STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395373	A. Building B. Wing	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwood Center for Rehabilitation and Nursing	276 Green Ave Extended Lewistown, PA 17044

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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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20725 Based on clinical record review and family and staff interview, it was determined that the facility failed to provide a personal funds quarterly statement for one of one resident reviewed for personal funds concerns (Resident 25). Findings include: Clinical record review for Resident 25 revealed that her sister was designated as her first emergency contact and her responsible party. An active physician's order dated [DATE], assessed Resident 25 as incapable of understanding (her rights and responsibilities). Interview with Resident 25's sister on [DATE], at 11:44 AM revealed that she has never received an accounting statement of her sister's personal funds. Resident 25's sister confirmed that Resident 25's social security income is automatically forwarded to the facility for her care, and that she has obtained money from the business office to buy incidentals for her sister. Resident 25's sister stated that she did not know the balance in her sister's personal funds account. The surveyor reviewed the above concerns regarding Resident 25's personal funds quarterly statement during an interview with the Nursing Home Administrator and the Director of Nursing on [DATE], at 2:00 PM. The surveyor requested evidence that Resident 25's sister signed an authorization for the facility to establish a personal fund for Resident 25. A resident fund management service (RFMS) report dated from [DATE], through [DATE], provided by the facility on [DATE], revealed that the facility was designated as the representative payee and that Resident 25's name was on the statement; however, neither Resident 25's sister's name nor address was printed on the statement. The statement indicated that Resident 25 had $5,899.69 in her account as of [DATE]. The facility did not provide an authorization that stipulated Resident 25's sister agreed to the personal funds account as of [DATE], at 3:20 PM. (continued on next page)

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

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

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Employee 1, business office manager, on [DATE], at 3:20 PM the surveyor reviewed the concern that Resident 25's sister's name and address was not noted on the accounting statement provided for Resident 25, that there was no evidence that the facility provided Resident 25's sister a quarterly statement of her personal funds, and that the facility did not provide an authorization signed by Resident 25's sister that established the personal fund. Interview with Employee 1 on [DATE], at 8:30 AM revealed that the RFMS authorization available from the facility dated [DATE], did not include written authorization (a signature) from Resident 25's responsible party to establish a personal funds account. The authorization form was signed only by a facility representative. The form indicated that the statement address was Resident 25's sister's address. Employee 1 indicated that Resident 25's mother was Resident 25's responsible party until she died , and Resident 25's sister has been the family member involved in her care since that time. The facility could not provide an authorization signed by either Resident 25's mother or Resident 25's sister to establish a personal funds account. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.29(a) Resident rights

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38839 Based on clinical record review and staff interview, it was determined that the facility failed to involve a resident in establishing advance directives for one of 32 residents reviewed (Resident 93). Findings include: Clinical record review for Resident 93 revealed the resident was admitted to the facility on [DATE]. Review of a 5-day Admission MDS (minimum data set, an assessment completed at periodic intervals of time to assess resident care needs) completed on [DATE], revealed facility staff assessed the resident as having a BIMS (brief interview of mental status) score of 15, indicating the resident was cognitively intact. Record review for Resident 93 also revealed a POLST (Pennsylvania orders for lift sustaining treatment) dated [DATE], that indicated Resident 93 desired to be a full code (attempt CPR (cardiopulmonary resuscitation) when the person has no pulse and is not breathing). The POLST was signed by the resident's sister who was listed as an emergency contact and a responsible party in the resident's clinical record. There was no evidence to indicate Resident 93 was involved in making the decision regarding her resuscitation. A quarterly MDS dated [DATE], for Resident 93 revealed the resident was again assessed as having a BIMS score of 15, indicating the resident was cognitively intact. Further record review for Resident 93 revealed the resident's electronic record reflected an active order for the resident to be a DNR (do not resuscitate, do not perform CPR if the person has no pulse and is not breathing). A new POLST for the resident dated February 19, 2025, was identified and indicated the resident was changed to a DNR. The POLST dated February 19, 2025, was signed by the resident's son who was listed as an emergency contact for the resident. There was no evidence Resident 93 was involved in making the decision regarding her wishes for resuscitation. Facility staff were not able to provide any evidence Resident 93 was involved in the decision regarding her resuscitation status on [DATE], or February 19, 2025, or that the resident was deemed not capable of being involved or making decisions regarding her health. The above information was reviewed with the Nursing Home Administrator and Director of Nursing on [DATE], at 2:40 PM. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 29512 Based on observation and resident 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 three of five nursing halls (100, 200, and 400 Nursing Halls, Residents 16, 42, 91, and 101). Findings include: Clinical record review for Resident 91 revealed that the facility admitted him on March 5, 2025. On March 25, 2025, at 12:10 PM the drywall to the right of Resident 91's wall heater was marred and gouged. Concurrent interview with Resident 91 revealed that this occurred before their admission. On March 26, 2025, at 1:59 PM the drywall was marred behind Resident 42's head of the bed. Concurrent interview with the Director of Nursing acknowledged the drywall concerns for both Resident 91 and 42. Observation of Resident 16's room on March 25, 2025, at 11:27 AM revealed marring and uneven drywall on the wall outside the bathroom and between the closets. The bathroom walls were also marred. A cobweb was observed hanging from the wall to the center ceiling light in the bathroom. Dirt and debris was observed on the floor along the edge and corners of the bathtub. A light bulb was not working in the light fixture above the resident's sink. A follow up observation of Resident 16's room and bathroom on March 27, 2025, at 9:41 AM revealed the above observations remained unchanged. Observation of Resident 101's room on March 25, 2025, at 10:57 AM revealed loose dirt in a corner behind the door along with a candy wrapper. The wall behind the door was all marred. The bathroom door frame and the bathroom door were all marred, and the wood was visible at the bottom of the bathroom door. The bathroom wall near the wall register was patched but not painted. The above information was reviewed with the Nursing Home Administrator and Director of Nursing on March 27, 2025, at 2:40 PM. 28 Pa. Code 201.18(b)(3) Management

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 38839 Based on clinical record review, review of select policies and procedures, and staff and resident interview, it was determined that the facility failed to thoroughly investigate and notify the appropriate agencies of an identified incident of potential resident misappropriation of property (money) for one of two residents reviewed for abuse concerns (Resident 36). Findings include: Review of the facility's active policy entitled Abuse Prevention Program, revealed it is the facility's policy to have the residents be free from abuse, neglect, misappropriation of resident property and exploitation. The policy indicates all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source will be promptly reported to local, state, and federal agencies (as defined by the current regulations) and thoroughly investigated by facility management. The individual conducting the investigation will at a minimum, review the completed documentation forms, review the resident's medical record to determine events leading up to the incident, interview the person(s) reporting the incident, interview any witnesses to the incident, interview the resident, roommate, family members, and visitors, and other residents to who the accused employee provides care or services to. In an interview with Resident 36, of March 25, 2025, at 12:58 PM the resident stated he has lost a wallet with money in it at the facility, and another time just money out of the wallet. Resident 36, who presented during the interview as significantly visually impaired held up his wrist and stated a key hanging from a bracelet on his wrist was to a locked drawer he now had in his room. Resident 36 indicated in the interview noted above that he can't see, but heard someone in his drawer by his bed, one time he lost 40 dollars and another time he lost a wallet and 50 some dollars. He stated he was never refunded any money, and didn't know what ever happened with the investigation, but he did get a key to have a drawer locked in his room. Resident 36 indicated there is a couple staff that he now allows to get items for him from the drawer since he can't see. Resident 36 did not give specific dates of the incidents. Clinical record review for the last three months for Resident 36 did not reveal any documentation of any incidents of reported misappropriation of any property for the resident. Further information was requested from the Nursing Home Administrator and Director of Nursing on March 27, 2025, at 2:40 PM. On March 28, 2025, at 11:36 AM a typed document was provided by social services entitled, with Resident 36's name and Missing Money Investigation, the typed document included a summary of conversations between social services, administration and a typed summary of email conversations between facility staff and unknown persons. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The document indicated that social services was informed on December 18, 2024, at 1:09 PM that Resident 36 was missing 40 dollars and that the resident stated he had a bifold wallet in his bedside drawer and 40 dollars was in the wallet brought in by a family member recently. Resident 36 was last aware of the cash being in the wallet on December 14, 2024, and the resident was alleging agency staff may have taken the money as he heard them opening and closing the drawer at some point. The document further noted Resident 36 stated he was told the staff member was looking for cream, or looking for a comb, stating the staff knew he could not see. The resident indicated he was fed up with this as it was now $95 that had been stolen from him. Information under the same date on the document indicated the resident agreed to a key at the time to lock the bedside drawer. Continued entries on the typed document indicated administration was aware on December 18, 2024, of the resident's allegation of missing money and requested staff pull schedules and start the process of reviewing staff who worked in the hall where the resident resides, and statements were to be collected from the staff. A follow up entry on the document dated December 20, 2024, confirmed the resident's family member did leave the resident two 20-dollar bills on a recent visit to the facility. It was also noted Resident 36 then shared a specific name of someone he feels may have been involved in the missing money. There was no evidence of any staff statements, roommate statements, or an alleged perpetrator statement. The next entry on the document was not dated until March 20, 2025, over three months later, noting Resident 36, was asking for an update on the missing money from December 2024. On March 27, 2025, it was noted on the typed document, A call to the Area Agency on Aging finds the issue unsubstantiated. There was no further evidence on the missing money investigation for Resident 36. There was no evidence of any review of schedules, or staff interview/statements regarding the missing money, when the allegation was presented in December 2024. There was no evidence of notification to local law enforcement, or the Department of Health field office as required. A grievance was identified for Resident 36 dated March 27, 2024, a year prior, referencing the resident's first report of a missing wallet, as the resident referenced above of an incident occurring prior to the December 2024, incident. Interview with the Director of Nursing on March 28, 2025, at 12:24 PM confirmed the facility had no evidence of a completed investigation of Resident 36's missing money reported on December 18, 2024, or that it was reported to local law enforcement of the Department of Health field office as required. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (e)(1) 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. 20725 Based on a review of select facility policies and procedures, a review of select personnel records, and staff interview, it was determined that the facility failed to complete required background check screening for one of five newly hired employees reviewed (Employee 3) Findings include: In accordance with Act 13 Elder Abuse Mandatory Reporting and Act 169 Criminal Background Checks, nursing facilities are required to obtain a criminal background check on all newly hired employees. Facilities are required to obtain the Pennsylvania State Police (PSP) background check within 30 days of hire on all prospective employees. If the applicant has not been a Pennsylvania resident for the two years before application, they will need to have a PSP criminal history background check completed and a Federal Bureau of Investigation (FBI) Background Check. The facility policy entitled, Criminal History Background Check Policy, last reviewed without changes on January 29, 2025, revealed that if the applicant/employee has been a resident of Pennsylvania for more than two years, the criminal history information will be obtained from the Pennsylvania State Police. If the applicant/employee has been a resident of Pennsylvania for less than two years, the criminal history information will be obtained from the Federal Bureau of Investigation (FBI) through fingerprint-based background checks. Review of Employee 3's (licensed practical nurse) personnel record revealed that the facility hired her on January 21, 2025. A consent to conduct a criminal background check signed by Employee 3 on November 13, 2024, indicated that her most recent previous address was not in Pennsylvania, but in Virginia. An Acknowledgement and Provisional Employment from Pennsylvania form signed by Employee 3 on November 13, 2024, stipulated that she was not a resident of Pennsylvania for the past two years. Employee 3 listed a previous address in Virginia. Employee 3's personnel record did not contain evidence that the facility obtained an FBI criminal background check for the employee who was not a resident of Pennsylvania for two years preceding her hire date. Interview with Employee 2 (human resources) on March 27, 2025, at 9:30 AM, 10:30 AM, and 11:24 AM indicated that the facility had no further evidence of an FBI criminal background check for Employee 3. Interview with the Director of Nursing on March 28, 2025, at 12:45 PM confirmed that the facility could not provide evidence that the facility identified the need for an FBI criminal background check for Employee 3 before the surveyor's questioning. 483.12(b)(1)-(5)(ii)(iii) Develop/implement Abuse/neglect Policies Previously cited deficiency 3/29/24 28 Pa. Code 201.14(a) Responsibility of licensee (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0623 Level of Harm - Potential for minimal 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** 29512 Based on clinical record review and staff interview, it was determined that the facility failed to notify the State Ombudsman of a transfer to the hospital with the required information for three of six residents reviewed (Residents 77, 93, and 110). Findings include: Clinical record review for Resident 77 revealed that they were transferred to the hospital on February 13, 2025, after there was a change in their condition. There was no documentation that the facility provided written notification to the State Ombudsman as required regarding the transfer. The above information was reviewed during an interview with the Director of Nursing on March 28, 2025, at 10:51 AM. Clinical record review for Resident 93 revealed the resident was sent to the hospital on February 6, 2025, for a change in condition and admitted . There was no documentation that the facility provided written notification to the State Ombudsman as required regarding the transfer. The Director of Nursing confirmed the above findings for Resident 93 in an interview on March 27, 2025, at 12:48 PM. Clinical record review for Resident 110 revealed nursing documentation dated January 17, 2025, at 1:41 PM that the hospital admitted him for dehydration (loss of more fluid than what is consumed; the body does not have enough water and other fluids to carry out its normal functions), hypotension (low blood pressure), and altered mental status. His BNP (B-type natriuretic peptide (BNP), a chemical produced by the heart in response to an overload of pressure that is often found with congestive heart failure (CHF, inability of the heart to pump effectively resulting in an overload of fluid in the body) was elevated at 8,000 (for people who don't have heart failure, normal BNP levels are less than 100 picograms per milliliter (pg/mL). BNP levels over 100 pg/mL may be a sign of heart failure). Interview with the Director of Nursing on March 26, 2025, at 3:30 PM and March 27, 2025, at 12:45 PM revealed that the facility did not notify the State Ombudsman of Resident 110's hospitalization on [DATE]. The person responsible to make State Ombudsman notifications did not do so unless a resident was permanently discharged from the facility. 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/discharge Previously cited 3/29/2024 28 Pa. Code 201.14 (a) Responsibility of license 28 Pa. Code 201.29(a) Resident rights

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 20725 Based on clinical record review, observation, and staff and resident interview, it was determined that the facility failed to provide personal and oral hygiene assistance for dependent residents for three of three residents reviewed for activities of daily living (ADL) concerns (Residents 110, 36, and 93). Findings include: Observation of Resident 110 on March 25, 2025, at 12:46 PM revealed that his fingernails were several millimeters longer than the tips of his fingers and were discolored. Interview with Resident 110 on the date and time of the observation revealed that he required the assistance of staff to trim his fingernails. Resident 110 stated that staff told him that they would trim them; however, no one has. Clinical record review for Resident 110 revealed a plan of care initiated by the facility on September 25, 2024, due to Resident 110's deficits in ADL self-care performance. Interventions listed on the plan of care instructed staff to check Resident 110's nail length and trim and clean his nails on the day he received bathing assistance. The surveyor reviewed the above concern regarding Resident 110's fingernails during an interview with the Nursing Home Administrator and the Director of Nursing on March 26, 2025, at 2:00 PM. Observation of Resident 110 on March 28, 2025, at 11:40 AM revealed that his fingernails were clipped to an appropriate length. Interview with Resident 110 on the date and time of the observation confirmed that staff trimmed his fingernails after he and the surveyor spoke on March 25, 2025. An observation and interview of Resident 93 on March 25, 2025, at 12:20 PM revealed a buildup of a white/yellow substance on the resident's lower teeth near the gumline and between her teeth. Resident 93 indicated she does not brush her teeth and staff do not assist her in doing so. A 5-day MDS (minimum data set, an assessment completed at periodic intervals of time to assess resident care needs) dated February 13, 2025, indicated facility staff assessed Resident 93 as requiring substantial/maximum assistance for oral hygiene. A review of Resident 93's dental records revealed the resident was seen by the dentist at the facility on August 27, 2024. The dentist noted soft plaque/food debris buildup was heavy on the residents teeth and that the resident had an upper denture and some lower natural teeth. The dental report indicated the patient was instructed to clean the denture, remove it at night, and action to the nursing home staff indicated the patient needs help with daily oral hygiene. Resident 93 was again seen by the dentist on October 2, 2024, noting actions required by nursing home staff as patient needs help with daily oral hygiene, please make sure she removes dentures at bedtime, cleans them, and soaks them overnight. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 93 was again seen by the dentist on March 14, 2025, where she received a dental cleaning, and it was again noted as soft plaque/food debris buildup on the teeth as heavy with the action required by the nursing home staff again stating the patient needs help with daily oral hygiene. There was no evidence to indicate facility staff brushed Resident 93's lower natural teeth as she had received the dental cleaning on March 14, 2025, and buildup was observed on the resident's lower teeth as noted above on March 25, 2025. The above information regarding Resident 93 was reviewed with the Nursing Home Administrator and Director of Nursing on March 27, 2025, at 2:40 PM. An observation of Resident 36 on March 25, 2025, at 12:48 PM revealed he was lying in bed. The resident's finger nails on both hands significantly extended past the end of the fingers 1/4 inch or greater and appeared brown and black underneath the nail. Resident 36 indicated he can't see, and staff usually trims them, but they just happened to be observed at the longest point. Review of a quarterly MDS dated [DATE], revealed facility staff assessed the resident as dependent on staff for personal hygiene needs, and the resident's vision was severely impaired. The above information regarding Resident 36 was reviewed with the Nursing Home Administrator and Director of Nursing on March 27, 2025, at 2:30 PM. 483.24(a)(2) ADL Care Provided for Dependent Residents Previously cited deficiency 3/29/24 and 9/5/24 28 Pa. Code 211.12(d)(1)(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. 36798 Based on family and staff interview, and review of facility documents, it was determined that the facility failed to provide an ongoing program of activities designed to meet the individual needs and interests for one of three residents reviewed (Resident 101). Findings include: An interview with Resident 101's responsible party revealed concerns that there are no activities in the evenings on the 200 hall, memory care unit. Review of the facility activity calendars for January, February, and March 2025, revealed that there were no activities scheduled after 4:00 PM. Interview with the Director of Nursing and the Activity Director on March 27, 2025, at 2:15 PM confirmed the above noted findings related to the activity program for Resident 101 and the 200 hall. The facility failed to provide an ongoing program of activities to meet the needs of Resident101 and the 200 hall residents. 28 Pa. Code 201.29 (a) Resident rights

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 36798 Based on staff interview it was determined the facility failed to employ qualified activity personnel to oversee the facility's activity program (Employee 6) Findings included: Interview with Employee 6, Activity Director, on March 28, 2025, at 12:17 PM revealed that she was promoted from her nurse aide position to the activity director on February 17, 2025. Interview with the Director of Nursing on March 28, 2025, at 1:00 PM confirmed that Employee 6's qualifications were a certified nurse aide and that she did not possess the regulatory qualifications required to oversee the facility's activity programs. The facility failed to employee a qualified activity professional. 28 Pa Code: 201.3 (i)(ii) Resident activities coordinator. 28 Pa. Code: 201.18(b)(3) Management.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 29512 Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician ordered interventions and treatments for one of 24 residents (Resident 42); and regarding an implanted cardiac pacemaker for one of 24 residents reviewed (Resident 30). Findings include: Clinical record review for Resident 42 revealed current physician orders for the following: Geri sleeves to all four extremities and remove for care every shift for skin alterations Bilateral fall mats in place while resident was in bed every shift Observation of Resident 42 revealed the following: On March 26, 2025, at 1:55 PM Resident 42 was in bed resting. On March 27, at 1:05 PM Resident 42 was dressed in the solarium in their wheelchair. On March 27, 2025, at 2:06 PM Resident 42 was in bed resting. No Geri sleeves were observed on Resident 42's four extremities and no bilateral fall mats were observed while Resident 42 was in bed during the above observations. The above information was reviewed during an interview on March 27, 2025, at 2:20 PM with the Nursing Home Administrator and Director of Nursing. Interview with Resident 30 on March 26, 2025, at 9:58 AM revealed that he had a cardiac pacemaker (surgically implanted medical device with wires attached to heart muscle to deliver electrical impulses to maintain a normal heart rhythm when an abnormality in the heart rhythm is detected). Resident 30 stated that he has a machine at home that performs cardiac pacemaker checks. Resident 30 stated that, to the best of his knowledge, there was no monitoring of his pacemaker while he resided at the facility. Clinical record review for Resident 30 revealed a diagnoses list that included the presence of a cardiac pacemaker. Plans of care developed by the facility to identify Resident 30's medical care needs did not address the presence of an implanted cardiac pacemaker. Available active physician orders did not include care and services for an implanted cardiac pacemaker. No physician order addressed the use of a machine to monitor Resident 30's implanted cardiac pacemaker. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed the above concerns regarding Resident 30's implanted cardiac pacemaker during an interview with the Nursing Home Administrator and the Director of Nursing on March 26, 2025, at 2:00 PM. A plan of care initiated by the facility following the surveyor's questioning stipulated that Resident 30 had a cardiac pacemaker related to a diagnosis of atrial fibrillation (an irregular heart rhythm that can cause fatigue, palpitations, dizziness and stroke (brain damage from either a blood clot or bleeding in the brain). Nursing documentation following the surveyor's questioning dated March 27, 2025, at 6:53 PM revealed that Resident 30 reported to the staff that he has a machine that is in his home that checks his (pacemaker) appliance. Resident 30 stated that he had, no set schedule for pacemaker checks, that the cardiology office does not call him ahead of time, and that he does not have to, do anything special, for the report to run. Resident 30 stated that, as long as I'm within so many feet of my machine, they just run a report. I never know it even happens until they call me afterward and say that everything looks fine. The staff indicated that they would call Resident 30's family to inquire about bringing Resident 30's pacemaker machine into the facility while he is residing there. Nursing documentation dated March 27, 2025, at 7:08 PM revealed that staff contacted Resident 30's responsible party emergency contact to request that the family bring Resident 30's pacemaker check machine to the facility to allow for routine pacemaker checks while in the facility. 483.25 Quality of Care Previously cited 2/27/25 and 6/18/24 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38839 Based on clinical record review and staff interview, it was determined that the facility failed to implement interventions to prevent future falls or accidents for two of three residents reviewed for falls (Residents 93 and 110). Findings include: An interview and observation of Resident 93 on March 25, 2025, at 12:23 PM revealed she had been to the hospital recently for stitches in her head after she fell when she was trying to reach over and pick something up off the floor from the bed. A reddened area was observed on the right side of her eyebrow. Clinical record review for Resident 93 revealed a medical practitioner's note dated March 11, 2025, at 3:23 PM that indicated the resident was being seen as a follow up to an emergency room visit due to a fall with a laceration requiring eight stiches. Further clinical record review for Resident 93 revealed she was admitted to the facility from the hospital on May 8. 2024, after repeated falls at her prior place of living. Resident 93 was noted to have a fall in the facility on August 8, 2024, sustaining a skin tear to her elbow. The resident was educated to use her call bell for assistance and a sign was to be placed in her room as a reminder to use the bell. Clinical record review revealed that Resident 93 fell on [DATE] and 17, 2024, attempting to transfer in her room. Interventions included reminding the resident to use the call bell and ensure the sign was in place. Resident 93's care plan did reflect the addition every two-hour toileting on November 8, 2024, and non-skid strips to the floor on the right side of the resident's bed on November 20, 2024. Clinical record review revealed that Resident 93 fell on [DATE], at 7:30 PM. Resident 93 was found on her bathroom floor after she had removed her clothing and was in the bathtub and had got herself up from the floor and placed herself on the toilet. No injury was noted. The nurse aides assisted the resident with evening care and placed the resident in bed, although no new immediate interventions to prevent Resident 93 from falling/injury were identified. Clinical record review revealed that Resident 93 was found on the floor of her room scooting on her bottom towards the bathroom on December 2, 2024, at 5:04 AM, less than 10 hours after the fall the evening of December 1, 2024, noted above. A nursing follow up note dated December 2, 2024, at 5:57 AM indicated the resident stated to the writer she got out of bed because she had to pee. Resident 93 was noted to have pain in her face with a bruise noted to her left cheekbone area and left knee. Staff were requested to place gripper socks on the resident and educated her on using the call bell for assistance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On December 30, 2024, at 2:00 PM it was noted that Resident 93 was again found on the floor of her room as she attempted to self-transfer from her bed to her recliner. Resident 93 was again reminded to use her call bell for transfers. There were no new interventions identified. A nursing note dated March 11, 2025, at 5 12:08 AM noted the nurse was called to the unit at midnight as Resident 93 was found sitting on the floor next to her bed with a large amount of bleeding noted. A laceration was identified above her eyebrow. Resident 93 was transferred to the emergency room for treatment and received eight sutures to the area by her right eyebrow. The Director of Nursing confirmed there was no further information to indicate additional measures/interventions were implemented to prevent falls/injury for Resident 93 since November 20, 2024, after Resident 93 sustained falls on December 1, 2, and 30, 2024. Resident 93 then fell on [DATE], requiring sutures to a laceration sustained from a fall. Clinical record review for Resident 110 revealed nursing documentation dated for Tuesday, March 1, 2025, at 4:12 AM that staff entered Resident 110's room to find him sitting on the floor beside his bed. Resident 110's clinical record (physician orders, progress notes or care plan interventions) contained no evidence that the facility implemented any new fall prevention interventions in response to Resident 110's fall on March 1, 2025. Nursing documentation dated March 3, 2025, at 3:30 AM revealed that staff again found Resident 110 on the floor in his room after his roommate activated his call bell to inform staff that Resident 110 was on the floor. Review of the plan of care developed by the facility to address Resident 110's fall risk revealed that staff implemented three new interventions (fall mats, low bed, and a toileting program) after Resident 110's fall on March 3, 2025. Interview with the Director of Nursing on March 28, 2025, at 12:05 PM confirmed that the facility did not have evidence of the implementation of any new fall prevention intervention following Resident 110's fall on March 1, 2025. 483.25 (d)(1)(2) Free of Accident Hazards/Supervision/Devices Previously cited 3/29/24 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 19719 Based on closed clinical record review, select facility policies and procedures, and staff interviews, it was determined that the facility failed to ensure that intravenous catheters were assess and maintained per the resident plan of care for one of one resident reviewed (Resident 120). Findings include: Review of the policy entitled Midline Dressing Changes, last reviewed by the facility on January 29, 2025, indicates that the facility will change a resident's midline (an access line placed in an arm to administer medications) catheter 24 hours after its insertion, then every five to seven days. Nursing staff are to document the date and time of the dressing change, description of insertion site, and any noted complications. Review of Resident 120's clinical record revealed nursing documentation dated October 29, 2024, at 4:59 AM that indicated a midline was to be placed for intravenous (IV) access. The physician's order dated October 29, 2024, indicated nursing staff were to administer Rocephin (used to treat bacterial infections) 1 gm (gram) every day for 10 days through the IV. Review of Resident 120's plan of care for intravenous care dated November 5, 2024, seven days after insertion, indicated that nursing staff were to change Resident 120's IV dressing every seven days, flush both ports before and after medication administration, and monitor for signs and symptoms of infection. There was no documented evidence in Resident 120's closed clinical record to indicate that nursing staff changed her midline IV access dressing, flushed ports before and after medication administration, or monitored the site for signs and symptoms of infection. Interview with the Director of Nursing on March 31, 2025, at 1:55 PM confirmed the above finding for Resident 120. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services 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 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, clinical record review, and staff interview, it was determined that the facility failed to provide appropriate respiratory care and services for one of one resident reviewed (Resident 42). 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. Clinical record review for Resident 42 revealed the following current physician orders: Change the oxygen tubing weekly and as needed (PRN) every night shift every Sunday Change humidifier bottle (to help prevent dry nostrils [nose] while on oxygen) once weekly on Sunday during night shift and PRN Observation of Resident 42 revealed the following: On March 25, 2025, (Tuesday), at 12:15 PM Resident 42's oxygen tubing was dated March 16, 2025 (Sunday, nine days prior). On March 26, 2025 (Wednesday), at 12:43 PM and 1:55 PM Resident 42's oxygen tubing was now dated March 23, 2025 (Sunday, three days prior). On March 27, 2025, at 1:05 PM Resident 42's oxygen tubing continued to be dated March 23, 2025. There was no humidification bottle attached to Resident 42's oxygen during any of the observations. Clinical record review for Resident 42 revealed that on March 23, 2025, staff documented completion of Resident 42's oxygen tubing and humidification cannister changes but failed to change the tubing and/or apply a humidification bottle. On March 26, 2025, at 1:55 PM observation, interview, and review of Resident 42's oxygen tubing and humidification staff documentation occurred with the Director of Nursing (DON). The DON acknowledged that staff did not change Resident 42's tubing on March 23, 2025, changed it between the surveyor observations on March 25, 2025, and March 26, 2025, and backdated the tubing to March 23, 2025. The DON reveled that Resident 42 was not to have humidified oxygen ordered and/or administered. 483.25(i) Respiratory/tracheostomy Care and Suctioning Previously cited 3/29/24 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20725 Based on a review of select facility policies and procedures, clinical record review, observation, and staff interview, it was determined that the facility failed to thoroughly assess the potential entrapment risks from the use of bed rails for one of five residents reviewed for accident hazards (Resident 10). Findings include: The facility policy entitled, Bed Safety, last reviewed without changes on January 29, 2025, indicated that the facility would strive to provide a safe sleeping environment for the resident. The resident's sleeping environment shall be assessed by the interdisciplinary team, considering the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. Inspection by maintenance staff of beds and related equipment is part of the regular bed safety program to identify risks and problems including potential entrapment risks. The facility will ensure that bed side rails are properly installed using the manufacturer's instructions and other pertinent safety guidance to ensure proper fit (e.g. avoid bowing, ensure proper distance from the headboard and footboard, etc.); and identify additional safety measures for residents who have been identified as having a higher than usual risk for injury including entrapment (e.g. altered mental status, restlessness, etc.). References referred to at the end of the facility policy included the FDA (The United States Food and Drug Administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment. The FDA Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, is guidance that identifies key parts of the body at risk for entrapment, describes potential entrapment areas or zones, and recommends maximum and minimum dimensional limits of gaps or openings in hospital bed systems. Three key body parts at risk for life-threatening entrapment in the seven zones of a hospital bed system discussed in this guidance are the head, neck, and chest. To reduce the risk of head entrapment, openings in the bed system should not allow the widest part of a small head (head breadth measured across the face from ear to ear) to be trapped. FDA is using a head breadth dimension of 120 mm (4.75 inches) as the basis for its dimensional limit recommendations. To reduce the risk of neck entrapment, openings in the bed system should not allow a small neck to become trapped. FDA is recommending 60 mm (two and three-eighths inches) as an appropriate dimension for neck diameter. The openings in a bed system should be wide enough not to trap a large chest through the opening between split rails. FDA concurs with the dimension of 318 mm (12.5 inches) to represent chest depth for the population vulnerable to entrapment and has used this dimension as the basis for its recommended dimensional limits. This guidance describes seven zones in the hospital bed system where there is a potential for patient entrapment. Zone six is the space between the end of the rail and the side edge of the headboard or footboard. This space may present a risk of either neck entrapment or chest entrapment. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Information provided by the facility's bed manufacturer, Direct Supply, indicated that maintenance is typically responsible for testing and auditing the bed systems to verify that the hardware is in safe, functioning condition. The documentation stipulated that there are seven entrapment zones that have been identified by the FDA. The zones five through seven were not pointed out in the Bed Entrapment Grid but they are identified as: Zone five: space that occurs when a head and foot side rail (split rail) is used on the same side of a bed. Zone six: space that occurs between the end of the rail and the side edge of the headboard or footboard. This space can create a risk of either neck or chest entrapment. This gap can change when raising or lowering the head or foot sections of the bed. This space may increase, decrease, or become less accessible or disappear entirely. Zone seven: space that occurs between the inside surface of the headboard or footboard and the end of the mattress. This space can create a risk of head entrapment. Per the information, Zones five, six, or seven will keep the bed from passing the overall inspection. Observation of Resident 10's room on March 26, 2025, at 10:32 AM revealed bed rails mounted to the head of her bed bilaterally. Resident 10's bed was also equipped with a headboard and a footboard. A Bed System Measurement Device Test Results Worksheet (form the facility utilized to document the assessment of potential entrapment zones) dated January 14, 2025, noted an assessment of zones one through four. There was no documentation of an assessment for zone 6 although Resident 10's bed was equipped with a headboard. Interview with Employee 7, environment director, on March 28, 2025, at 12:08 PM indicated that maintenance staff measure six potential zones for resident bed entrapment; however, these six zones are not documented on the form in the resident's medical record and the facility did not have measurements that define when a space posed a risk versus passed inspection (e.g., a space measured greater than 12.5 inches). Review of the list of diagnoses in Resident 10's medical record included conversion disorder with seizures or convulsions (mental health condition that causes physical symptoms such as involuntary jerking motions) dated December 20, 2022. A review of Resident 10's medication regime revealed three medications (Lamictal, Keppra, and Depakote) designated for the treatment of a seizure disorder (a sudden, involuntary, burst of electrical activity in the brain that can affect awareness, movements, sensations or behaviors). A Side Rail and Entrapment assessment dated [DATE], for Resident 10, revealed that staff assessed Resident 10 as not having epilepsy or other involuntary movements, which may cause entrapment. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Side Rail and Entrapment assessment dated [DATE], for Resident 10 revealed that staff did not complete the second question of the Entrapment Risk Assessment portion of the assessment. The question required a yes or no response to whether Resident 10 had epilepsy or other involuntary movements, which may cause entrapment. Both assessments used to assess Resident 10's side rail entrapment risks failed to include her diagnosis of epilepsy. The surveyor reviewed the above concerns regarding Resident 10's use of side rails during an interview with the Director of Nursing on March 28, 2025, at 12:00 PM. 483.25(n)(1)-(4) Bed Rails Previously cited deficiency 3/29/24 28 Pa. Code 211.12(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36798 Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement an individualized person-centered care plan to address dementia and cognitive loss displayed by two of three residents reviewed (Residents 39 and 99). Findings include: Clinical record review for Resident 39 revealed the facility admitted her on October 12, 2024. A diagnosis of Dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life) was added to her diagnosis list on October 22, 2024. A review of Resident 39's admission Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated October 18, 2024, indicated that the facility determined a care plan for dementia and cognitive loss would be developed. A review of Resident 39's care plan revealed that there was no indication that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss. Clinical record review for Resident 99 revealed the facility admitted her on September 3, 2024, with a diagnosis of dementia. A review of Resident 99's admission MDS dated [DATE], indicated that the facility determined that a care plan for dementia and cognitive loss would be developed. A review of Resident 99's care plan revealed that there was no indication that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss The above noted findings were reviewed with the Director of Nursing and Nursing Home Administrator on March 27, 2025, at 2:10 PM. An Interview with the Director of Nursing on March 28, 2025, at 10:30 AM confirmed that the facility failed to develop a person-centered care plan related to dementia for Residents 39 and 99. 483.40(b)(3) Dementia Treatment and Services Previously cited 3/29/2024 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **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 ensure routine prophylactic dental services for three of six residents reviewed for dental concerns (Residents 10, 39, and 109). Findings include: Clinical record review for Resident 39 revealed an admission MDS (an assessment completed at intervals by the facility to determine care needs of the resident) dated October 18, 2024, that indicated she was edentulous (had no teeth) and had upper and lower dentures. Further clinical record review revealed no evidence that Resident 39 was seen by a dental provider or afforded the opportunity to receive dental services for prophylactic (routine) care. Interview with the Director of Nursing on March 27, 2025, at 2:02 PM confirmed the above noted findings that there was no evidence Resident 39 was provided or afforded the opportunity for prophylactic dental services. Interview with Resident 10 on March 26, 2025, at 10:18 AM indicated that she had natural teeth, had a history of having five teeth extracted, but she had not received professional dental prophylactic cleanings in the past year. Progress note documentation by the facility's consultant dentist dated April 30, 2024, noted that Resident 10's teeth had moderate soft plaque (soft, sticky film of bacteria built up on the teeth and gum line), light hard calculus deposits (tartar, hardened plaque), moderate gingival inflammation (earliest stage of gum disease), and that she was at moderate risk for caries (cavities, tooth decay). The plan indicated that the last adult prophylactic treatment occurred on June 14, 2023 (almost a year earlier); and that the next annual exam was anticipated for October 30, 2024. Resident 10's medical record did not contain evidence of professional dental services for the remainder of the [AGE] year. Progress note documentation by the facility's consultant dentist dated February 4, 2025, noted that .patient was scheduled to be treated today, but was not treated. Reason: Patient was unavailable: not transported to tx. (treatment) room. Interview with the Director of Nursing on March 28, 2025, at 10:30 AM revealed that the facility had no evidence Resident 10 received routine dental hygienist services for adult prophylactic dental cleanings in the past year. The interview confirmed that, although the plan from the dentist required another visit in October 2024, there was no evidence that this appointment occurred. The Director of Nursing stated that staff did not take Resident 10 to the dental treatment room in February 2025, because she had conjunctivitis (infection in the eye or eyelid); however, there was no indication that Resident 10 was rescheduled for the next month for professional dental services. (continued on next page)

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	395373	A. Building B. Wing	03/31/2025

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident 109 on March 25, 2025, at 1:31 PM revealed that she had natural teeth, a chipped front tooth, and that she did not receive professional dental services since residing in the facility (admitted [DATE]). Resident 109 stated that she had a dental appointment arranged before her admission to the facility; however, she had to cancel that appointment due to her medical conditions that resulted in her admission to the facility. Resident 109 stated that she had not received professional dental prophylactic cleanings since June or July 2024. Clinical record review of a plan of care initiated by the facility on December 10, 2024, noted that Resident 109 had a broken tooth. A consent form for the facility's contracted dental provider dated January 31, 2025, indicated that Resident 109 consented for professional dental services. Interview with the Director of Nursing on March 28, 2025, at 10:30 AM indicated that the facility could not add Resident 109 to the list of residents planned for the contracted dental provider in February 2025, due to the late date of Resident 109's consent for services. The interview indicated that the facility did not have evidence of an attempt to obtain professional dental services by the contracted provider in March 2025. The interview indicated that the contracted dental provider makes monthly visits to the facility. 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20725 The facility failed to store and prepare food in accordance with professional standards for food safety in the main kitchen and on one of three nursing units (,d+[DATE] solarium pantry). Findings include: The United States Food and Drug Administration (FDA) Cooling Cooked Time/Temperature Control for Safety Foods and the FDA Food Code: for Food Employees stipulates that the FDA Food Code requires a two-step cooling process for cooked food: a two-hour rapid cool from 135 degrees Fahrenheit to 70 degrees Fahrenheit followed by a four-hour window where foods must be cooled to 41 degrees Fahrenheit or less. This means that within two hours, the food must be cooled from cooking temperature (135 degrees Fahrenheit) to 70 degrees Fahrenheit to eliminate risk of pathogen growth. Over the next four hours the food must be cooled from 70 degrees Fahrenheit to 41 degrees Fahrenheit or less. If 70 degrees Fahrenheit is reached before two hours, you have the remaining time to reach 41 degrees Fahrenheit or less. Observation of a walk-in freezer in the facility's main kitchen on [DATE], at 10:11 AM with Employee 9, dietary manager, revealed the following foods identified as leftovers available for additional resident food service: Vegetable soup, two six-quart containers labeled [DATE] Bar-B-Cue pork labeled February 27, 2025 Ham and bean soup labeled [DATE] Loose fish portions labeled [DATE] Turkey labeled [DATE] A review of the Cooling Log provided by Employee 9 revealed that 11 food items recorded from [DATE] through 23, 2025 had no temperature assessments after 1.5 hours of cooling. The last temperature taken for 10 of the 11 food items ranged from 58 to 69 degrees Fahrenheit 1.5 hours after placed in cooling equipment. The corrective active grid included on the form instructed that if food was not below 41 degrees at six hours, discard. The cooling log did not indicate that the five leftover items observed in the freezer reached 41 degrees within six hours or less. Observation of the dry storage area of the facility's main kitchen on [DATE], at 10:13 AM with Employee 9 revealed approximately one-half of a one-gallon container of vegetable oil that was labeled with a used by date of [DATE]. Employee 9 confirmed that this product was still accessible for food preparation use. An opened container labeled pure lemon extract (labeled as arrived [DATE]) with less than one-quarter left in the container had no label when staff opened the food product or when staff should use the product by (discard date). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of the facility's main kitchen shelving on [DATE], at 10:26 AM with Employee 9 revealed a container marked as thickener with the scoop used by staff to dispense the product stored inside the container, in direct contact with the food product. CMS State Operations Manual Appendix PP, Guidance to Surveyors for Long Term Care Facilities, 483. 60(i)(1)-(2) Food safety requirements, stipulates that a potential cause of foodborne outbreaks is improper cleaning (washing and sanitizing) of equipment and protecting equipment from contamination via splash, dust, grease, etc. Dishwashing machines use either heat or chemical sanitization methods. Manufacturer's instructions must always be followed. The general recommendations according to the U.S. Department of Health and Human Services, Public Health Services, and the Food and Drug Administration Food Code for each method note that for low temperature dishwashing (chemical sanitization) the water temperature during the wash cycle is to be 120 degrees Fahrenheit. The chemical solution must be maintained at the correct concentration, based on periodic testing, at least once per shift, and for the effective contact time according to manufacturer's guidelines. Observation of the main kitchen dishwasher on [DATE], at 10:45 AM with Employee 9 revealed that the first cycle observed revealed a water temperature of 100 degrees Fahrenheit during the wash cycle and 110 degrees Fahrenheit during the rinse cycle. A second cycle observed with Employee 9 revealed a water temperature of 118 degrees during the wash cycle and 128 degrees during the rinse cycle. Observation of labeling on the dishwasher machine stipulated that water temperatures should be a minimum of 120 degrees Fahrenheit for both the wash and rinse temperatures. Observation of the main kitchen dishwasher on [DATE], at 9:32 AM with Employee 9 revealed that the first cycle observed revealed a water temperature of 110 degrees Fahrenheit during the wash cycle. A second cycle observed with Employee 9 revealed that the water temperature again reached a plateau at 110 degrees Fahrenheit. Interview with Employee 10, dietitian, and Employee 9 on [DATE], at 11:23 AM indicated that the facility's dishwasher maintenance contractor was contacted regarding the water temperatures recorded from the machine. The facility did not have a resolution to the findings during the onsite survey. Chapter 8 of the 2018 International Plumbing Code, 802.3.1 Air gap, stipulates that the air gap between the indirect waste pipe and the flood level rim of the waste receptor shall not be less than twice the effective opening of the indirect waste pipe. Chapter 8 of the 2018 International Plumbing Code, 802.3.2 Air break, stipulates that an air break shall be provided between the indirect waste pipe and the trap seal of the waste receptor. Observation of the facility's main kitchen ice machine on [DATE], at 10:58 AM revealed no visible air gap between the indirect waste pipe and the floor drain. Interview with Employee 7, environment director, on the date and time of the observation revealed that she did not believe that there was another air gap between the ice machine's indirect waste pipe and the facility's waste line. Interview with Employee 7 on [DATE], at 12:05 PM revealed that the facility's equipment maintenance contractor would be onsite the following day to repair the omitted air gap for the main kitchen and two other ice machines in the facility. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of the facility's main kitchen ice machine on [DATE], at 11:12 AM revealed an air gap between the machine's indirect waste pipe and the floor drain. Observation of the ,d+[DATE] hallway solarium pantry on [DATE], at 11:10 AM revealed a three-compartment divider on the counter that contained numerous individual packages of jellies, tea bags, sugar packets, and various condiments. Interview with Employee 11 (speech therapist) on the date and time of the observation confirmed that there was no decipherable date on the products to ensure safe consumption. Employee 11 stated that she believed that the container was communal condiments that anyone could use. Interview with Employee 12, assistant dietary manager, on [DATE], at 11:20 AM, revealed that, .they (nursing staff) take stuff off the cart provided by dietary and store them themselves in the solarium, which are then items available for resident use. Employee 12 confirmed that there is no monitoring of the expiration dates for those items and those individual items are not marked with a date received, opened, or expired. Observation of the main kitchen with Employee 10, dietitian, on [DATE], at 11:23 AM revealed a male dietary worker on the food service line with a mustache and facial beard hair not contained under a covering. Employee 10 directed the male employee to don a face covering over his facial hair. The surveyor reviewed the above concerns regarding the facility's main kitchen and ,d+[DATE] solarium pantry during an interview with the Nursing Home Administrator on [DATE], at 2:00 PM. 483.60(i)(1)-(2) Food safety requirements Previously cited deficiency [DATE] 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(e)(2.1) Management 28 Pa. Code 211.6(f) Dietary services

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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. 20725 Based on observation, clinical record review, and resident and staff interview, it was determined that the facility failed to implement enhanced barrier precautions for one of two residents reviewed for infection control concerns (Resident 173). Findings include: Review of the Centers for Medicare and Medicaid Services (CMS) memo entitled, Enhanced Barrier Precautions in Nursing Homes, dated March 20, 2024, revealed that nursing care facilities are to use enhanced barrier precautions (EBP, gown and glove use) for residents with chronic wounds or indwelling medical devices (i.e., indwelling urinary catheters) during high-contact resident care activities regardless of their multidrug-resistant organism status. High-contact activity would include things like dressing, transferring, changing linens, providing hygiene, changing briefs, wound care, or device care. Interview with Resident 173 on March 25, 2025, at 3:31 PM revealed that she has had a surgical wound open, that will not heal completely, since November 2024. Observation of Resident 173's room on the date and time of the interview revealed no evidence that the facility implemented enhanced barrier precautions for Resident 173. Clinical record review for Resident 173 revealed nursing documentation dated March 24, 2025, at 12:41 PM that per report from the hospital staff, Resident 173 had a laminectomy (surgical procedure that removes a portion of the vertebra, bones that form the spine) in November 2024. The surgical site on admission to the hospital was draining, she received services from a wound specialist, and she had a dry dressing intact to the surgical site. Nursing documentation dated March 24, 2025, at 6:51 PM revealed that Resident 173 arrived at the facility. Resident 173 had a possible abscess (collection of infectious fluids, pus) on her surgical area from a laminectomy in November and presented with an open surgical incision on her lower back that was draining clear fluids. The staff assessed the wound with yellow slough (unhealthy tissue of a wound bed that complicates healing). Interview with Employee 8 (licensed practical nurse) on March 25, 2025, at 3:42 PM confirmed that there was no indication at Resident 173's doorway or in her room that alerted staff or visitors of the implementation of enhanced barrier precautions. Clinical record review for Resident 173 revealed a physician's order dated March 25, 2025, at 4:37 PM (following the surveyor's questioning) for staff to implement enhanced barrier precautions every shift due to the presence of a wound. The surveyor reviewed the above concerns regarding the implementation of EBP for Resident 173 during an interview with the Nursing Home Administrator and the Director of Nursing on March 26, 2025, at 2:00 PM. 483.80(a)(1)(2)(4)(e)(f) Infection Prevention and Control (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Previously cited deficiency 3/29/24 28 Pa. Code 211.12(d)(1)(5) Nursing services