STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395386	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Village Retirement Center	5225 Wilson Lane Mechanicsburg, PA 17055

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40010 Based on review of policy review facility provided documents, facility policies and procedures, and interviews with staff and residents, it was determined that the facility failed to protect the resident's right to be free from mental abuse and neglect by Employee 3 for one of 21 residents (Resident 34) Findings include: Review of facility policy, Resident Rights-Abuse and Crimes against, revised June 16, 2023, revealed, Residents of [NAME] have a right to be free from abuse, neglect, misappropriation of funds and property, and exploitation as defined below. The abuse, neglect, misappropriation of funds or property, or exploitation of residents by [NAME] associates is strictly prohibited and will result in disciplinary action, up to and including termination of employment. Review of Resident 34's clinical record revealed diagnoses that included difficulty walking (Problems with the joints [such as arthritis], bones [such as deformities], circulation [such as peripheral vascular disease], or even pain can make it difficult to walk properly) and muscle weakness (commonly due to lack of exercise, aging, muscle injury, or pregnancy). Review of Resident 34's care plan revealed a care plan with a focus area of Resident 34 has an ADL (activities of daily living) self-care performance deficit. This care plan has an intervention of: Resident 34 requires maximum assistance by staff for toileting, and Resident 34 requires extensive assistance by 1-2 staff to move between surfaces. Stand lift and 2-staff assist, as needed. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident 34 on November 12, 2024, at 9:47 AM, revealed that on November 5, 2024, at 6:00 AM, she rang her call bell to request help going to the bathroom. Employee 3 answered her call bell and, when asked for assistance, responded by refusing to help Resident 34 to the bathroom and telling her to go in her brief. Resident 34 stated that this was humiliating but she did not question Employee 3 because she was afraid. Resident 34 stated that she did not void in her brief and a short time later rang her call bell again, and when Employee 3 entered the room, Resident 34 suggested to Employee 3 that they compromise and Employee 3 assist Resident 34 onto the bedpan. Resident 34 said that Employee 3 agreed to this, helped Resident 34 onto the bedpan, and then Employee 3 sat in the Resident's room next to Resident 34 chewing gum while Resident 34 was on the bedpan. Resident 34 stated that she was unable to void on the bedpan with Employee 3 sitting there and was taken off the bedpan. Resident 34 stated that she later rang the call bell a third time, a different staff member answered, and she was finally taken to the bathroom where she was able to void. Resident 34 stated that later that day she completed a grievance form and turned it in to facility staff. Review of facility provided documents dated November 6, 2024, at 11:30 AM, revealed that when Employee 3 was questioned about the allegations made by Resident 34, she refused to make any statement or tell them what had occurred. Employee 3 was tearful and departed premises. Review of facility investigation, concluded that Employee 3 did not honor Resident 34's choice to use the bathroom, causing the Resident mental anguish. Resident 34 also disclosed that Employee 3 told her she would not take her to the bathroom and angrily responded to Resident 34's request. Therefore, the facility found that the allegations of mental abuse were substantiated. Interview with Nursing Home Administrator on November 14, 2024, at 11:30 AM, revealed that the facility is aware of the alleged abuse by Employee 3 and it should not have occurred. He feels that the facility responded correctly to the incident when made aware and it is unfortunate that Employee 3 took it upon herself to act like this. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(b)(2) Management 28 Pa. Code 201.18(e)(1) Management

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46253 Based on facility policy review, observations, clinical record review, and staff interviews, it was determined that the facility failed to ensure care and services are provided in accordance with professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for three of 21 residents reviewed (Residents 6, 22, and 63). Findings include: Review of facility policy, titled Weight and Height Measurement, last revised December 4, 2023, read, in part, Policy: To define a systematic approach to weighing and determining height for residents in order to facilitate a plan to identify significant weight loss or weight gain. Procedure: In Skilled Nursing, residents' weight will be monitored weekly upon admission/readmission for four weeks and monthly thereafter or as indicated by the resident's condition or physician's order. All weights will be entered into the electronic medical record. Weights should be obtained in consistent circumstances, such as the same time of day and with similar clothing. All data will be reviewed by the Director of Nursing (DON)/designee. Review of Resident 6's clinical record revealed diagnoses that included Alzheimer's Disease (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning) and age-related physical debility. Observation of Resident 6 on November 12, 2024, at 9:56 AM, revealed that the Resident was seated in a broda chair with their legs extended, slightly dangling, and unable to reach the floor. The chair leg rests were noted to be laying on the floor beside Resident 6's chest of drawers. Observation of Resident 6 on November 13, 2024, at 9:38 AM, revealed that the Resident was seated in a broda chair with their legs extended, slightly dangling, and unable to reach the floor. The chair leg rests were noted to be laying on the floor underneath a chair in Resident 6's room. During a staff interview with Employee 1 on November 13, 2024, at 9:41 AM, Employee 1 revealed that this was a temporary chair for Resident 6 and was only to be used for a couple days because Resident 6's normal chair needed some repairs. Employee 1 further indicated that it had been over a week since Resident 6 had been using this temporary chair. Employee 1 said they were told not to use leg rests on the chair because they would be a safety risk if Resident 6 were to slide down in the chair onto the leg rests, the chair could flip over. Employee 1 also said that one day last week they had used a chair to prop Resident 6's legs up on to keep them from hanging down. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on November 13, 2024, at 1:40 PM, the DON confirmed that Resident 6's normal chair was needing repaired as the chair back would not adjust. She indicated that she had asked maintenance for an update on the chair a few days ago and that she would follow-up with maintenance again. Email communication received from the NHA on November 13, 2024, at 3:11 PM, indicated that the repair part had arrived at the facility that day, the chair had been repaired, Resident 6 has received their normal chair, and the temporary chair was removed from Resident 6's room. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additional email communication received from the NHA on November 14, 2024, at 9:03 AM, indicated that therapy had determined that the temporary chair being utilized for Resident 6 was appropriate and that leg rests were an appropriate nursing measure. The email further indicated that Resident 6's had utilized the temporary chair from November 4-13, 2024. The NHA indicated that he did not know why the leg rests for the temporary chair were not being applied by staff. During a final interview with the NHA and DON on November 14, 2024, at 11:18 AM, the DON indicated that she would expect staff to report any concerns they had with the use of the leg rests while utilizing the temporary chair for Resident 6. Review of Resident 22's clinical record revealed diagnoses that included dysphagia (difficulty swallowing), Alzheimer's disease, and muscle weakness. Review of Resident 22's clinical record revealed she had a weight loss of 13.9 pounds (12%) from September 2, 2024, to October 8, 2024, confirmed by a reweigh. Review of Resident 22's clinical record revealed a dietitian assessment in response to the weight loss on October 10, 2024, with plans to add a nutritional supplement drink and monitor weights. The dietitian assessed Resident 22 again on October 23, 2024, with plans to monitor weights. Review of Resident 22's care plan revealed a focus area for significant weight loss with an intervention for review weights and notify MD and responsible party of significant weight changes, with a start date of May 3, 2024. Further review of Resident 22's clinical record on November 12, 2024, failed to reveal a November 2024 weight measure. During an email correspondence with the NHA and DON on November 12, 2024, at 1:54 PM, the surveyor inquired how often Resident 22 should be getting weighed and if she should have a physician order for weight monitoring. Review of Resident 22's physician orders on November 13, 2024, revealed she had a new order for Monthly Weight and Vital Signs every day shift every 4 weeks on Wednesday on Shower day, with a start date of November 13, 2024, at 7:00 AM, and her weight had been obtained that morning. Review of Resident 22's clinical record revealed her preferred shower schedule is Wednesdays on 7-3 shift. Interview with Employee 6 (Registered Dietitian) on November 13, 2024, at approximately 11:00 AM, she explained her process for notifying the MD of significant weight changes, and that Resident 22 should be on monthly weight monitoring. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON on November 13, 2024, at 1:59 PM, she revealed each resident gets a weight measure obtained monthly per their standing physician orders, unless otherwise specified by the dietitian or physician. The surveyor inquired if Resident 22's weight should have been obtained on the 6th of November, the week prior for consistency purposes, and to capture significant weight changes. The DON replied it should just be done once per month. The surveyor also referenced consistency of time of day and similar clothing per facility policy, and that obtaining weights on random days of the month may not capture significant weight changes from month to month. Further review of Resident 22's clinical record revealed her weight was noted to be obtained while she was in a wheelchair in April 2024, June 2024, July 2024, and August 2024; it was obtained on evening shift instead of day shift in April 2024, July 2024, and October 2024; and it was noted to be obtained sitting (not in wheelchair) in May 2024, September 2024, and October 2024. Interview with Employee 5 (Licensed Practical Nurse) on November 14, 2024, at 11:47 AM, revealed their process on the unit for obtaining monthly weights is on Resident's shower day, they are weighed undressed in the shower chair and by the 7th of each month, for consistency. Review of Resident 22's nurse aide documentation on November 14, 2024, at 10:36 AM, failed to reveal documentation to indicate Resident 22 received a shower on November 6, 2024. During an interview with the DON on November 14, 2024, at 11:06 AM, the surveyor inquired if she could locate documentation to indicate Resident 22 received a shower or refused a shower on November 6, 2024. Follow-up interview with the DON and Employee 5 on November 14, 2024, at 11:47 AM, revealed Resident 22 did get a shower on November 6, 2024, and did get a weight obtained that morning. Employee 5 stated that she forgot to put the weight measure into the electronic health record. During a final interview with the NHA and DON on November 14, 2024, at 12:32 PM, the surveyor revealed the overall concern with inconsistent weight monitoring for Resident 22, including documented use of different scales, different shifts, and missed entry of the November 2024 weight measure into the electronic health record. The DON expressed that weight monitoring has been an issue at the facility. No further information was provided. Review of Resident 63's clinical record revealed diagnoses that included atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) and Alzheimer's Disease (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning). Observation of Resident 63 and their room on November 12, 2024, at 10:17 AM, revealed the presence of a pacemaker monitoring device on the top of their chest of drawers. Review of Resident 63's clinical record physician orders, physician services assessments and notes, nurse assessments and notes, and care plan on November 13, 2024, at 9:00 AM, failed to reveal any documentation indicating Resident 63 had a pacemaker. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a staff interview with Employee 2 (Licensed Practical Nurse) on November 13, 2024, at 10:30 AM, Employee 2 indicated that they were not sure if Resident 63 had a pacemaker but confirmed that the device on Resident 6's chest of drawers was a pacemaker monitoring device. Employee 2 pressed the display screen on the monitor, which indicated a green checkmark and a date of 10/1/2024. Employee 2 said the checkmark would indicate that a check was successfully completed, and the date indicated when the pacemaker check was last completed. A follow-up review of Resident 63's clinical record on November 13, 2024, at 1:15 PM, revealed a nurse note dated November 13, 2024, at 12:04 PM, that indicated that facility staff had spoken with Resident 63's daughter, and she confirmed that Resident 63 had a pacemaker. Resident 63's daughter indicated that she had brought the monitor in but not when she first moved in. The note indicated that the daughter was not sure if she had spoken to a nurse about the pacemaker monitor, but that she checks it when she visits to make sure that it is plugged in and working. The note also indicated that the daughter said that she receives the reports from the automatic checks that are completed and confirmed that she had not brought any of these reports in and given them to the nurse. The note indicated that the nurse had asked the daughter to bring in these reports and the daughter agreed to do so when she was able. During a staff interview with the NHA and DON on November 13, 2024, at 1:52 PM, the DON confirmed that the facility was not aware that the Resident had a pacemaker until today. Email communication received from the DON on November 13, 2024, at 5:13 PM, indicated that she could not find any documentation of Resident 63 having a pacemaker, confirmed that they were not aware that Resident 63 had a pacemaker, and the daughter had brought in a monitoring device without notifying anyone. The DON provided two electrocardiogram (EKG- a quick test to check the heartbeat which records the electrical signals in the heart) reports for Resident 63 dated July 26, 2024, and August 7, 2024, which were both ordered and reviewed by their primary care physician. During a final staff interview with the NHA and DON on November 14, 2024, at 11:20 AM, the DON indicated that she could not confirm when Resident 63's daughter brought the pacemaker monitor into the facility. The DON also shared that Resident 63's pacemaker was not visible but was located after palpation. The DON indicated that the facility was not aware of what cardiology office would be completing the automatic pacemaker checks as Resident 63 has not had any cardiology appointments since she was admitted on [DATE]. The DON indicated that the facility would continue to follow-up. The DON indicated she could not answer as to whether staff should have seen the monitor. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(c)(d) Resident Care Policies 28 Pa. Code 211.12(c)(d)(1)(2)(3)(5) Nursing Services

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 46253 Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure that residents were free of unnecessary psychotropic medications for one of five residents reviewed (Resident 63). Findings include: Review of facility policy, titled IIIB2: Medication Management, dated July 1, 2023, revealed, in part, c. PRN [as needed] orders for antipsychotic drugs are limited to 14 days without exception. If the attending physician or prescribing practitioner wishes to continue a PRN antipsychotic drug beyond 14 days, the attending physician or prescribing practitioner must first perform an in-person evaluation of the resident and then write a new order. Review of Resident 63's clinical record revealed diagnoses that included Alzheimer's Disease (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and delusional disorder (a mental health condition in which a person cannot tell what is real from what is imagined). Review of Resident 63's current physician orders revealed an order for haloperidol (an antipsychotic medication used to treat psychosis, a collection of symptoms that affect your ability to tell what is real and what is not) powder gel 0.5 mg (milligrams)/1 ml (milliliters) apply to skin topically every 12 hours as needed for dementia with aggression, dated October 11, 2024, with no duration indicated; and lorazepam (a medication used to treat anxiety) gel 0.5 mg/ml apply 1 ml topically three times a day for agitation, dated September 27, 2024. Review of Resident 63's Psychotropic Consent Form dated March 22, 2024, failed to include haloperidol or lorazepam. Review of Resident 63's physician order history revealed that they were originally ordered haloperidol on May 8, 2024, and originally ordered lorazepam on April 1, 2024. Review of 63's clinical record failed to reveal any documentation that Resident 63's Representative had received education on the risks versus benefits of haloperidol or lorazepam and gave consent for the use of these medications. Review of Resident 63's physician order history revealed that the original haloperidol order dated May 8, 2024, did not include a 14 day stop date, and was continued until June 3, 2024. Review of Resident 63's physician order history revealed that there was a haloperidol order dated September 11, 2024, which did not include a 14 day stop date, and was continued until October 11, 2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 63's clinical record progress notes failed to reveal any documentation that their physician performed an in-person evaluation on September 11, 2024. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing on November 14, 2024, at 11:33 AM, the NHA confirmed that the facility had no additional documentation to provide that Resident 63's Representative received education of risks versus benefits of haloperidol or lorazepam and gave consent for the use of these medications prior to their use. He indicated that he would expect the education be provided and consent obtained before medications were administered. The NHA also confirmed that a 14 day stop date should have been given with every renewed order for the haloperidol, and that Resident 63 should have had an in-person evaluation by their physician prior to renewing the haloperidol order on September 11, 2024. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(d) Resident Care Policies 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48484 Based on completion of one meal test tray and resident and staff interviews, it was determined that the facility failed to provide food at appetizing temperatures at one of one meal tested . Findings include: Review of facility document, titled Tray/Meal Assessment, dated 2022, read, in part, Resident acceptance is used as a guide as well as consideration to the time the food sits between 135 degrees Fahrenheit (F - a unit of measure), and 41 degrees F. Interview with Resident 34 on November 12, 2024, at 11:30 PM, revealed that she often recieves cold food on her meal tray and has to request that it be reheated. A test tray was completed on November 13, 2024, at 1:26 PM, utilizing a lunch tray served from the steam table in the colonial heights pantry. The test tray was served and placed in a closed food cart approximately two minutes prior to being delivered to the oak lane dining area with other trays to be delivered at that time. The test tray included: cheese quesadilla, sweet potato fries, tomato florentine soup, coffee, and water. Test tray temperatures were taken by Employee 4 (Dining Supervisor) and revealed: Cheese quesadilla was 121.6 degrees F, and tasted cold. Sweet potato fries were 105.8 degrees F, and tasted cold. During an interview with the Nursing Home Administrator on November 13, 2024, at 1:54 PM, the surveyor revealed the concern with the aforementioned test tray items not within appetizing temperatures. No further information was provided. 28 Pa. Code 201.14(a) Responsibility of licensee