STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395374	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yeadon Rehabilitation and Nursing Center	Lansdowne and Lincoln Ave Yeadon, PA 19050

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 46508 Based on observation, staff interview and review of facility policy, it was determined that the facility failed to ensure that personal privacy was maintained related to patient care and tracheostomy care for one of 35 residents observed. (Resident R130) Findings include: Review of facility policy on Dignity dated April 1, 2022, reveal that under section Policy: each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Under section Policy Interpretation and Implementation #11. Staff shall promote, maintain, and protect residents' privacy, including bodily privacy, during assistance with personal care and during treatment procedures. Observation of tracheostomy care conducted on June 25, 2024, at 12:36 p.m. with Licensed nurse, Employee E14 and Unit Manager, Employee E15 and in the presence of Resident R130's husband revealed that Resident R130's bed was located close to the door and her roommate's bed was located closest to the window. Further observation revealed that Resident R130's privacy curtain on the side of her bed facing the door (Resident R130's right side) was open and the curtain on the side of her bed facing the window (Resident R130's left side) was half closed. Resident R130's roommate was in bed and awake at the time of the observation. Employee E15 and resident's husband were standing talking to each other inside the room close to the door. Employee E14 was standing on the side of the bed closest to the window (Resident R130's left side). She was facing the door and Surveyor was standing at the foot of the bed facing Resident R130. Further observation revealed that, Licensed nurse, Employee E14 started preparing the tracheostomy supplies in Resident R130 overhead table located on the side of the bed closest to the window (Resident R130's left side) and started the tracheostomy care without closing the privacy curtain. Further, Resident R130's door was open, and Resident can be seen from the hallway through the open door. Interview with Licensed nurse, Employee E14 conducted at the time of the observation revealed that she was extremely nervous, which made her make the mistakes. Further, Licensed nurse, Employee E14 revealed that this was not the first time she performed a trach care and that she was just nervous and does not like to be watched which caused her to make the mistakes. (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 210.29(i) Residents right 28 Pa. Code 211.12(d)(1)(3) Nursing services

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 38735 Based on closed clinical record review, review of facility policy and interviews with staff, it was determined that the facility failed to ensure that resident assessments were completed in a timely manner for one of three discharged records reviewed (Residents R77). Findings include: Review of the undated facility policy titled MDS 3.0 Completion revealed that, According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI (Resident Assessment Instrument) specified by the State. Clinical record review for Resident R77 revealed a nursing note written on April 2, 2024, indicating that the resident was discharged in stable condition ambulating independently with daughter, with all belongings, scripts, paperwork and medications. Further review of the clinical record for Resident R77 revealed an April 2, 2024, MDS (Minimum Data Set, comprehensive assessment of resident) that indicated the discharge status as 04 - Short-Term General Hospital. Interview on June 27, 2024, at 11:38 a.m., with Employee E16, Resident Assessment Coordinator, confirmed that the resident was discharged with her daughter and the MDS was coded in error. 28 Pa. Code 201.2(a) Requirements 28 Pa. Code 211.5(f) Clinical records

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 46106 Based on review of clinical records, interview with staff and review of facility policy, it was revealed that the facility failed to revise a resident's PASARR (Pre-Admission Screening and Resident Review) with mental health diagnosis for one of 35 resident's records reviewed (Resident R77). Findings include: Review of the facility policy titled, PASARR date on April 1, 2022, stated the facility will coordinate assessment with the pre-admission screening and resident (PASARR) program. Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II residents review upon a significant change in status assessment. Review of the clinical record on June 25, 2024 for Resident R77 revealed diagnoses that included schizoaffective disorder (schizoaffective -a mental disorder condition mix schizophrenia symptoms by delusions, hallucinations and mood disorder); major depressive disorder (depression-a mood disorder that causes a persistent feeling of sadness and loss of interest); anxiety (anxiety-intense, excessive and persistent worry and fear about everyday situations) and psychotic (psychotic -a mental disorder form of thinking, hallucinations means seeing). Review of Resident R77's PASARR Level I screen completed on August 15, 2019, failed to indicate the resident's mental health diagnosis. Section III- (Mental Health) indicated serious mental illness diagnoses that include Schizophrenia, Anxiety Disorder, Bipolar disorder Depressive Disorder may lead to chronic disability. Section III-A (related questions related to the resident's diagnoses) answered No that the resident does not have a mental health condition or suspect dental health condition that may lead to a chronic disability. Review resident's new diagnoses schizoaffective disorder, depressive that was add on January 25, 2022, facility failed to update resident's R77 PASSARR with a newly mental disorder and do a significant change in status assessment. Interview with Social Worker, Employee E4 on June 26, 2024, at 1:40 p.m. confirmed that resident's PASSARR was not update with the new diagnoses. 28 Pa. Code 211.5(f)(iv)(vi) Medical records

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 29720 Based on observation, record review and interview with staff, it was determined that the facility failed to develop a resident's care plan related to oxygen therapy for one of 35 clinical records reviewed. (Resident R112). Findings include: Observation on June 24, 2024 at 11:00 a.m. revealed Resident R112 in bed receiving oxygen therapy via nasal cannula. Observation of the oxygen concentrator revealed that it was set at 2 liters per minute. Review of Resident R112's current care plan revealed that there was no care developed for oxygen therapy. Interview on June 25, 2024 at 2:20 p.m. with Licensed nurse, Employee E19 confirmed that Resident R112's care plan was not updated to include oxygen administration. 28 Pa. Code 211.12(d)(1) Nursing services

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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. 29720 Based on observation, record review and interviews with staff and resident, it was determined that the facility failed to ensure a physician order was obtained realated to oxygen therapy for one of 35 clinical records reviewed. (Resident R112). Findings include: Observation on June 24, 2024 at 11:00 a.m. revealed Resident R112 was in bed and receiving oxygen therapy via nasal cannula. Review of Resident R112's clinical record did not reveal oxygen therapy was included with physician orders. Interview on June 25, 2024 at 2:20 p.m. with Employee E19 confirmed that Resident R112 was receiving oxygen therapy without a physician order. 28 Pa Code 211.3(b) Oral and telephone orders 28 Pa Code 211.5(f)(i) Clinical records

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 46993 Based on observations, review of clinical records and interview with staff, it was determined that facility did not ensure to provide sufficient services to restore bladder function for one of 35 residents reviewed. (Resident R61) Findings include: Review of Residents R61's clinical record revealed a medical history of calculus of ureter (kidney stones), benign prostatic hyperplasia with lower urinary tract symptoms, neuromuscular dysfunction of bladder, presence of urogenital implants, urinary tract infections, colostomy status. During observations of wound care treatment on June 25, 2024, at 10:45 a.m., Resident R61 had bloody urine in the suprapubic catheter. Interview conducted with Licensed nurse, Employee 12 was assigned to care for Resident R61 stated that it's always been like that . Review of R61's nursing notes, dated June 6, 2024, at 3:17 p.m. and June 3, 2024 at 8:33 a.m. indicate that some sm (small) blood strands noted in urine; unit mgr (manager) aware-will obtain C&S (culture and sensitivity). Already on abt. (antibiotic). Review of R61's care plan included interventions for neurogenic bladder status post suprapubic catheter, monitor/record/report to MD (physician) for s/s (signs and symptoms) UTI (urinary track infection): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, foul smelling urine, Review of consult request documentation completed by Unit Manager, Employee E18, states . Is the nephrostomy tube permanent? If not what needs to be done to have it removed? If it is permanent how often does it need to be replaced? Also, is the hematuria normal with this condition? Further review of progress notes, dated June 17, 2024 at 4:10 p.m revealed urology appointment canceled related to transportation issues. Interview with Regional Nurse, Employee E17, on June 27, 2024 revealed that Unit Clerk, Employee E10, had miscommunication when scheduling for Resident R61's appointment and requested resident to be transported via wheelchair instead of a stretcher resulting in cancelled appointment to see urologist. 28 Pa Code 211.12(d)(1)(3)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38735 Based on clinical record review, review of professional literature, review of facility policies and interviews with staff, it was determined that the facility failed to assess a PICC line in accordance with professional practice standards for two of four residents with peripheral central cathether lines (Resident R179). Findings include: Review of the undated facility policy, Documentation Guidelines for Infusion Therapy revealed that Midline Catheters and PICCs (Peripherally Inserted Central Catheter Line) documentation at established intervals, including the external length of the catheter and the original length of the catheter inserted, and arm circumference to check for edema and rule out deep vein thrombosis. According to the standards of nursing practice guidelines in the Journal of the American Nurse's Association, dated November 2013, complications of a PICC line (Peripherally Inserted Central Catheter Line, type of IV used for long term use) includes, but is not limited to catheter-tip migration (assessed by external length of the catheter-amount of catheter tubing that is visible outside of the vein moves from original insertion and may cause medical complications). Clinical record review for Resident R179 revealed that the resident was admitted on [DATE], with a right upper arm PICC Line to be used for IV antibiotic therapy. Further review of the clinical record revealed a June 13, 2024 order for central line/midline change dressing weekly on Thursday; measure external catheter length with each dressing change; measure arm circumference on admission and as needed. Continued review of the clinical progress notes revealed no documentation of external catheter length or arm circumference. Interview with the Unit Manager on the Transitional Care Unit, Employee E8, on June 2, 2024, at 10:47 a.m. confirmed that the external catheter length and arm circumference should be measured weekly with the dressing change and that it should be documented in the progress notes, and that Resident R179's progress notes do not include this documentation. Interview with LPN on unit, Employee E9, on June 2, 2024, at 11:25 a.m. confirmed that she did not document the measurements of the arm circumference or the external catheter length since Resident R179 was admitted . The facility failed to assess a PICC line catheters as ordered by the physician and in accordance with professional practice standards. 28 Pa Code 211.5(f) Clinical records. 28 Pa Code 211.12(d)(5) Nursing services.

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508 Based on observation, review of clinical record, review of facility policies, interview with staff and resident, it was determined the facility failed provide tracheostomy care consistent with professional standards of practice for one of one resident observed. This failure resulted in an Immediate Jeopardy situation for Resident R130 who was decannulated, experienced respiratory and emotional distress and potential death. (Resident R130) Findings include: Review facility, policy title Tracheostomy dated April 1, 2022, revealed that under section Policy Statement it was stated that it was the policy of the corporation to establish standards for the care and maintenance of tracheostomy tubes. Following these standards will assist in maintaining a patent airway, reduce the risk of this for nosocomial infection, and help to prevent excoriation, breakdown, and infection of surrounding skin. Under section Procedure Trach care is performed every shift (TID-three times a day) and as needed. Partial trach care does not include inner cannula changes. Inner cannulas are changed during trach care every night shift. #3. Daily trach care does not include trach tie changes unless needed. Trach ties are routinely changed every Tuesday (day shift) and Friday (night shift) and as needed. #5. e. Clean the top surface of the faceplate as necessary using sterile NSS (normal saline solution) and 4x4's, f. Remove the inner cannula, g. Place new sterile inner cannula into trach. h. place new drainage sponge under trach flanges. Review of the undated facility policy and procedure for Accidental Decannulation Responsestated under the section purpose: establish a standardized procedure for responding to accidental decannulation to ensure patient safety and effective management of the situation. Under section Scope: This policy applies to all healthcare professionals involved in the care of patients with tracheostomies within the facility. Under section Policy: Healthcare professionals must follow the outlined procedure to ensure the patient is stabilized and the tracheostomy tube is reinserted promptly and safely. Under section procedure. #1. Visualize Tracheal Stoma: Ensure the stoma is patent if the stoma has closed. All oxygen and other inhaled therapies must be delivered via mask to the nose and or mouth. #2 Determine Trach Tube Size: Establish if the same size or smaller trach tube must be inserted. #3. Stabilize Patient: Ensure the patient is stabilized from a respiratory standpoint. Administer oxygen ventilation via patent airway (stoma, mask, etcetera) if the patient is in distress. #4. Alert Additional Staff. Call for additional assistance from staff. #10. Insert Obturator: Remove the inner cannula from the trach tube and insert the obturator. #11 Apply Lubricating Gel: Apply water based lubricating gel to the tip of the obturator and distal end of the tracheostomy tube. #18 Accompany the Patient: Accompany that patient until stabilized, ensuring good oxygen saturation, respiratory rate, heart rate, and assessment of any respiratory or cardiovascular distress. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review the facilities tracheostomy care competency checklist reveal that The employee demonstrates skills and competence in the following: #1 physicians order is checked prior to beginning of treatment. #2 Privacy is provided to resident. #3. Explain procedure to resident even if unresponsive. #4 Perform hand hygiene. #5 Apply pulse oximetry and monitor as needed. Number six. Dawn face mask, gown and goggles and splashing is anticipated. #7 [NAME] sterile gloves. #8 Suction inner cannula. #9 Remove. Oxygen source #12. Remove and dispose gloves. #14 Perform hand hygiene. #15 Don's sterile gloves. #16 Clean stoma site and face plate, swivel neck plate of outer cannula with cotton tip applicator and sterile gauze 4X4's moistened with normal saline. Using each applicator once moving from the stoma outward. Disposable inner cannulas should not be cleaned and reused as per manufacturer's recommendations. Disposable inner cannulas should be replaced every shift with tracheostomy care. Review of Resident R130's clinical record revealed that Resident R130 was admitted to the facility on [DATE], with diagnoses of Cerebral Infarction due to unspecified occlusion or stenosis of the left middle cerebral artery, Cognitive Communication Deficit, Hemiplegia and Hemiparesis (weakness to one side of the body) following Cerebral Infarction (stroke) affecting right dominant side, aphasia (disorder that affects communication) following cerebral infarction, Chronic respiratory failure with hypoxia (low oxygen), chronic respiratory failure with hypercapnia (elevated carbon dioxide levels), chronic obstructive pulmonary disease (process that causes decreased ability of the lungs to perform), obesity and tracheostomy (tube inserted through the neck to assist breathing) status. Review of Resident R130's quarterly Minimum Data Set (MDS- assessment of resident's care needs) dated May 3, 2024, section C0500 BIMS (Brief interview for mental status) revealed that Resident R130 scored 12 which indicated that Resident R130 was moderately impaired in cognition. Review of section O (Special treatments and procedures) 0110, C1(oxygen), D1(suctioning), E1(tracheostomy care) confirmed that Resident R1 received oxygen, was suctioned, and received tracheostomy care. Review of Section G (ADL-activities of daily living) reveled that Resident R130 required extensive assistance in bed mobility and transfer and required supervision with eating. Review of Resident R130's February 2024 physician's order revealed an order obtained February 6, 2024 for Shiley#8 (a tracheostomy tube) IC85 cuffed DIC (disposable inner cannula) obtained on March 28, 2024, order for Trach care daily and PRN (as needed), remove and dispose of inner cannula. Replace with new inner cannula every day shift for reduce risk of infection and as needed. Continued review of physician's orders revealed an order obtained on February 8, 2024 to change O2 (oxygen) and trach tubing weekly every night shift every Wednesday and to check and change trach ties during 11-7 shift on Monday and Thursday, every night shift. Further review of Resident R130's physician orders revealed an order for the following respiratory treatments: Pulmicort Suspension 0.5 MG/2ML (Budesonide) 3 ml (milliliters) inhale orally via nebulizer every 12 hours for SOB (shortness of breath) supplementary. Documentation Codes: Pre and Post Tx (treatment) Lung Sounds C = Clear O = Other (see progress note) Pre and Post Tx - P, R and O2 Sat results MNS -Rinse and expectorate after each use -Start Date-June 12, 2024. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML1 application inhale orally every 6 hours for SOB-Start Date-February 7, 2024. Acetylcysteine Inhalation Solution 20 % (Acetylcysteine) 4 ml via trach every 6 hours as needed for SOB-Start Date-February 6, 2024. Tracheostomy care observation conducted on June 25, 2024, at 12:36 p.m. with Licensed nurse, Employee E14 and Unit Manager, Employee E15, with Resident R130's husband in the room, revealed that Employee E14 started to set-up the tracheostomy care supplies on top of Resident R130's overbed table. After setting up the overbed table with the tracheostomy care supplies, Employee E14, proceeded to remove the gauze from around Resident R130's stoma. Employee E14 then proceeded to untie the tracheostomy tie from the flange, discarded the trach tie and proceeded to remove the entire tracheostomy tube out. Employee E14 proceeded to remove the inner cannula from the tracheostomy tube and place the tracheostomy tube on a gauze on top of the overbed table. Employee E14 proceeded to wipe off secretions from the inner cannula. Nurse Manager Employee E15 was talking to Resident R130's husband who was standing close to the door. Further observation revealed that the privacy curtain was not drawn and Resident R130 was visible from where the husband and Nurse Manager, Employee E15 were standing. Observation of Resident R130 after she was decannulated revealed that Resident R130 started to slowly raise her hand started waving while looking towards the Employee E14, then towards Employee E15 and to the observing surveyor. Resident R130 then started to frantically waive her hand and repeatedly hit her chest with her hand, started to flail her hand around and started to appear in distress. The resident's face was in a panic state, eyes wide open and started mouth something. Further Resident R130's started to become flushed. (Resident R130 could not make any vocal sounds). Surveyor then informed Licensed nurse, Employee E14 and Nurse Manager, Employee E15 that Resident R130 looked like she was not able to breathe. Nurse Manager, Employee E15 asked Resident R130 if she was OK and if she could breathe. The resident shook her head and continued to flail her hands around. Nurse manager, Employee E15 then instructed Licensed nurse, Employee E14 to re-insert the tracheostomy tube. Licensed nurse, Employee E14 then picked up the trach tube and said: I have to clean this first. Nurse Manager, Employee E15 instructed Licensed nurse, Employee E14 again to insert tracheostomy tube back. Licensed nurse, Employee E14 then proceeded to re-insert the trach tube into the stoma. Further observation revealed that the tracheostomy tube was re-inserted without using an obturator, but Licensed nurse, Employee E14 was able to successfully re-insert the tracheostomy tube. Immediately after the tracheostomy tube was re-inserted into the stoma, Resident R130 started coughing violently. Resident R130 started to slowly calm down and stopped flailing her hands around after the tube was re-inserted but continued to cough for several minutes. Licensed nurse, Employee E14 then suctioned Resident R130 and wiped off copious secretions coming from the trach. Licensed nurse, Employee E14 then started preparing a respiratory treatment for Resident R130's, administered Resident R130's respiratory treatment via nebulizer without changing her gloves. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further, Licensed nurse, Employee E14 was then observed rummaging through Resident R130's drawers without changing her gloves. Interview with Licensed nurse, Employee E14 revealed that she was looking for tracheostomy tie. Licensed nurse, Employee E14 eventually found the tracheostomy tie and secured the tracheostomy tube. Licensed nurse, Employee E14, then adjusted Resident R130's bed by pressing on the panel at the foot of the bed without changing her gloves. Licensed nurse, Employee E14 then changed the gloves and continued to clean the inner cannula with a wet gauze and re-inserted the inner cannula. Interview conducted at the time of the observation with Licensed nurse, Employee E14 revealed that this was not the first time she performed a trach care and that she was just nervous and does not like to be watched which caused her to make the mistakes. Interview with Director of Nursing, Employee E2 conducted on June 25, 2024, at 2:05 p.m. revealed that only the Respiratory Therapist and the Pulmonologist can remove the tracheostomy tube and that Licensed nurse, Employee E14 was only supposed to clean the outside of the trach and change the dressing and should not have removed the tracheostomy tube. Further, Licensed nurse, Employee E14 revealed that Resident R130's inner cannula was disposable and should have been discarded and replaced with a new one instead of being re-inserted. Interview with Resident R130 conducted on June 27, 2024, at 11:12 a.m. revealed that resident did not have a Passy Muir (speaking valve) on and was not able to speak. When asked where the Passy Muir was, she shook her head and pointed at her trach. When asked if she remembered what happened the day before, Resident R130 nodded her head. When asked if she was scared, Resident R130 nodded her head. Follow-up interview with Resident R130 conducted on June 27, 2024, at 11:32 a.m. with Speech therapist, Employee E23 confirmed that Resident R130 did not have her Passy Muir on, and that resident was not able to produce a vocal sound and not able to speak. Observation of Resident R130's bedside tabletop drawer revealed an unopened plastic containing a Passy Muir. Resident R130 was asked if she remembered what happened the other day, she nodded, when asked if she was scared during the incident the other day resident nodded. Based on the above findings an Immediate Jeopardy situation was identified to the Nursing Home Administrator on July 3, 2024 at 11:08 a.m. for the failure of the faciltiy to provide tracheostomy care to a resident in accordance with professional standards of practice. This failure resulted in Resident R130 being decannulated and experiencing respiratory and emotional distress An Immediate Jeopardy template was provided to the Nursing Home Administrator. The facility developed the following approved action plan: -The tracheostomy appliance was reinserted on June 25, 2024. Resident was assessed by Nurse Practitioner and Pulmonologist on June 25, 2024. Resident was stable with no physical distress noted. - Employee involved in the incident was suspended pending investigation on June 25, 2024. -Current residents with tracheostomy care needs were assessed on June 25, 2024, to ensure equipment was present and tracheostomy was in place and stable. (continued on next page)

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	395374	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yeadon Rehabilitation and Nursing Center	Lansdowne and Lincoln Ave Yeadon, PA 19050

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

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-In service was initiated on June 25, 2024, with licensed staff in the building and is ongoing. Facility is at 84%. 100% staff educated will be completed on July 3, 2024. -The facility has been conducting 5 weekly observations of tracheostomy care being completed. Facility will review during facility's monthly QAPI (quality assurance performance improvement). Facility conducted observations of five residents on June 25, 2024, with no negative findings noted. Facility conducted observations of five residents on June 27, 2024 with no negative findings noted. Facility conducted observations of five residents on July 1, 2024, with no negative findings noted. -Facility Policy titled Tracheostomy Care was reviewed and revised on July 3, 2024. Review of the facility documentation revealed the facility's action plan was immediately initiated, observation of tracheostomy care on three residents with tracheostomy (Residents R5, R81, R167) revealed that the physician's orders were followed, and tracheostomy care was performed according to standard of practice. Interview with nine day shift nursing staff and five evening shift nursing staff conducted on July 3, 2024, from 2:52 p.m. to 4:10 p.m. to assess staff knowledge on tracheostomy care and responses to an emergency decannulation revealed that all fourteen staff interviewed were knowledgeable on tracheostomy care, responses to an emergency decannulation. Immediate Jeopardy was lifted on July 3, 2024, at 4:20 p.m. 28 Pa. Code 201.14(a) Responsibility of licensee 28 PA. Code 210.18(1) Management 28 Pa. 211.10 (c)(d) Resident care policies 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38735 Based on observations, interviews with staff, and a review of facility policies and documentation, it was determined that the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety. Findings include: The Policy: Food Storage, which was dated January 17, 2019, states, All foods should be covered, labeled and dated and Frozen food must be maintained at a temperature to keep the food frozen solid. An initial tour of the Food Service Department was conducted on June 24, 2024, at 9:45 a.m. with Employee E3, Food Service Director (FSD), which revealed the following: Observation in the walk-in refrigerator revealed an open box of hot dogs with the inner plastic lining open to the air and no date when product was open. Observation in the walk-in freezer revealed an internal thermometer reading 17 degrees above zero and there were several food items not frozen solid including donut holes, sausage links and tater tots. Interview with the FSD on June 24, 2024, at 9:55 a.m. confirmed that these food items should be frozen solid, and that they had recently had a problem with the freezer and had to call a repairman. A review of the Freezer Temperature Log for June 2024, revealed that on June 19, 2024, the A.M. freezer temperature was 30 degrees and the P.M. freezer temperature was 32 degrees, and the comments section read, call fridge tech. Observations in the hot production area of the kitchen near the steamer revealed debris on the floor in the corner and the baseboards were soiled and dirty. Observations in the dish room revealed a film of dirt on the wall behind the dish counter and under the counter including debris on the floor in the corners and dirty baseboards. Interview with FSD at 10:15 a.m. on June 24, 2024, confirmed the above findings. Observations during a follow-up visit on June 26, 2024, at 10:10 a.m. revealed a white PVC pipe above the prep sink covered in a thick layer of dust. Observation in the walk-in freezer revealed that the inside thermometer was reading 9 degrees above zero and the whipped cream was soft as was the donuts and French fries, and there was an open box of beef liver which was open to the air. Observation in the kitchen near the toaster revealed a fan with a heavy accumulation of dust and dirt on the surface of the fan blades and grill. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with FSD at 10:25 a.m. on June 24, 2024, confirmed the above findings. 28 PA Code: 201.14(a) Responsibility of licensee. 28 PA Code: 201.18(e)(1) Management. 28 Pa. Code 201.18(b)(3) 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. 46508 Based on observation, interview with staff and review of facility policy, it was determined that the facility failed to ensure proper infection control procedures during tracheostomy care for one of one resident observed with a tracheostomy. The facility failed to ensure the proper processing of lines and accessibility to hand washing station in the laundry. (Resident R130) Findings include: Review of Facility Policy on Infection Control Program Overview dated October 24, 2022, revealed that under section Purpose: The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Under section Goals: The goal of the infection control program are to provide a safe, sanitary and comfortable environment, prevent the development and transmission of communicable diseases and infections, ensure compliance with state and federal regulations relating to infection control. Under sections Scope of the infection control program: The infection control program is comprehensive and that it addresses detection, prevention and control of infections among residents, staff, volunteers, visitors and others. Major activities of the program are preventing, identifying, reporting, investigating and controlling infections and communicable diseases for residents, staff volunteers, visitors and others. Under section Division of responsibilities for infection control activities: The governing body is responsible for the infection control program. Infection Preventionist is responsible to carry out the daily functions of the infection control program. Those functions are described in the Infection prevention is job description. The infection prevention is the required state and federal training. Observation of tracheostomy care conducted on June 25, 2024, at 12:36 p.m. with Licensed nurse, Employee E14 and Unit Manager, Employee E15, revealed that Licensed nurse, Employee E14 and Unit Manager, Employee E15 had put on personal protective equipment (face shield, gown, and gloves) prior to entering Resident R130's room. Further observation revealed that Resident R130 had just finished eating lunch. Further, an overhead table with half eaten food, a plastic cup labelled McDonald's and a small item wrapped in McDonald's wrapper on it was next to Resident R130's bed. Licensed nurse, Employee E14 proceeded to remove the plate with half eaten food, leaving the Mc Donald's drink and the item in McDonald's wrapper on the table. Employee E14 then proceeded to wipe the half part of the top of the overhead table with sanitizing wipes but did not wipe the the other half top of the overhead table where the McDonald's drink and the item wrapped in McDonald's wrapper was. Further, Employee E14 started to set-up the tracheostomy care supplies on top of Resident R130's overhead table, next to the Mc Donald's food items. After setting up the tracheostomy care supplies, Employee E14 then asked Resident R130 if she could remove the Mc Donald's items from the overhead table. With Resident R130's permission, she removed the McDonald's items but did not sanitize the area. Employee E14 then changes her gloves with a pair coming from the tracheostomy care kit and proceeded to remove the gauze from around Resident R130's stoma. Employee E14 then proceeded to untie the tracheostomy tie from the flange, discarded the trach tie and proceeded to remove the entire tracheostomy tube out. Employee E14 proceeded to remove the inner cannula from the trach tube and place the trach tube on a gauze on top of the overhead table and wiped off secretions from the inner cannula. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Licensed nurse, Employee E14 conducted at the time of the observation revealed that she was extremely nervous, which made her make the mistakes. Further Employee E14 revealed that this was not the first time she performed a trach care and that she was just nervous and does not like to be watched which caused her to make the mistakes. Observation of the laundry department conducted on June 25, 2024, at 8:12 am with Facility Administrator Employee E1 and Director of Housekeeping, Employee E21 revealed that, upon entering the soiled area of the laundry room, a pile of soiled clothing was observed on the floor next to two large bins filled with resident clothing. Further observation of the soiled area of the laundry room revealed a sink for washing employee's hands located in far end to the right corner of the soiled area of the laundry room. Further, a soap dispenser was affixed to the wall above the sink. Further observation revealed that the sink was surrounded by large plastic containers of laundry detergents and other laundry chemicals which rendered the sink and the hand soap inaccessible to anyone. Further observation of the laundry room revealed that there was no hand sanitizer and sink available anywhere else in the laundry area. Interview with Director of Housekeeping, Employee E21 revealed that the sink was not working. Further, Employee E21 confirmed that large containers of laundry chemicals like laundry detergents and fabric softener were stored around the sink making it inaccessible to the laundry personnel. Refer to F695 28 Pa. Code 201.14(a)Responsibility of licensee 28 Pa. Code 211.12(d)(1)(5) Nursing services