STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395393	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedarwood Rehabilitation & Healthcare Center	951 Washington Avenue Tyrone, PA 16686

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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 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. 48809 Based on review of facility policies, investigative reports, and clinical records, as well as staff interviews it was determined that the facility failed to ensure that residents were free from neglect for one of 46 residents reviewed (Resident 95). Findings include: The facility's current policy regarding abuse, neglect, exploitation, and misappropriation indicated that the residents are to be protected from abuse, neglect, exploitation, or misappropriation of property by anyone, including facility staff. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 95, dated December 12, 2024, revealed that the resident was cognitively intact, required maximum assistance from staff for transfers, and had diagnoses that included arthritis (a chronic condition that causes joint inflammation, pain, stiffness, and swelling), and had a total knee arthroplasty (a surgical procedure that replaces the knee joint with artificial parts). The resident's activities of daily living care plan, revised on December 6, 2024, indicated that she was a physical assist of two for transfers. A nursing note for Resident 95, dated December 13, 2024, at 12:53 p.m., revealed that the resident was complaining of a new pain to her right shoulder with active range of motion. Investigation documentation provided by the facility, dated December 13, 2024, at 5:00 p.m., revealed that the resident notified physical therapy that Nurse Aide 1 transferred Resident 95 by herself twisting her arm and causing her right shoulder pain. The Director of Physical Therapy notified the Director of Nursing to begin an investigation. A witness statement, dated December 13, 2024, indicated that Nurse Aide 1 did not look to verify the transfer status prior to transferring Resident 95 and transferred the resident from her wheelchair to her bed by herself. Education paperwork provided by the facility, dated October 15, 2024, revealed that Nurse Aide 1 was educated on following care plans. Interview with the Director of Nursing on January 8, 2025, at 12:20 p.m. confirmed that Resident 95 required a two-person physical assist for transfers and confirmed that Nurse Aide 1 transferred Resident 95 by herself resulting in pain to the resident's right shoulder. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 43856 Based on clinical record reviews and staff interviews, it was determined that the facility failed to notify the resident, responsible party, and Ombudsman, in writing, regarding the reason for hospitalization for two of 46 residents reviewed (Residents 19, 67). Findings include: A annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 19, dated November 2, 2024, indicated that the resident was cognitively intact and required assistance from staff for daily care needs. A nursing note for Resident 19, dated June 6, 2024, at 12:59 p.m., revealed that the certified registered nurse practitioner (CRNP) reviewed lab results and wrote an order to send Resident 19 to the hospital for evaluation. The resident's responsible party was also notified and was agreeable for the resident to be transported to the hospital. There was no documented evidence that a written notice of Resident 19's transfer to the hospital was provided to the resident's responsible party and the Ombudsman regarding the reason for transfer. A quarterly MDS assessment for Resident 67, dated November 8, 2024, indicated that the resident was cognitively impaired and was dependent on staff for daily care needs. A nursing note for Resident 67, dated September 24, 2024, at 4:31 p.m., revealed that the resident was diaphoretic and hard to arouse. The family requested that the resident be sent to emergency room . The physician was updated and was in agreement. An order was received to transport the resident to the hospital. There was no documented evidence that a written notice of Resident 67's transfer to the hospital was provided to the resident's responsible party and the Ombudsman regarding the reason for transfer. Interview with the Director of Nursing on January 8, 2025, at 1:30 p.m. confirmed that the facility did not provide a written notice to the resident, the resident's responsible party, or Ombudsman when Residents 19 and 67 were transferred to the hospital. 28 Pa. Code 201.25 Discharge Policy. 28 Pa. Code 201.29(f)(g) Resident Rights.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 43856 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that appropriate parties were notified about the facility's bed-hold policy upon transfer to the hospital for two of 46 residents reviewed (Residents 19, 67). Findings include: A facility policy for Bed Holds, dated January 25, 2024, included that residents and/or representatives are informed in writing of the facility and state bed-hold policies. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 19, dated November 2, 2024, indicated that the resident was cognitively intact and required assistance from staff for daily care needs. A nursing note for Resident 19, dated June 6, 2024, at 12:59 p.m., revealed that the certified registered nurse practitioner (CRNP) reviewed lab results and wrote an order to send Resident 19 to the hospital for evaluation. The resident's responsible party was also notified and was agreeable for the resident to be transported to the hospital. There was no documented evidence that the resident and/or the responsible party was notified about the facility's bed-hold policy at the time of the above transfer to the hospital for Resident 19. A quarterly MDS assessment for Resident 67, dated November 8, 2024, indicated that the resident was cognitively impaired and was dependent on staff for daily care needs. A nursing note for Resident 67, dated September 24, 2024, at 4:31 p.m., revealed that the resident was diaphoretic and hard to arouse. The family requested the resident be sent to emergency room . The physician was updated and in agreement and an order was received to transport the resident to the hospital. There was no documented evidence that the resident and/or the responsible party was notified about the facility's bed-hold policy at the time of the above transfer to the hospital for Resident 67. Interview with the Director of Nursing on January 10, 2025, at 10:15 a.m. confirmed that there was no documented evidence that a bed-hold notice was issued to Residents 19 and 67 or their responsible parties and there should have been. 28 Pa. Code 201.29(d) Resident Rights. 28 Pa. Code 211.5(f) Clinical Records.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 38012 Based on clinical record reviews and staff interview, it was determined that the facility failed to develop comprehensive care plans that included specific and individualized care regarding the use of an anti-coagulant (blood thinner) for one of 46 residents reviewed (Resident 99). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 99, dated November 25, 2024, revealed that the resident was cognitively intact and that she was medicated with an anti-coagulant. Physician's orders for Resident 99, dated January 2, 2025, included an order for the resident to take 5 milligrams (mg) Eliquis (anti-coagulant) every 12 hours. Review of Resident 99's Medication Administration Record, dated January 2025, revealed that the resident was medicated with Eliquis twice daily. There was no documented evidence that Resident 99's care plan included a care plan for the use of an anti-coagulant. Interview with the Director of Nursing on January 10, 2025, at 1:14 p.m. confirmed that Resident 99's care plan was not individualized regarding the resident's use of an anti-coagulant and it should have been. 28 Pa. Code 201.24(e)(4) Admission Policy. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48809 Based on review of clinical records and observations, as well as resident and staff interviews, it was determined that the facility failed to ensure that care plans were updated to reflect changes in care needs for one of 46 residents reviewed (Resident 91). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 91, dated November 6, 2024, revealed that the resident was cognitively intact, required substantial assistance with care needs, and was receiving an intravenous antibiotic (when the antibiotic is given through the vein). Review of Resident 91's intravenous access care plan, dated November 24, 2024, indicated that the resident had a peripherally inserted central catheter (PICC) in her right upper arm for administration of antibiotics. Physician's orders for Resident 91, dated December 10, 2024, included an order for the PICC line to be removed. Observations on January 7, 2025, at 10:30 a.m. revealed that the resident did not have a PICC line in her right upper arm. Interview with the Director of Nursing on January 10, 2025, at 12:42 p.m. confirmed that Resident 91's care plan was not updated to reflect that the PICC line was discontinued and should have been. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 48809 Based on review of the Pennsylvania Nurse Practice Act and clinical records, as well as staff interviews, it was determined that the facility failed to clarify physician's orders for one of 46 residents reviewed (Resident 59). Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect, complete, and review ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 59, dated November 15, 2024, indicated that the resident was understood, could understand others, and was cognitively impaired. Physician's orders, dated January 8, 2024, included orders for the resident to receive 10 mg of Lexapro (a medication used to treat depression and certain anxiety disorders) and to give two tablets one time a day for a total of 15 mg. The resident's Medication Administration Record (MAR) for January 2024 revealed that staff administered 15 mg Lexapro on January 8 and 9, 2024. Observations of Licensed Practical Nurse 2 on January 9, 2025 at 8:08 a.m. revealed that Resident 59 received one and one-half tablets of Lexapro. An interview with Licensed Practical Nurse 2 at the time of administration revealed that the order was confusing and should have been clarified, and that the resident's pills came from the pharmacy as 10 mg and to give one and one-half tablets for a total of 15 mg. Interview with the Director of Nursing on January 9, 2025, at 2:02 p.m. confirmed that the order for 10 mg of Lexapro to give two tablets one time a day for a total of 15 mg should have been clarified. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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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. 38012 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders for medications were followed for one of 46 residents reviewed (Resident 99). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 99, dated November 25, 2024, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and had a diagnosis of renal failure requiring dialysis (a procedure that removes waste products and excess fluid from the blood when the kidneys are no longer functioning properly). Physician's orders from the dialysis center for Resident 99, dated December 24, 2024, included an order for the resident to receive 210 milligrams (mg) of Auryxia (treats anemia) five times a day with meals and snacks. Review of Resident 99's Medication Administration Record (MAR), dated January 2025, revealed that the resident was receiving Auryxia three times per day and not the ordered five times per day. Interview with Director of Nursing on January 10, 2025, at 1:14 p.m. confirmed that Resident 99 was not receiving Auryxia five times per day as ordered by the physician and she should have been. 28 Pa. Code 211.12(d)(1)(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. 48809 Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents receive adequate supervision and assistance to prevent accidents for two of 46 residents reviewed (Residents 79, 95). Findings include: The facility's policy for using a lifting machine, dated January 25, 2024, revealed that staff must be competent in the use of mechanical lifts per manufacturer's instructions. Manufacturer's instructions for the Maxi Move mechanical lift revealed that the breaks were to be engaged when lifting and lowering a patient. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 79, dated October 11, 2024, revealed that the resident was cognitively intact, required extensive assistance with daily care needs including transfers, and had diagnoses that included spondylosis (a chronic condition that involves the breakdown of the spine's joints and disks). A care plan, dated September 26, 2024, revealed that the resident was to be transferred by two staff using a mechanical lift with the green sling. Observations of Nurse Aide 3 and Nurse Aide 4 on January 7, 2025, at 10:54 a.m. using the mechanical lift to transfer Resident 79 from her wheelchair into her bed revealed that the brakes on the left were not engaged during the transfer. Interview with Nurse Aide 3 and Nurse Aide 4 on January 7, 2025, at 10:55 a.m. confirmed that they should have had the brakes on while raising the resident out of her wheelchair and lowering her into the bed. Interview with the Assistant Director of Nursing on January 7, 2025, at 11:05 a.m. confirmed that the brakes should have been engaged when using the mechanical lift to transfer Resident 79 from her wheelchair to her bed. An admission MDS for Resident 95, dated December 12, 2024, revealed that the resident was cognitively intact, required maximum assistance from staff for transfers, had diagnoses that included arthritis (a chronic condition that causes joint inflammation, pain, stiffness, and swelling), and had a total knee arthroplasty (a surgical procedure that replaces the knee joint with artificial parts). The resident's care plan, revised on December 6, 2024, indicated that she was a physical assist of two for transfers. A nursing note for Resident 95, dated December 13, 2024, at 12:53 p.m., revealed that the resident was complaining of a new pain to her right shoulder with active range of motion. Investigation documents provided by the facility, dated December 13, 2024, at 5:00 p.m. indicated that the resident notified physical therapy that Nurse Aide 1 transferred Resident 95 by herself twisting her arm and causing the right arm pain. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Physical Therapy notified the Director of Nursing to begin an investigation. A witness statement, dated December 13, 2024, indicated that Resident 95 was transferred from her wheelchair to her bed by herself, and Nurse Aide 1 did not look to verify her transfer status prior to transferring the resident. Education paperwork provided by the facility, dated October 15, 2024, revealed that Nurse Aide 1 was educated on following care plans. Interview with the Director of Nursing on January 8, 2025, at 12:20 p.m., 3:45 p.m., and 4:45 p.m. confirmed that Nurse Aide 1 transferred Resident 95 by herself and the resident required a two-person physical assist. 28 Pa. Code 211.12(d)(3) Nursing Services.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 43856 Based on review of facility policy and clinical records, and staff interviews, it was determined that the facility failed to ensure that physician's orders for enteral feedings were followed for three of 46 residents reviewed (Residents 16, 54, 67). Findings include: The facility's policy regarding enteral nutrition, dated January 25, 2024, revealed that adequate nutritional support through enteral nutrition is provided to residents as ordered, and is monitored the by the dietician who makes recommendation for interventions for nutritional adequacy. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 16, dated November 18, 2024, indicated that the resident was cognitively intact, required maximum assistance from staff for care, and had an enteral feeding tube (feeding through a tube inserted directly into the stomach). Physician's orders for Resident 16, dated January 6, 2025, included an order for the resident to receive Jevity 1.5 (a type of enteral feeding) at a rate of 60 milliliters (ml)/hour. Review of Resident 16's Medication Administration Record (MAR) for January 2025 revealed no documentation to indicate the amount of Jevity 1.5 that was administered each shift. Observation of the EntraFlo Nutrition Delivery system on January 8, 2025, at 1:52 p.m. revealed that the resident received 1880 ml at a rate of 60 ml/hr that shift. Interview with Licensed Practical Nurse (LPN) 5 on January 8, 2025, at 1:52 p.m. revealed that the resident should be receiving 480 ml per shift; however, she does not know how to clear the machine in the case that it would be stopped during care to ensure the resident receives the correct amount. Interview with the Registered Dietician on January 8, 2025, at 1:30 p.m. revealed that she was using the amount administered to determine the resident's correct rate, and it was important that the correct amount administered was recorded. Interview with the Director of Nursing on January 8, 2025, at 2:41 p.m. confirmed that staff were not documenting the amount of Jevity 1.5 Resident 16 was receiving and they should have been. A quarterly MDS assessment for Resident 54, dated November 5, 2024, indicated that the resident was severely cognitively impaired, required maximum assistance from staff for care, and had an enteral feeding tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician's orders for Resident 54, dated October 28, 2024, included an order for placement and the residual volume (the amount of stomach contents drained from a stomach following administration of enteral feed) to be checked prior to medication and enteral feeding administration. If there was more than 250 ml GRV (gastric residual volume), withhold further feeding and recheck in one hour. Notify the physician if the GRV was more than 250 ml on the second check. If the GRV was greater than 500 ml, withhold feeding and notify the physician. Observations on January 9, 2025, at 8:56 a.m. revealed that LPN 6 opened the cap of Resident 54's feeding tube and inserted the syringe without the plunger to check the residual volume. She stated that there was no residual volume observed and proceeded to administer medications and the enteral feeding. Interview with LPN 6 on January 9, 2025, at 9:18 a.m. revealed that she was not aware that the plunger had to be inserted into the syringe and to gently pull back on the plunger to withdraw stomach contents in order to properly verify the residual volume. Interview with the Director of Nursing January 9, 2025, at 10:12 a.m. confirmed that the plunger should have been inserted into the syringe to properly verify the residual volume. A nutrition note for Resident 54, dated October 8, 2024, at 2:35 p.m., revealed that the resident had an 11. 4-pound weight loss in 30 days and recommended a reweigh to confirm the weight loss; however, there was no documented evidence that the reweigh was obtained to confirm Resident 54's weight loss. A nutrition note for Resident 54, dated October 28, 2024, at 12:36 p.m., revealed that the resident's weight had significantly declined in the last 30 days. A recommendation for weekly weights for four weeks was made as well as adjustments to feeding orders to monitor weight trends. There was no documented evidence to indicate that the weekly weights for four weeks were obtained to monitor weight trends. Interview with Director of Nursing January 9, 2025, at 1:30 p.m. confirmed that the reweigh and weekly weights for four weeks for Resident 54 were not obtained and they should have been. A quarterly MDS assessment for Resident 67, dated November 8, 2024, indicated that the resident was cognitively impaired and was dependent on staff for daily care needs and had an enteral feeding tube. Physician's orders for Resident 67, dated September 30, 2024, included an order to check residual volume before beginning a feeding and before medication administration, if greater than 100 cc, hold feeding and recheck in one hour. If not resolved call the physician. Review of Resident 67's MAR for January 2025 revealed that the residual volume was being documented as verified every shift and not before each feeding and medication administration as ordered. Interview with the Director of Nursing on January 9, 2025, at 1:30 p.m. confirmed that the residual volume should have been verified before each feeding and before medication administration and it was not. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42079 Based on review of manufacturer's instructions, facility policies, and clinical records, as well as observations and staff interviews, it was determined that the facility failed to discard expired insulin pens in two of three medication carts reviewed (second and third floor long hall medication carts). Findings include: A facility policy regarding medication labeling and storage, dated [DATE], indicated that multi-dose vials that have been opened or accessed, are dated and discarded within 28 days unless manufacturer specifies a shorter or longer date for the open vial, and discarded according to the manufacturer's expiration date. Manufacturer's directions for use of Lantus Solostar u100 Insulin pen (a long acting insulin), dated [DATE], indicated to discard Solostar Lantus after 28 days out of cool storage. Manufacturer's directions for use of Humalog u100 Insulin pen (a short acting insulin), dated 2023, indicated to discard a 3 milliliter single patient use Humalog pen after 28 days once opened and in use. Physician's orders for Resident 17, dated [DATE], included an order for the resident receive 5 units of Lantus subcutaneously at bedtime for diabetes mellitus (a chronic disease that causes high blood sugar levels). Observations of the 3rd floor medication cart on [DATE], at 10:07 a.m. revealed a Lantus Insulin pen for Resident 17 that was dated as opened on [DATE], and was still in the cart. Interview with Licensed Practical Nurse 7 at the time of observation confirmed that the pen should have been discarded and it was not. Current physician's orders for Resident 89 included an order for the resident receive 1 unit of Lispro (Humalog) for a blood glucose of ,d+[DATE] milligrams per deciliter (mg/dL), 2 units for a blood glucose of , d+[DATE] mg/dl, 3 units for a blood glucose of ,d+[DATE] mg/dl, 4 units for a blood glucose of ,d+[DATE] mg/dl, and 5 units for a blood glucose of ,d+[DATE] mg/dl before meals. Observations of the 2nd floor medication cart on Januray 9, 2025, at 10:18 p.m. revealed a Lispro insulin (Humalog) pen for Resident 89 that was dated as opened on [DATE]. Interview with Registered Nurse 8 at the time of observation confirmed that Resident 89's Lispro insulin (Humalog) pen should have been discarded and it was not. Interview with the Director of Nursing on [DATE], at 12:47 p.m. confirmed that insulin pens should be discarded 28 days after being opened and in use. 28 Pa. Code 211.9(a)(1) Pharmacy Services. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1) Nursing Services.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 42079 Based on a review of facility policies and written menus, as well as observations and staff and resident interviews, it was determined that the facility failed to follow their planned menu. Findings include: A facility policy, dated January 24, 2024, indicated that menus shall be written in advance and posted in resident areas. Any menu substitutions or deviations from the posted menu shall be made in an emergency situation only and recorded on the substitution log. An interview with a group of residents on January 7, 2025, revealed that they do not always get what is on the menu. The facility's written and printed menu for the lunch meal on January 7, 2025, indicated that the residents were to receive chunky cheeseburger casserole, glazed sweet carrots, garlic bread, a lemon brownie, and choice of beverage. Observations in the kitchen on January 7, 2025, at 9:17 a.m. revealed a yellow cake in the walk-in cooler for the lunch meal. Observations of the lunch meal in the Third floor dining room on January 7, 2025, at 12:30 p.m. revealed that the facility served a blonde brownie and not a lemon brownie as listed on the menu. Interview with the Dietary Manager on January 9, 2025, at 12:10 p.m. confirmed that a blonde brownie was served and not the lemon brownie, because she did not have a recipe for the lemon brownie.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48809 Based on a review of facility policies and observations, as well as resident and staff interviews, it was determined that the facility failed to serve food that was palatable. Findings include: A facility policy for food preparation and service, dated January 25, 2024, revealed that food should be distributed and served in a manner that complies with safe food handling practices with hot foods above 130 degrees Fahrenheit (F). Interview with a group of residents on January 8, 2025, at 1:30 p.m. revealed that the food delivered to the resident rooms was served cold. Observations in the kitchen for the lunch meal service on January 10, 2025, at 11:31 a.m. revealed that a test tray left the kitchen and arrived on the fourth floor at 11:32 a.m. The lunch meal on January 10, 2025, consisted of ground sausage and noodles, broccoli, rootbeer float dessert cup, milk, and coffee. Trays were passed to the residents in their rooms and the last resident was served and eating at 11:50 a.m. The test tray on January 10, 2025, at 11:52 a.m. revealed that the temperature of the ground sausage and noodles was 120 degrees Fahrenheit (F), the broccoli was 120 degrees F, the rootbeer float dessert cup was 49.0 degrees F, the milk was 46.4 degrees F, and the coffee was 165.0 degrees F. The ground sausage and noodles and broccoli were cool and unappetizing. Interview with the Dietary Manager on January 10, 2025, at 12:03 p.m. confirmed that foods should be served to residents at proper and palatable temperatures. 28 Pa. Code 211.6(b) Dietary Services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42079 Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to store and prepare food in accordance with professional standards for food service safety. Findings include: The facility's policy regarding food and snacks kept on nursing units, dated [DATE], revealed that all foods stored in the refrigerator or freezer will be labeled with the resident's name and use-by dates, and that beverages are dated when opened and discarded after 24 hours. Observations in the kitchen on [DATE], at 9:27 a.m. revealed a box of frozen 1.5 ounce egg patties that were open to air and dated [DATE]. Interview with the Dietary Manager on [DATE], at 9:40 p.m. confirmed that the box of egg patties were open to air. Observations of the resident refrigerator on the second floor on [DATE], at 12:33 p.m. revealed two opened and undated one-pint containers of 2 percent milk labeled with a resident's first name, one opened half-gallon of 1 percent milk that was three quarters full, without a name, and a sell by date of [DATE], and one pint of ice tea that was full, had a sell-by date of [DATE], and did not have a name. Interview with Registered Nurse 10 on [DATE], at 12:41 p.m. confirmed that the food items mentioned above should have been labeled, dated, and thrown out after they expired. Interview with the Dietary Manager on [DATE], at 12:46 p.m. confirmed that the items stored in the resident refrigerator should have been labeled, dated, and thrown out after they expired. Observations of dishwashing on [DATE] at 1:12 p.m. revealed that the dishwasher was not reaching a hot water final rinse of 180 degrees Fahrenheit (F). Dietary Aide 11 was spraying and racking the dirty dishes for the dishwasher. The final rinse gauge on the dishwasher was not moving at all. Dietary Aide 12 took over the dishwashing at 1:15 p.m. and revealed that the final rinse was not coming to temperature because the hot water booster was not turned on. When Dietary Aide 12 took over dishwashing, Dietary Aide 11 moved from the dirty dish side where he was spraying and racking dirty dishes to the clean side where he immediately began to move and stack the clean dishes without washing his hands. Interview with Dietary Staff 11 on Januray 9, 2025, at 1:30 p.m. revealed that normally he washes his hands when entering the kitchen, if he has left the kitchen area. Interview with the Dietary Manager on [DATE], at 2:06 p.m. confirmed that the dishwasher was a hot water sanitizer but could also use chemicals if necessary and that the hot water booster should have been on to sanitize the dishes. Interview with the Director of Nursing on [DATE], at 3:55 p.m. revealed that she would expect that dietary staff would wash their hands between dirty and clean tasks. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.6(f) Dietary Services.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 42079 Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plans of corrections for a State Survey and Certification (Department of Health) survey ending February 8, 2024, and complaint investigation surveys ending June 4, 2024; July 22, 2024; September 17, 2024; and December 11, 2024, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility-maintained compliance with cited nursing home regulations. The results of the current survey, ending January 10, 2025, identified repeated deficiencies related to creating and implementing care plans, revision of care plans, quality of care, meeting professional standards, free of accidents, menus made in advance and followed, nutritious and palatable food service, and food prepared, stored, and served under sanitary conditions. The facility's plan of correction for a deficiency regarding developing comprehensive care plans, cited during the survey ending February 8, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F656, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding the development of comprehensive care plans. The facility's plan of correction for a deficiency regarding a failure to update residents' care plans, cited during the survey ending February 8, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F657, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding updating residents' care plans. The facility's plan of correction for a deficiency regarding the meeting professional standards, cited during the survey ending September 17, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F658, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding meeting professional standards. The facility's plan of correction for a deficiency regarding quality of care, cited during the surveys ending and June 4, 2024 and July 22, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding quality of care (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's plan of correction for a deficiency regarding accident hazards, cited during the surveys ending and December 11, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F689, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding accident hazards. The facility's plans of correction for deficiencies regarding failure to provide menus made in advance and followed, cited during the surveys ending December 11, 2024, revealed that the facility developed plans of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F803, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding following menus as posted. The facility's plans of correction for deficiencies regarding failure to provide nutritious and palatable food service, cited during the surveys ending December 11, 2024, revealed that the facility developed plans of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F804, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding nutritious and palatable food service. The facility's plans of correction for deficiencies regarding failure to prepare, store, and serve food under sanitary conditions, cited during the surveys ending February 8, 2024 and December 11, 2024, revealed that the facility developed plans of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F812, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding preparation, storage, and service of food under sanitary conditions. Refer to F656, F657, F658, F684, F689, F803, F804, F812. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38012 Based on observations and staff interviews, it was determined that the facility failed to provide comfortable temperatures for one of three dining rooms in the facility (fourth floor Dining Room). Findings include: Observations in the fourth floor dining room on January 7, 2025, at 11:40 a.m. revealed that there were five residents waiting for lunch. The temperature in the dining room was 64 degrees Fahrenheit. Observations in the fourth floor dining room on January 9, 2025, at 12:16 p.m. revealed that there were five people eating there and the temperature ranged from 60 to 70 degrees Fahrenheit. Interview with the Maintenance Director on January 7, 2025, at 11:40 a.m. revealed that the doors to the fourth floor dining room were closed and the heat was not circulating into the dining room from the hallways. He indicated that when the doors were open, the dining room was warm. At 2:20 p.m. the temperature in the fourth floor dining room was 73.4 degrees Fahrenheit. Interview on January 9, 2025, at 2:18 p.m. with the owner of the heating, ventilation, and air conditioning (HVAC company) company that came to the facility on [DATE], revealed that the dampers were slightly open to the outside and once closed the cold air stopped circulating into the dining room and the dining room temperatures were within normal range. Interview with the Maintenance Director on January 7, 2025, at 11:40 a.m. and again on January 8, 2025, at 12:22 p.m. revealed that the temperature was outside the acceptable parameters in the fourth floor dining room. He further stated staff would need to leave the doors open to the dining room so that heat from the hallway could enter the dining room. 28 Pa. Code 207.2(a) Administrator's Responsibility.