During an interview on 8/21/24, at 10:41 a.m. the Assistant Director of Nursing (ADON) Employee E2 stated that Resident R99's seatbelt is not considered to be a restraint as he can remove the seatbelt by himself. ADON Employee E2 was asked to produce any assessments that were completed to ensure that Resident R99 had been evaluated for the use of a seatbelt and that he can remove the seatbelt by himself. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/21/24, at 1:21 p.m. the ADON Employee E2 confirmed the facility failed to assess Resident R99 for use of a seatbelt to rule out as a restraint and failed to develop a resident centered care plan for the use of a seatbelt for Resident R2. 28 Pa. Code: 211.8(d)(e) Use of restraints. 28 Pa. Code: 201.18(b)(1)(e)(1) Management.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for five of seven residents sampled with facility-initiated transfers (Residents R41, R49, R68, R116, and Closed Resident Record CR134). Findings include: Review of facility policy Medical Emergency dated 6/3/24, indicated if transfer is required complete transfer form and send appropriate documentation with the resident. Review of the clinical record indicated Resident R41 was admitted to the facility on [DATE]. Review of Resident R41's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/18/24, indicated diagnoses of high blood pressure, heart failure (a progressive heart disease that affects pumping action of the heart muscles), and depression (a constant feeling of sadness and loss of interests). Review of the clinical record indicated Resident R41 was transferred to hospital on 2/22/24 and returned to the facility on [DATE]. Review of Resident R41's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R49 was admitted to the facility on [DATE]. Review of Resident R49's MDS dated [DATE], indicated diagnoses of high blood pressure, heart failure, and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of the clinical record indicated Resident R49 was transferred to hospital on 6/12/24 and returned to the facility on [DATE]. Review of Resident R49's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R68 was admitted to the facility on [DATE]. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R68's MDS dated [DATE], indicated diagnoses of high blood pressure, unsteadiness on feet, and depression. Review of the clinical record indicated Resident R68 was transferred to hospital on 5/5/24 and returned to the facility on [DATE]. Review of Resident R68's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R116 was admitted to the facility on [DATE]. Review of Resident R116's MDS dated [DATE], indicated diagnoses of high blood pressure, atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), and end stage renal disease (ESRD, an inability of the kidneys to filter the blood). Review of the clinical record indicated Resident R116 was transferred to hospital on 12/8/23 and returned to the facility on [DATE]. Review of Resident R116's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Closed Resident Record CR134 was admitted to the facility on [DATE]. Review of Closed Resident Record CR134's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia (high fat levels in the blood), and muscle weakness. Review of the clinical record indicated Closed Resident Record Review CR134 was transferred to the hospital on 5/26/24 and did not return to the facility. Review of Closed Resident Record CR134's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. During an interview on 8/22/24, at 11:09 a.m. Assistant Director of Nursing (ADON) Employee E2 stated, We sent a manilla envelope with residents to the hospital. It has their POLST (a form the specifies the level of care desired in a medical emergency), two copies of the face sheet, and a copy of the MAR (medication list). There is probably no documentation about what is sent unless it's in a progress note. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/22/24, at 11:25 a.m. ADON Employee E2 confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for five of seven residents sampled with facility-initiated transfers as required. 28 Pa. Code 201.29 (a) (c.3) (2) Resident rights.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for five of seven residents (Residents R41, R49, R68, R116, and Closed Resident Record CR134). Findings include: Review of the clinical record indicated Resident R41 was admitted to the facility on [DATE]. Review of Resident R41's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/18/24, indicated diagnoses of high blood pressure, heart failure (a progressive heart disease that affects pumping action of the heart muscles), and depression (a constant feeling of sadness and loss of interests). Review of the clinical record indicated Resident R41 was transferred to hospital on 2/22/24 and returned to the facility on [DATE]. Review of Resident R41's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE]. Review of the clinical record indicated Resident R49 was admitted to the facility on [DATE]. Review of Resident R49's MDS dated [DATE], indicated diagnoses of high blood pressure, heart failure, and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of the clinical record indicated Resident R49 was transferred to hospital on 6/12/24 and returned to the facility on [DATE]. Review of Resident R49's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE]. Review of the clinical record indicated Resident R68 was admitted to the facility on [DATE]. Review of Resident R68's MDS dated [DATE], indicated diagnoses of high blood pressure, unsteadiness on feet, and depression. Review of the clinical record indicated Resident R68 was transferred to hospital on 5/5/24 and returned to the facility on [DATE]. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R68's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE]. Review of the clinical record indicated Resident R116 was admitted to the facility on [DATE]. Review of Resident R116's MDS dated [DATE], indicated diagnoses of high blood pressure, atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat), and end stage renal disease (ESRD, an inability of the kidneys to filter the blood). Review of the clinical record indicated Resident R116 was transferred to hospital on 12/8/23 and returned to the facility on [DATE]. Review of Resident R116's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE]. Review of the clinical record indicated Closed Resident Record CR134 was admitted to the facility on [DATE]. Review of Closed Resident Record CR134's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia (high fat levels in the blood), and muscle weakness. Review of the clinical record indicated Closed Resident Record Review CR134 was transferred to the hospital on 5/26/24 and did not return to the facility. Review of Closed Resident Record CR134's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE]. During an interview on 8/22/24, at 10:37 a.m. Social Services Director Employee E5 stated, I do not send notification to the Ombudsman for transfers to the hospital and discharges from the facility. They have never asked me to send anything monthly. During an interview on 8/22/24, at 10:40 a.m. Social Services Director Employee E3 confirmed that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for five of seven residents as required. 28 Pa. Code 201.29 (a) (c.3) (2) Resident rights.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated and revised to reflect the resident's specific care needs for four of four residents (Residents R23, R38, R78, and R337). Findings include: Review of facility policy Care Plan and Interdisciplinary Care Conferences dated 6/3/24, indicated the care plan is a working tool that is reviewed and revised at specific intervals and as needed to reflect response to care and changing needs and goals. The purpose of the care plan is to structure and guide therapeutic interventions to meet resident's needs and achieve expected outcomes. Review of the clinical record indicated Resident R23 was admitted to the facility on [DATE]. Review of Resident R23's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/14/24, indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), repeated falls, and diabetes (too much sugar in the blood). Review of a Health Status Note dated 8/14/24, completed by Registered Nurse (RN) Employee E14 stated, Resident is intermittently confused. Presents at times alert and oriented x 2-3 and others to self. Witnessed by secretary exiting the front doors. Secretary was able to promptly redirect resident back inside to the front office. Myself and other staff members were able to redirect resident from office to her home unit. Resident states, That blue car there is my sisters and she is coming to get me. Family notified of occurrence and are in agreement with Wanderguard (a wearable alarming bracelet used for residents with wandering behaviors). Social Work will be notified that a follow up BIMS (Brief Interview for Mental Status) is to be completed. Physician aware of situation and ordered Wanderguard and urinalysis. Review of a physician order dated 8/14/24, indicated Resident R23 is to have a Wanderguard on at all times. Review of Resident R23's care plan on 8/22/24, failed to include goals and interventions for elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) risk and Wanderguard implementation. Review of the clinical record indicated Resident R38 was admitted to the facility on [DATE]. Review of Resident R38's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia, and need for assistance with personal care. Review of a Behavior Note dated 8/4/24, completed by RN Employee E15 stated, Resident active exit seeking. Wanderguard placed on his left wrist. Front door locked and staff notified of situation. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a physician order dated 8/4/24, indicated Resident R38 is to have a Wanderguard on at all times. Review of Resident R38's care plan on 8/22/24, failed to include goals and interventions for elopement risk and Wanderguard implementation. Review of the clinical record indicated Resident R78 was admitted to the facility on [DATE]. Review of Resident R78's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia, and muscle weakness. Review of a physician order dated 8/13/24, indicated Resident R78 is to have a Wanderguard on at all times on her wheelchair with a Wanderguard serial number. Review of Resident R78's care plan on 8/22/24, indicated Resident R78 had a Wanderguard with a different serial number and had failed to be updated to reflect the current Wanderguard serial number. Review of the clinical record indicated Resident R337 was admitted to the facility on [DATE]. Review of Resident R337's MDS dated [DATE], indicated diagnoses of dementia, muscle weakness, an need for assistance with personal care. Review of a physician order dated 8/5/24, indicated Resident R337 is to have a Wanderguard on at all times. Review of Resident R337's care plan on 8/22/24, failed to include goals and interventions for elopement risk and Wanderguard implementation. During an interview on 8/22/24, at 10:55 a.m. the Assistant Director of Nursing Employee E2 confirmed that the facility failed to ensure that a resident's care plan was updated and revised to reflect the resident's specific care needs as required. 28 Pa. Code 211.5(f) Clinical records. 28 Pa. Code 211.11(a) Resident care plan. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on a review of the clinical record and staff interviews, it was determined that the facility failed to provide an ongoing program of activities to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for one of six residents (Resident R90). Findings include: Review of the facility Activity Protocol policy dated 6/3/24, indicated the activity department will provide resident centered activities in both group and independent leisure setting that promote each resident's physical, mental, and psychosocial well-being. It was indicated residents will be offered activities daily. Review of Resident R90's clinical record indicated an admitted [DATE], with diagnoses of cerebrovascular accident (also known as a stroke, occurs when blood flow to a part of your brain is stopped either by a blockage or the rupture of a blood vessel), aphasia (disorder that affects how you communicate), and dementia (a group of symptoms affecting memory, thinking and social abilities). Review of Resident R90's care plan last revised 4/27/24, indicated the resident prefers to pursue her own daily activities with cues and assistance as needed. It was indicated the resident enjoys being outside when the weather is nice, likes to actively participate in one-on-one activity visits one to two times a week, and prefers to have pets to be a part of her life. Review of Resident R90's Minimum Data Set (MDS- a periodic assessment of care needs) dated 5/9/24, indicated the diagnoses were current. Review of Resident R90's Activity Review dated 2/1/24, indicated the resident enjoys crafts, country music, looking at magazines, and enjoys being outside when the weather is nice. It was indicated the resident used to like to garden and likes to sit outside in the garden area. Review of Resident R90's clinical record for July 2024, revealed the facility failed to provide an ongoing program of activities to meet the resident's interests. It was documented the resident was not available for activities because she was in bed sleeping a total of 19 times in July. No follow-up was documented. Review of Resident R90's clinical record for August 2024, revealed the facility failed to provide an ongoing program of activities to meet the resident's interests. It was documented the resident was not available for activities because she was in bed sleeping a total of 16 times in August. No follow-up was documented. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/21/24, at 10:01 a.m. the Director of Activities Employee E9 indicated if a resident is unable to express their interests, a family member is contacted to obtain the resident's activity preferences. It was indicated a resident's activity preferences are documented in the resident's clinical record. The Director of Activities, Employee E9 indicated when staff complete an activity with a resident, it is documented in their electronic medical record under the activity documentation section. During an interview on 8/21/24, at 10:13 a.m. the Director of Activities Employee E9 confirmed the facility failed to complete a quarterly Activity Review for April through June 2024, for Resident R90. The Director of Activities confirmed the facility failed to provide an ongoing program of activities to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for one of six residents (Resident R90). 28 Pa. Code: 201. 18(b)(3) Management. 28 Pa. Code: 207.2(a) Administrators Responsibility.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to monitor resident wounds and complete weekly skin assessments for four of four residents (Residents R52, R66, R88, and R96), failed to notify a physician of abnormal glucose readings via a Capillary Blood Glucose (CBG) level as per order for one of two residents (Resident R49), and failed to follow physician orders to monitor daily weights for one of three residents (Resident R116). Findings include: Review of the facility Skin Integrity and Wound Management policy dated 6/2/24, indicated the implementation of an individual resident's skin integrity and wound management occurs within the care delivery process. Staff continually observes and monitor residents for changes and implements revisions to the plan of care as needed. It was indicated staff must perform skin inspections on admission and weekly by a licensed nurse and it must be documented in the resident's electronic record. Wound assessment and proper forms must be completed upon initial identification of altered skin integrity, weekly, and with any deterioration of wound. The Centers for Disease Control defines diabetes as: Diabetes Mellitus is a chronic (long-lasting) health condition that affects how your body turns food into energy. Most of the food you eat is broken down into sugar (also called glucose) and released into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy. If you have diabetes, your body either doesn't make enough insulin or can't use the insulin it makes as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in your bloodstream. Over time, that can cause serious health problems, such as heart disease, vision loss, and kidney disease. Hypoglycemia is a condition that occurs when blood glucose is lower than normal, usually below 70 milligrams per deciliter (mg/dl). If left untreated, hypoglycemia may lead to weakness, confusion, unconsciousness, arrhythmias and even death. People with Diabetes Mellitus may be prescribed injectable insulin to assist in maintaining acceptable levels of CBG's. Hyperglycemia, or high blood glucose, occurs when there is too much sugar in the blood. This happens when your body has too little insulin. Hyperglycemia is blood glucose greater than 125 mg/dL while fasting (not eating for at least eight hours), or a blood glucose greater than 180 mg/dL one to two hours after eating. Review of the facility's policy Hypoglycemia Protocol dated 6/3/24, indicated the purpose of this is to provide safe and effective care that will prevent complications. Hyperglycemia is a more common cause of illness among people with diabetes and is the cause of secondary complications of the disease. If resident is hyperglycemic, recheck the blood sugar and notify physician. Review of the facility's policy Physician Orders dated 6/3/24, indicated the physician orders are followed in accordance with good nursing principles and practices and are transcribed and carried out by persons legally authorized to do so. Review of the clinical record indicated Resident R52 was admitted to the facility on [DATE]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R52's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/3/24, indicated diagnoses of high blood pressure, difficulty walking, and open wound right lesser toe(s) without damage to nail. Review of a Weekly Skin & Wound Note dated 8/9/24, completed by Wound Care Nurse Employee E3 stated, Resident R52 has a wound on right foot second toe. 7/31/24 is when the wound was found acquired in-house on 7/31/24. The wound appears unchanged. The plan of care has been reviewed and updated. Resident wound(s) will be reassessed in one week. Review of Resident R52's clinical record failed to reveal documentation of the resident's right foot second toe wound the week of 8/12/24. Review of Resident R52's care plan 8/21/24, failed to reveal a plan of care for the resident's right foot second toe wound. Review of the clinical record indicated Resident R66 was admitted to the facility on [DATE]. Review of Resident R66's MDS dated [DATE], indicated diagnoses of high blood pressure, acquired absence of right leg below knee, and muscle weakness. Review of a Weekly Skin & Wound Note dated 8/2/24, completed by Registered Nurse (RN) Employee E6 stated, Resident R66 was assessed for one or more wounds that are non-pressure related. Resident has a wound on the right leg. End of right about knee amputation site. 5/21/24 is when the wound was found on admission. The plan of care has been reviewed and updated. Resident wound(s) will be reassessed in one week. Review of Resident R66's clinical record failed to reveal documentation of the resident's right above knee amputation site for the weeks of 8/5/24 and 8/12/24. Review of the clinical record indicated Resident R88 was admitted to the facility on [DATE]. Review of Resident R88's MDS dated [DATE], indicated diagnoses of diabetes (too much sugar in the blood), abnormal posture, and schizophrenia (a mental disorder in which a person experiences delusions, hallucinations, disorganized speech and behavior). Review of a Weekly Skin & Wound Note dated 7/26/24, completed by RN Employee E13 stated, Resident R88 was assessed for one or more wounds that are non-pressure related. Resident has a wound on the right side of their head/neck: upper cheek next to right eye. 11/30/23 Is when the wound was found in-house acquired. It is not healing well. Biopsy site. The size has increased. The plan of care has been reviewed and updated. Resident wound(s) will be reassessed in one week. Review of Resident R88's clinical record failed to reveal documentation of the resident's right head/neck upper cheek wound for the weeks of 7/29/24, 8/5/24, and 8/12/24. Review of Resident R88's care plan 8/21/24, failed to reveal a plan of care for the resident's right head/neck upper cheek wound. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/21/24, at 2:21 p.m. Wound Care Nurse Employee E3 confirmed the facility failed to implement a care plan for Residents R52 and R88 and failed to monitor residents wounds and complete weekly skin assessments for Resident R52, R66, and R88. Review of the clinical record indicated that Resident R96 was admitted to the facility on [DATE], with the diagnoses of dementia (a group of symptoms affecting memory, thinking and social abilities), anxiety, and dysphagia (difficulty swallowing). Review of Resident R96's MDS dated [DATE], indicated the diagnoses were current. Review of Resident R96's progress note dated 7/30/24, indicated the resident was assessed for a non-pressure related wound. It was indicated the resident had a wound on her left buttock that was acquired in-house. It was indicated the measurements were 0.5 cm x 0.5 cm x 0.1 cm. It was indicated the resident had incontinence related dermatitis. It was documented that the plan of care was reviewed and updated. Resident wound will be reassessed in one week. Review of Resident R96's Non-Pressure Wound Tool dated 7/30/24, indicated the resident developed a wound to her left buttock measuring 0.5 cm x 0.5cm x 0.1 cm. It was indicated the resident requires reassessment of wound in one week. Review of Resident R96's clinical record failed to reveal documentation of the resident's left buttock wound the week of 8/5/24, and 8/12/24. Review of Resident R96's care plan on 8/20/24, at 12:09 p.m. failed to include the resident's left buttock wound. During an interview on 8/20/24, at 12:47 p.m. Wound Care Nurse, Employee E3 confirmed the facility failed to implement a care plan for one of three resident's wounds (Resident R96), and monitor resident wounds and complete weekly skin assessments for one of three residents (Resident R96). A review of the admission record indicated Resident R49 was admitted [DATE]. Review of Resident R49's MDS dated [DATE], indicated that he was admitted with diagnoses that included diabetes mellitus (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), high blood pressure, and heart failure (a chronic condition in which the heart doesn't pump blood as well as it should). Review of Resident R49's current care plan updated on 4/12/24, indicated to check blood sugar levels as ordered. Review of Resident R49's physician order dated 7/24/24, indicated to administer insulin subcutaneously per sliding scale (varies of dose of insulin based on blood glucose level) and notify the physician if the blood sugar results are greater than 401 mg/dl. Review of Resident R49's Blood Glucose records from July 2024 to August 2024, indicated the following blood glucose measurements: 7/7/24 - 491 mg/dl (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/13/24 - 457 mg/dl 7/23/24 - 463 mg/dl 7/25/24 - 457 mg/dl 8/6/24 - 470 mg/dl 8/10/24 - 487 mg/dl Review of Resident R49's clinical progress notes did not include physician notifications for the abnormal blood glucose levels for 7/7/24, 7/13/24, 7/23/24, 7/25/24, 8/6/24 and 8/10/24. During an interview on 8/21/24, at 2:40 p.m. Assistant Director of Nursing (ADON) Employee E2 stated, The physician should have been notified with blood glucose levels above 401 mg/dl per physician order and there is no documentation of the physician being notified of Resident R49's elevated blood glucose levels on 7/7/24, 7/13/24, 7/23/24, 7/25/24, 8/6/24 and 8/10/24. During an interview on 8/21/24, at 2:46 p.m. ADON Employee E2 confirmed that the facility failed to notify a physician of abnormal glucose readings via a Capillary Blood Glucose (CBG) level as per order for one of two residents (Resident R49). A review of the admission record indicated Resident R116 was admitted [DATE]. Review of Resident R116's MDS dated [DATE], indicated that he was admitted with diagnoses that included high blood pressure, atrial fibrillation (an irregular heartbeat), and end stage renal disease (a condition that occurs when the kidneys can no longer function properly). Review of Resident R116's current care plan updated on 4/5/24, indicated to weigh and record weight. Notify physician of any significant weight changes. Review of Resident R116's physician order dated 8/11/24, indicated congestive heart failure (chronic condition in which the heart doesn't pump blood as well as it should) Protocol; document daily weights. Notify physician for weight gain of two pounds in 24 hours or five pounds in a week. Review of Resident R116's weight records from 8/11/24, indicated the following weight measurements: 8/11/24 - no weight obtained 8/12/24 - no weight obtained 8/13/24 - no weight obtained 8/14/24 - 281.3 pounds 8/15/24 - no weight obtained 8/16/24 - no weight obtained (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/17/24 - no weight obtained 8/18/24 - no weight obtained 8/19/24 - 286.2 pounds 8/20/24 - no weight obtained Review of Resident R116's clinical progress notes did not indicate that weights were obtained on above dates and failed to indicate that resident refused to have his weights taken. During an interview on 8/21/24, at 2:00 p.m. ADON Employee E2 stated, I don't see that the weights were gotten. During an interview on 8/21/24, at 2:46 p.m. ADON Employee E2 confirmed that the facility failed to follow physician orders to monitor daily weights for one of three residents (Resident R116). 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.29(d) Resident Rights 28 Pa. Code 211.10 (c)(d) Resident Care policies 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075 Based on facility policy review, observation, clinical record review, and staff interviews, it was determined that the facility failed to provide colostomy (a surgical process that diverts bowel through an artificial opening in the abdomen wall) care and services consistent with professional standards of practice for one of two residents reviewed (Resident R76). Findings include: Review of facility policy Ostomy Care dated 6/3/24, indicated ostomy care will be provided for residents who have a colostomy. Ostomy appliances are changed as needed. The purpose is to maintain integrity of peristomal skin (skin around the opening), manage odor, and promote resident ' s self-esteem. Access the color of the stoma (the opening and skin integrity. Review of the admission record indicated Resident R76 was admitted to the facility on [DATE]. Review of Resident R76's MDS (MDS - a periodic assessment of care needs) dated 5/28/24, indicated the diagnoses of high blood pressure, depression, and heart failure (a condition that occurs when the heart can ' t pump enough blood and oxygen to support the body ' s organs). Section H0100 indicated a colostomy was present. During an observation of Resident R76 on 8/21/24, at 10:45 a.m. indicated he had a colostomy. Review of Resident R76's care plan dated 3/28/24, indicated to monitor skin around stoma site with each change, report abnormal findings, and size and type of appliances used. Review of Resident R76's current physician orders failed to indicate any orders for colostomy, including colostomy care, monitor site of stoma, and size and type of appliances used. During an interview on 8/21/24, at 11:00 a.m. Assistant Director of Nursing (ADON) Employee E2 stated, I don't see any orders for his colostomy. I bet they didn't reorder them when he came back from the hospital. During an interview on 8/21/24, at 11:06 a.m. the ADON Employee E2 confirmed the facility failed to provide colostomy care and services consistent with professional standards of practice for one of two residents reviewed (Resident R76). 28 Pa. Code: 211.11 (a)(c)(d) Resident care plan 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code:211.12(d)(1) 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075 Based on facility policy review, clinical record review, observations, and staff interviews, it was determined that the facility failed to maintain sanitary conditions of respiratory equipment for one of four residents reviewed (Resident R81). Findings include: Review of the facility policy Oxygen Therapy via Nasal Cannula dated 6/3/24, indicated oxygen therapy via nasal cannula will be administered as ordered by a physician and will include correct flow rate, concentration, mode of delivery, and frequency. Oxygen will be set up, delivered, and monitored by a licensed nurse or a respiratory therapist, as appropriate. Nasal cannula labeled with resident's name and date of initial set up. Replace cannula every seven days, date, and store in plastic bag when not in use. Review of admission record indicated Resident R81 admitted to the facility on [DATE]. Review of Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/6/24, indicated the diagnoses of high blood pressure, depression, and cancer (a large group of diseases that can affect any part of the body when cells divide uncontrollably and spread into surrounding tissues). MDS Section O: Special Treatments, procedures and programs indicated resident on continuous oxygen therapy. Review of Resident R81's physician order dated 6/3/24, indicated four liters of oxygen via nasal cannula continuously and change tubing every week. Observation of Resident R81 on 8/19/24, at 12:45 p.m. indicated a nasal cannula (light weight tube) in her nose to provide oxygen from a concentrator. The cannula failed to be labeled with a date. During an interview on 8/19/24, at 12:47 p.m. Registered Nurse Employee E6 confirmed Resident R81's nasal cannula failed to be labeled with a date. During an interview on 8/19/24, at 3:00 p.m. Assistant Director of Nursing Employee E2 confirmed that the facility failed to maintain sanitary conditions of respiratory equipment for one of four residents reviewed (Resident R81). 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services. 28 Pa. Code: 211.11 (a)(c)(d) Resident care plan.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on review of facility policy, resident record review, and staff interviews, it was determined that the facility failed to provide trauma survivors with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for four of four residents (Resident R50, R67, R68, and R128). Findings include: Review of facility job description Social Worker, indicated that the Social Worker will carry out social evaluations and plan interventions based on evaluation findings, and counsel residents/ family/caregivers as needed in relationship to stress and other identified coping difficulties. Ensure compliance with all Federal, State, and local regulations. Review of the clinical record indicated Resident R50 was admitted to the facility on [DATE]. Review of Resident R50's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/17/24, indicated diagnoses of PTSD (post-traumatic stress disorder- a mental health condition that is caused by an extremely stressful or terrifying event), high blood pressure, and malnutrition (lack of sufficient nutrients in the body). Review of Resident R50's care plan on 8/20/24, failed to address PTSD by identifying any triggers or how to avoid them. Review of the clinical record indicated Resident R67 was admitted to the facility on [DATE]. Review of Resident R67's MDS dated [DATE], indicated diagnoses of PTSD, high blood pressure, and difficulty walking. Review of Resident R67's care plan on 8/20/24, failed to address PTSD by identifying any triggers or how to avoid them. Review of the clinical record indicated Resident R68 was admitted to the facility on [DATE]. Review of Resident R68s MDS dated [DATE], indicated diagnoses of PTSD, high blood pressure, and unsteadiness on feet. Review of Resident R68's care plan on 8/20/24, failed to address PTSD by identifying any triggers or how to avoid them. Review of the clinical record indicated Resident R128 was admitted to the facility on [DATE]. Review of Resident R128s MDS dated [DATE], indicated diagnoses of PTSD, anoxic brain injury (lack of oxygen to the brain resulting in death of brain cells) and unsteadiness on feet. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R128's care plan on 8/20/24, failed to address PTSD by identifying any triggers or how to avoid them. During an interview on 8/20/24, at 12:57 p.m. Assistant Nursing Home Administrator Employee E1 confirmed that the facility failed to provide trauma survivors with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for four of four residents (Resident R50, R67, R68, and R128). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1) Management.

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F 0742 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 mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on clinical records and facility policy review, and staff interview, it was determined that the facility failed to ensure that a resident who displayed mental or psychosocial adjustment difficulties received appropriate treatment and services to correct the problem for one of six residents (Resident R84). Findings include: Review of the facility Behavior Standard policy last reviewed 6/3/24, indicated residents with dementia receive person-centered care and their individual needs and preferences are recognized. Review of the facility policy Comprehensive Care Plan-CU8.5 dated 6/3/24, indicated a resident's care plan reflects the individual's goals and choices, and identifies individual specific interventions. Review of the facility's Care Plan and Interdisciplinary Care Conferences- NU 6.1 dated 6/3/24, indicated an individualized, interdisciplinary care plan is initiated within 24 hours for each resident as part of the care delivery process. Review of Resident R7's clinical record indicated the resident was admitted to the facility on [DATE], with diagnoses that included high blood pressure, depression, dementia (loss of cognitive function, thinking, remembering, and reasoning). A Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated 5/22/24, indicated the diagnoses were current. Review of Resident R7's hospital discharge summary dated 5/15/24, uploaded to the resident's clinical record on 5/16/24, indicated Resident R7 reason for inpatient admission was for suicidal thoughts or behaviors. Review of Resident R7's progress note dated 5/15/24, entered by Registered Nurse Employee E11 indicated the resident was admitted to the facility from the hospital. It was documented that Resident R7 was admitted from a Psych Hospital with suicidal ideation and behaviors. Review of Resident R7's progress note dated 5/16/24, entered by Social Worker Employee E5 indicated Resident R7 arrived post psych hospitalization for threats of suicide and mental illness. Review of Resident R7's care plan dated 5/29/24, failed to include a care plan for the resident's history of suicidal ideation. During an interview on 8/20/24, at 12:57 p.m. Nursing Home Administrator confirmed the facility failed to ensure Resident R7 received appropriate treatment and services for mental or psychosocial adjustment difficulties. 28 Pa. Code 201.18(b)(1) Management. (continued on next page)

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	395371	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quality Life Services - Apollo	151 Goodview Drive Apollo, PA 15613

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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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on a review of clinical records and staff interview, it was determined that the facility failed to ensure a resident with dementia receives the appropriate treatment and services to attain or maintain his highest practicable physical, mental, and psychosocial well-being for one of four residents reviewed (Resident R7). Findings include: Review of the facility Behavior Standard policy last reviewed 6/3/24, indicated residents with dementia receive person-centered care and their individual needs and preferences are recognized. Review of Resident R7's clinical record indicated the resident was admitted to the facility on [DATE], with diagnoses that included high blood pressure, depression, dementia (loss of cognitive function, thinking, remembering, and reasoning). A Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated 5/22/24, indicated the diagnoses were current. Review of Resident R7's care plan dated 5/29/24, failed to include a care plan for the resident's dementia. During an interview on 8/20/24, at 12:54 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E10, confirmed Resident R7 has no care plan for dementia. RNAC Employee E10 confirmed the facility failed to ensure a resident with dementia receives the appropriate treatment and services to attain or maintain his highest practicable physical, mental, and psychosocial well-being for one of four residents reviewed (Resident R7). 28 Pa Code 211.12 (d)(1)(2)(3)(5) Nursing services

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to properly store medications in two out of three medication carts (Pleasant Valley Back Medication Cart and Buttercup Back Hallway Medication Cart) and one of three medication rooms (Angel Wing Medication Room). Findings include: Review of facility policy Medication Storage in the Facility dated [DATE], indicated medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal. Drugs dispensed in the manufacturer's original container will carry the manufacturer's expiration date. Once opened, these will be good to use until the manufacturer's expiration date is reached unless the medication Is in a multi-dose injectable vial, an ophthalmic medication (medication dispensed into the eye), or an item for which the manufacturer has specified a useable life after opening. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. The expiration date of the vial or container will be 30 days unless the manufacturer recommends another date or regulations/guidelines require different dating. During an observation on [DATE], at 9:06 a.m. of the Pleasant Valley Back Medication Cart indicated the following medications not dated upon opening: - Resident R88's Novolog insulin multi-dose vial (a rapid-acting insulin), no date opened. - Resident R88's Novolog insulin pen (a prefilled pen to inject rapid-acting insulin under the skin), no date opened. - Resident R88's Lantus insulin pen (a prefilled pen to inject long-acting insulin under the skin), no date opened. During an interview on [DATE], at 9:10 a.m. Licensed Practical Nurse (LPN) Employee E4 confirmed the above observations. During an observation on [DATE], at 9:30 a.m. of the Buttercup Back Hall Medication Cart indicated the following medications were expired or not dated upon opening: - Resident R60's Ellipta (an oral breathing inhaler), expired. - Resident R98's Ellipta, no date opened. - Resident R110's Brimonidine (medicated eye drops), expired. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on [DATE], at 9:35 a.m. a drawer holding medications on the Buttercup Back Hall Medication Cart had liquid and powder all over the bottom of the drawer. During an interview on [DATE], at 9:38 a.m. LPN Employee E7 confirmed the above observations. During observations on [DATE], at 1:48 p.m. of the Angel Wing Medication Room with Registered Nurse (RN) Employee E8, observations found two bottles of ProSource (a protein supplement) that expired [DATE], three culture swabs that expired [DATE], and two culture swabs that expired [DATE]. During an interview on [DATE], at 1:49 p.m. RN Employee E8 confirmed that the facility failed to properly store medications in the Angel Wing Mediation Room as required. During an interview on [DATE], at 2:50 p.m. the Nursing Home Administrator confirmed that the facility failed to properly store medications in two out of three medication carts (Pleasant Valley Back Medication Cart and Buttercup Back Hallway Medication Cart) and one of three medication rooms (Angel Wing Medication Room). 28 Pa. Code: 211.9(a)(1)(h)(k)(l)(1) Pharmacy services. 28 Pa. Code:211.12(d)(1)(2)(3)(5) Nursing services.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 48546 Based on review of facility policy, Quality Assurance attendance records, and staff interview, it was determined that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all of the required committee members for one of one of three quarters (January 2024 through March 2024). Findings include: Review of facility policy Quality Assurance Performance Improvement (QAPI) Structure, Scope and Plan dated 6/3/24, indicated a QAPI Committee shall be established to administer the QAPI Plan as it pertains to that home. Members of the homes' QAPI Committee will consist of at least the following: Nursing Home Administrator, Director of Nursing, Medical Director, Personal Care Administrator, Consultant Pharmacist, Direct Care Team Member, Medical Records representative, Laundry/Housekeeping Director, Maintenance Director, Activities Director, Social Worker, Culinary Director, Human Resources Director, RNAC, at least one member of the Safety Committee, Laboratory representative, Community Member, and Representatives from any Performance Improvement Process (PIP) Teams. A review of the QAPI Committee meeting sign-in sheets from the period of January 2024 through March 2024, did not reveal that the Nursing Home Administrator (NHA) was in attendance. During an interview on 8/23/24, at 9:33 a.m. the NHA confirmed that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all of the required committee members as required. 28 Pa Code: 201.18(e)(1)(2)(3)(4) Management.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50075 Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to properly monitor resident's personal refrigerators to ensure that food is properly stored and maintained for three out of three residents (R22, R76, and R110). Findings include: Review of facility policy Food Brought in From Outside Sources dated 6/3/24, indicated it is the policy of the facility to provide safe and sanitary storage, handling, and consumption of food, including food and fluids brought in from outside sources. - The refrigerators will be maintained at or below 41 degrees. - Freezers will be kept at zero degrees and below. - Facility staff will monitor and document the temperature daily. - Sanitation of the refrigerator will be maintained by facility staff member. - Items brought into the facility must be labeled with the resident ' s name and date it was prepared. During an observation on 8/21/24, at 10:05 a.m. Resident R22 had a small personal refrigerator on his bedside nightstand. During an observation on 8/22/24, at 9:15 a.m. the contents inside included 4 cans of soda, 3 applesauce, 5 pudding, 1 yogurt, and 1 ice cream in the freezer. During an observation on 8/22/24, at 9:17 a.m. there was no thermometer inside and no temperature log that included daily monitoring for Resident R22's personal refrigerator. During an interview on 8/22/24, at 9:18 a.m. Assistant Director of Nursing (ADON) Employee E2 stated, They should have a temperature log, a thermometer, and should be checked daily, and confirmed the above findings. During an observation on 8/21/24, at 10:10 a.m. Resident R76 had a small personal refrigerator on his bedside nightstand. During an observation on 8/22/24, at 9:20 a.m. the contents inside included 4 bottles of tea, 3 cans of soda, banana nut bread laying on paper towels, 2 undated containers with food content, 4 bottles of water, 9 yogurts, and an undated opened bottle of hot sauce. During an observation on 8/22/24, at 9:22 a.m. there was no thermometer inside and no temperature log that included daily monitoring for Resident R76's personal refrigerator. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/22/24, at 9:24 a.m. ADON Employee E2 stated, They should have a temperature log, a thermometer, and should be checked daily, and confirmed the above findings. During an observation on 8/21/24, at 10:15 a.m. Resident R110 had a small personal refrigerator on his bedside nightstand. During an observation on 8/22/24, at 9:30 a.m. the contents inside included 4 bottles of tea, 1 apple juice, and a personal cup with a straw. The freezer door was iced shut and unable to be opened. During an observation on 8/22/24, at 9:35 a.m. there was no thermometer inside and no temperature log that included daily monitoring for Resident R110's personal refrigerator. During an interview on 8/22/24, at 9:38 a.m. ADON Employee E2 stated, They should have a temperature log, a thermometer, and should be checked daily, and confirmed the above findings. During an interview on 8/22/24, at 9:40 a.m. the ADON Employee E2 confirmed that the facility failed to properly monitor resident's personal refrigerators to ensure that food is properly stored and maintained for three out of three residents (R22, R76, and R110). 28 Pa. code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b) (1) (e) (1) Management. 28 Pa. Code: 211.10 (d) Resident care policies. 28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on facility policy, clinical record review and staff interview, it was determined that the facility failed to make certain that a pneumococcal immunization was offered to one of five residents (Resident R25). Findings include: Review of the facility policy Standing Orders for Administering Pneumococcal Vaccine to Adults last reviewed 6/3/24, indicated that the pneumococcal vaccination will be offered and documented in the resident's medical chart and personal immunization record card. Review of the Admission Record indicated that Resident R25 was admitted to the facility on [DATE]. Review of Minimum Data Set (MDS-periodic assessment of care needs) dated 7/8/24, included diagnoses of high blood pressure, constipation, and depression. Review of Resident R25's clinical record on 8/21/24, at 9:20 a.m. indicated a consent was required for the pneumovax immunization. During an interview on 8/22/24, at 10:23 a.m. the Infection Preventionist Employee E3 confirmed that the facility failed to make certain that a resident was assessed for and offered pneumococcal immunization for one of five residents. 28 Pa. Code 211.5(f) Clinical records