STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395395	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River's Bend Health & Rehab Center	800 King Russ Road Harrisburg, PA 17109

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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 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 46253 Based on facility policy review, personnel file review, and staff interviews, it was determined that the facility failed to ensure that residents were protected from the potential for abuse by failing to perform a FBI criminal history background check prior to hire for one of five personnel files reviewed (Employee 6). Findings Include: Review of facility policy, titled Pennsylvania Resident Abuse, with a last revised date of August 30, 3023, revealed, in part, 1. a. The facility will do the following prior to hiring a new employee: .iv. Conduct a criminal background check in accordance with State law and Facility policy. Review of facility policy, titled Employee Background Screening Policy, with a last revised date of February 16, 2024, revealed, in part, Part 2: Criminal Background Check A. Each facility shall conduct a criminal background check of all employees, as required by law upon hire. The HR department shall oversee and monitor the process .Pennsylvania-if the applicant has not been a Pennsylvania resident for two consecutive years before application, they will need to have a PA State Police criminal history background check AND an FBI Background Check. Review of the personnel file for Employee 6 revealed that they were hired on Janaury 15, 2024. Further review of Employee 6's personnel file revealed an Application for Employment that was hand written, dated December 13, 2023. Employee 6 indicated on this application that they had resided at their given Pennsylvania address from February 23, 2023 through current December 18, 2023 and, prior to that, had resided in Oregon from 2018 to 2020. Further review of the personnel file for Employee 6 revealed a typed Application for Employment that indicated that they had been employed in the state of Oregon until 2024. Further review of the personnel file for Employee 6 revealed a Resume, undated, that indicated they had been employed in Oregon from April 2018 until February 2023, and that she had worked at another facility in PA from February 2023 through current. Further review of the personnel file for Employee 6 revealed a reference check completed by Employee 8 (Human Resources Coordinator) on December 27, 2023, that confirmed Employee 6 was employed at the facility in Oregon from April 2018 to February 2023. (continued on next page)

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

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Employee 6 and the Director of Nursing (DON) on April 11, 2024, at 11:45 AM, Employee 6 indicated that they had written the wrong date on their written application and that the information was correct on their resume. Employee 6 indicated that they had not resided in Pennsylvania for two years at the time they were applying at the facility. They indicated that they had only lived in Pennsylvania for about a year. During an interview with Employee 8 on April 11, 2024, at 12:23 PM, they indicated that they were doing a written and an electronic/typed application at the time Employee 6 was applying, and that they would go by the hand-written one. Review of Employee file revealed that they had a Pennsylvania State Police background check that was initiated on December 22, 2023, and results received on January 11, 2024. There was no evidence that a FBI background check was completed for Employee 6 prior to hire since they had not resided in the state of Pennsylvania for two consecutive years prior to the time of hire. During an interview with the Nursing Nome Administrator (NHA) and DON on April 11, 2024, at 12:23 PM, the NHA confirmed that a FBI check should have been completed for Employee 6 when it was acknowledged on their reference that they had not resided in Pennsylvania for two consecutive years prior to hire. She further indicated that the employee has been placed on Administrative leave and has been sent to get an FBI check completed. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.19 (8) Personnel policies and procedures

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37817 Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to notify the resident/resident representative and/or the representative of the Office of the State Long-Term Care Ombudsman of resident transfers, in writing, to include to include the following: the reason for the transfer or discharge, date of transfer, location of transfer, statement of the resident's appeal rights, and name, address (mailing and email), and telephone number of the Office of the State Long-Term Care Ombudsman for six of 11 resident records reviewed (Residents 20, 34, 76, 81, 97, and 184). Findings include: Review of facility policy, Resident Discharge/Transfer Letter Policy, last revised April 19, 2023, read, in part, for emergency transfers, signature of administrator/designee will be acquired/obtained as soon as practicable. If signature is obtained after resident transfers, it will be given to resident at that time, if applicable. The policy failed to document notification of transfer and required appeals information to the resident/resident representative. Review of Resident 20's clinical record revealed diagnoses that included chronic systolic congestive heart failure (a specific type of heart failure that occurs in the left ventricle and the ventricle cannot contract normally when the heart beats), chronic obstructive pulmonary disease (COPD - a type of progressive lung disease characterized by long term respiratory symptoms and airflow limitations), and dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning). Review of Resident 20's clinical record revealed that the Resident was transferred to the hospital on January 29, 2024, and remained hospitalized through February 2, 2024. Review of Resident 20's Notice of Transfer or discharge date d January 29, 2024, revealed that it was addressed to Resident 20, and in the section titled Verification of Receipt of Notice, it was signed by two staff members but was not signed by the resident or resident representative. Review of the facility Ombudsman notification of Resident transfers for the month of January 2024, failed to include Resident 20. Further review of Resident 20's clinical record revealed that the Resident was transferred to the hospital on February 27, 2024, and remained hospitalized until February 29, 2024. Review of Resident 20's Notice of Transfer or discharge date d February 27, 2024, revealed that it was not addressed to anyone, and in the section titled Verification of Receipt of Notice, it was signed by two staff members. Further review of Resident 20's clinical record progress notes failed to reveal documentation that the information contained on their Notice of Transfer or Discharge was provided to Resident 20 or their Representative. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on April 10, 2024, at 11:17 AM, the NHA confirmed that they had no additional information that they could provide to support that Resident 20 or their Representative was provided the Notice of Transfer. The DON said the facility practice had been that they were reviewed and signed by two staff members during emergent transfers, and that calls are made to the Responsible Parties and the Notice of Transfer would be sent certified mail the next day. She further indicated that this should have been documented in the progress notes. During an interview with the DON on April 10, 2024, at 1:38 PM, she confirmed that Resident 20 was not on the Ombudsman report and should have been. Review of Resident 34's clinical record revealed diagnoses that included chronic obstructive pulmonary disease and chronic diastolic congestive heart failure (heart failure that occurs when the heart does not relax properly between beats, causing the heart to be unable to pump an adequate amount of blood to the body). Review of Resident 34's clinical record revealed that the Resident was transferred to the hospital on August 11, 2023. Review of Resident 34's Notice of Transfer or discharge date d August 11, 2024, revealed that it was addressed to Resident 34, but in the section titled Verification of Receipt of Notice, it was signed by two staff members but was not signed by the resident or resident's responsible party. Review of Resident 34's clinical record revealed that the Resident was transferred to the hospital on January 24, 2024. Review of Resident 34's Notice of Transfer or discharge date d January 24, 2024, revealed that it was addressed to Resident 34, but in the section titled Verification of Receipt of Notice, it was signed by two staff members, but was not signed by the resident or the resident's responsible party. Review of the facility Ombudsman notification of Resident transfers for the month of January 2024 failed to include Resident 34. Review of Resident 34's clinical record revealed that the Resident was transferred to the hospital on April 3, 2024. Review of Resident 34's Notice of Transfer or discharge date d April 3, 2024, revealed that it was addressed to Resident 34, but in the section titled Verification of Receipt of Notice it was signed by the DON and not signed by the resident or resident's responsible party. Review of Resident 34's clinical record progress notes failed to reveal documentation that the information contained on their Notice of Transfer or Discharge was provided to Resident 20 or their Representative for their hospital transfers on August 11, 2023; January 24, 2024; or April 3, 2024. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the NHA and DON on April 10, 2024, at 11:17 AM, the NHA confirmed that they had no additional information that they could provide to support that Resident 34 or their Representative was provided the Notice of Transfer for the aforementioned hospital transfer dates. The DON said the facility practice had been that they were reviewed and signed by two staff members during emergent transfers, and that calls are made to the Responsible Parties and the Notice of Transfer would be sent certified mail the next day. She further indicated that this should have been documented in the progress notes. During an interview with the NHA and DON on April 10, 2024, at 2:15 PM, the NHA confirmed that Resident 34 was not included on the Ombudsman report for their January 2024 transfer and should have been. She further indicated that they had no documentation to provide that the Ombudsman reports were completed in July and August of 2023. Review of Resident 76'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), osteoporosis (a condition in which the bones become brittle and fragile), and muscle weakness. Review of Resident 76's clinical record revealed that the Resident was transferred to the hospital on February 13, 2024. Review of Resident 76's Notice of Transfer or discharge date d February 13, 2024, revealed that it was addressed to Resident 76, but in the section titled Verification of Receipt of Notice, it was signed by two staff members. Review of Resident 76's clinical record progress notes failed to reveal documentation that the information contained on their Notice of Transfer or Discharge was provided to Resident 76 or their Representative for their hospital transfers on February 13, 2024. During an interview with the NHA and DON on April 10, 2024, at 11:17 AM, the NHA confirmed that they had no additional information that they could provide to support that Resident 76 or their Representative was provided the Notice of Transfer for their hospital transfer on February 13, 2024. The DON said the facility practice had been that they were reviewed and signed by two staff members during emergent transfers, and that calls are made to the Responsible Parties and the Notice of Transfer would be sent certified mail the next day. She further indicated that this should have been documented in the progress notes. Review of Resident 81's clinical record revealed diagnoses that included sepsis (an infection of the blood stream), hypertension (persistent high blood pressure), and chronic kidney disease (CKD - a condition characterized by a gradual loss of kidney function). Review of Resident 81's clinical record revealed she was hospitalized on [DATE]; January 21, 2024; and March 6, 2024. Review of Ombudsman notification documentation of January 2024 hospital transfers failed to reveal notification of Resident 81's hospital transfer on January 21, 2024. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Employee 1 (Social Services Director) on April 10, 2024, at 9:19 AM, the surveyor questioned the lack of Resident 81 being on the Ombudsman transfer notification for her January 2024 hospitalization . Employee 1 revealed her hospitalization was missed on the report. Review of Resident 81's clinical record revealed the Notice of Transfer or Discharge for all three hospitalization s were signed by nursing staff. Further review of Resident 81's clinical record progress notes failed to reveal documentation that the information contained on their Notice of Transfer or Discharge was provided to Resident 81 or their Representative for their hospitalization s on December 22, 2023; January 21, 2024; and March 6, 2024. During an interview with the NHA on April 10, 2024, at 2:39 PM, the surveyor revealed the concern with the lack of documentation to indicate Notice of Transfer or Discharge was provided to Resident 81 or their Representative for the three aforementioned hospitalization s and lack of notification to the Ombudsman for her January 2024 hospital transfer. The NHA revealed her understanding with the concerns. Review of Resident 97's clinical record on April 10, 2024, at 10:55 AM, revealed diagnoses that included acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood) and urinary tract infection (UTI - an infection caused by bacteria in any part of the urinary system). Further review of Resident 97's clinical record revealed that on January 11, 2024, and March 8, 2024, Resident 97 was transferred out of the facility to the hospital, and was subsequently admitted to the hospital. Review of Resident 97's documents, titled Notice of Transfer or Discharge, revealed on January 11, 2024, two staff members had signed the acknowledgment of receipt as the Resident Representative. Review of the document dated March 8, 2024, revealed no signature had been obtained to acknowledge receipt of notification of transfer. Further review of Resident 97's clinical record progress notes failed to reveal documentation that the information contained on their Notice of Transfer or Discharge documents was provided to Resident 97 or their Representative. During an interview on April 10, 2024, at 11:17 AM, with the NHA and DON, the NHA confirmed no additional information could be provided. The DON stated it was the expectation of the facility that Notice of Transfer or Discharge documents are reviewed/signed by staff during emergent transfers, that calls are made to the Responsible Parties to review the documents, and the document is to be sent via certified mail the next day. The DON stated it was the expectation of the facility that review of the transfer notice with the Resident/Representative be documented in the progress notes. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 184's clinical record documented diagnoses that included diabetes mellitus (the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine), congestive heart failure (CHF - the heart doesn't pump blood as well as it should), and left and right above the knee amputations. Review of Resident 184's clinical record documented the Resident was transferred to the hospital on January 16, 2024, the transfer notice was not signed by the Resident or the Resident Representative, and the progress notes didn't reflect that the Resident Representative was notified of the transfer notice and appeals process. During an interview on April 10, 2024, at 11:02 AM, with NHA, it was revealed that if the transfer is emergent, staff will call the Resident Representative to inform them of transfer. Pa. Code 201.29(a)(c.3)(2) Resident Rights Pa. Code 211.12(d)(2)(3) Nursing Services

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37817 Based on clinical record review, policy review, and staff interviews, it was determined that the facility failed to ensure that the resident and resident representative received written notice of the facility bed-hold policy at the time of transfer for seven of 11 resident records reviewed (Residents 20, 34, 59, 76, 81, 97, and 184). Findings Include: Review of facility policy, Bed Hold Letter, revised September 26, 2020, read, in part, Business Office or designee will complete the Medicaid Bed Hold Letter and sent to the appropriate parties, certified/return receipt requested or provided directly to the responsible party, and a copy will be maintained in the Resident's financial file. Review of Resident 20's clinical record revealed diagnoses that included chronic systolic congestive heart failure (a specific type of heart failure that occurs in the left ventricle, and the ventricle cannot contract normally when the heart beats), chronic obstructive pulmonary disease (COPD - a type of progressive lung disease characterized by long term respiratory symptoms and airflow limitations), and dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning). Review of Resident 20's clinical record revealed that the Resident was transferred to the hospital on January 29, 2024, and remained hospitalized through February 2, 2024. Review of Resident 20's Bedhold Policy dated January 29, 2024, revealed that it was signed by two staff members. Review of Resident 20's clinical record progress notes failed to reveal documentation that the facility Bedhold Policy was provided to Resident 20 or their Representative for their January 29, 2024, hospital transfer. Further review of Resident 20's clinical record revealed the Resident was transferred to the hospital on February 27, 2024, and remained hospitalized until February 29, 2024. Review of Resident 20's Bedhold Policy dated February 27, 2024, revealed that it was signed by two staff members. Review of Resident 20's clinical record progress notes failed to reveal documentation that the facility Bedhold Policy was provided to Resident 20 or their Representative for their February 27, 2024, hospital transfer. During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on April 10, 2024, at 11:17 AM, the NHA confirmed that they had no additional information that they could provide to support that Resident 20 or their Representative was provided the Bedhold Policy. The DON said the facility practice had been that this would be reviewed with the Resident or their Representative and be signed by two staff members during emergent transfers, and that calls are made to the Responsible Parties and the Bedhold Policy would be sent certified mail the next day. She further indicated that this should have been documented in the progress notes. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 34's clinical record revealed diagnoses that included chronic obstructive pulmonary disease and chronic diastolic congestive heart failure (heart failure that occurs when the heart does not relax properly between beats, causing the heart to be unable to pump an adequate amount of blood to the body). Review of Resident 34's clinical record revealed that the Resident was transferred to the hospital on August 11, 2023, and remained hospitalized until August 24, 2023. Review of Resident 34's Bedhold Policy dated August 11, 2023, revealed that it was signed by two staff members. Review of Resident 34's clinical record progress notes failed to reveal documentation that the facility Bedhold Policy was provided to Resident 34 or their Representative for their August 11, 2023, hospital transfer. Review of Resident 34's clinical record revealed that the Resident was transferred to the hospital on January 24, 2024. Review of Resident 34's Bedhold Policy dated January 24, 2024, revealed that it was signed by two staff members. Review of Resident 34's clinical record progress notes failed to reveal documentation that the facility Bedhold Policy was provided to Resident 34 or their Representative for their January 24, 2024, hospital transfer. Review of Resident 34's clinical record revealed that the Resident was transferred to the hospital on April 3, 2024. Review of Resident 34's Bedhold Policy dated April 3, 2024, revealed that it was signed by two staff members. Review of Resident 34's clinical record progress notes failed to reveal documentation that the facility Bedhold Policy was provided to Resident 34 or their Representative for their April, 2024, hospital transfer. During an interview with the NHA and DON on April 10, 2024, at 11:17 AM, the NHA confirmed that they had no additional information that they could provide to support that Resident 34 or their Representative was provided the facility Bedhold Policy for the aforementioned hospital transfer dates. The DON said the facility practice had been that they were reviewed and signed by two staff members during emergent transfers, and that calls are made to the Responsible Parties and the Bedhold Policy would be sent certified mail the next day. She further indicated that this should have been documented in the progress notes. Review of Resident 59's clinical record on April 9, 2024, at 12:03 PM, revealed diagnoses that included end stage renal disease (condition in which kidneys cease functioning), dependence on renal dialysis (treatment that removes extra fluid and waste products from the blood when the kidneys are not able to), and urinary tract infection (UTI - an infection caused by bacteria in any part of the urinary system). (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident 59's clinical record revealed that on January 29, 2024, Resident 59 was admitted to the hospital. Review of Resident 59's document, titled Bed Hold Policy, revealed on January 29, 2024, two staff members had signed the document. Further review of Resident 59's clinical record progress notes failed to reveal documentation that the information contained on the bed-hold policy document was provided to Resident 59 or their Representative. During an interview on April 10, 2024, at 11:17 AM, with the NHA and DON, the NHA confirmed no additional information could be provided. The DON stated it was the expectation of the facility that bed-hold policy documents are reviewed/signed by staff during emergent transfers, and that calls are made to the Responsible Parties to review the documents, and the document is to be sent via certified mail the next day. The DON stated it was the expectation of the facility that review of the bed-hold policy with the Resident/Representative be documented in the progress notes. Review of Resident 76'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), osteoporosis (a condition in which the bones become brittle and fragile), and muscle weakness. Review of Resident 76's clinical record revealed that the Resident was transferred to the hospital on February 13, 2024, and remained hospitalized until February 17, 2024. Review of Resident 76's Bedhold Policy dated February 13, 2024, revealed that it was signed by two staff members. Review of Resident 76's clinical record progress notes failed to reveal documentation that the facility Bedhold Policy was provided to Resident 76 or their Representative for their hospital transfer on February 13, 2024. During an interview with the NHA and DON on April 10, 2024, at 11:17 AM, the NHA confirmed that they had no additional information that they could provide to support that Resident 76 or their Representative was provided the facility Bedhold Policy for their hospital transfer on February 13, 2024. The DON said the facility practice had been that they were reviewed and signed by two staff members during emergent transfers, and that calls are made to the Responsible Parties and the Bedhold Policy would be sent certified mail the next day. She further indicated that this should have been documented in the progress notes. Review of Resident 81's clinical record revealed diagnoses that included sepsis (an infection of the blood stream), hypertension (persistent high blood pressure), and chronic kidney disease (CKD - a condition characterized by a gradual loss of kidney function). Review of Resident 81's clinical record revealed she was hospitalized on [DATE]; January 21, 2024; and March 6, 2024. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 81's clinical record revealed the Bed Hold Policy document for all three hospitalization s were signed by nursing staff. Further review of Resident 81's clinical record progress notes failed to reveal documentation that the Bed Hold Policy information was provided to Resident 81 or their Representative for her hospitalization s on December 22, 2023; January 21, 2024; and March 6, 2024. During an interview with the NHA on April 10, 2024, at 2:39 PM, the surveyor revealed the concern with the lack of documentation to indicate the Bed Hold Policy was provided to Resident 81 or their Representative for the three aforementioned hospitalization s. The NHA revealed her understanding with the concern. Review of Resident 97's clinical record on April 10, 2024, at 10:55 AM, revealed diagnoses that included acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood) and UTI. Further review of Resident 97's clinical record revealed that on January 11, 2024, and March 8, 2024, Resident 97 was transferred out of the facility to the hospital and was subsequently admitted to the hospital. Review of Resident 97's document, titled Bed Hold Policy, revealed on January 11, 2024, and March 8, 2024, two staff members had signed the document. Further review of Resident 97's clinical record progress notes failed to reveal documentation that the information contained on the bed-hold policy documents were provided to Resident 97 or their Representative. During an interview on April 10, 2024, at 11:17 AM, with the NHA and DON, the NHA confirmed no additional information could be provided. The DON stated it was the expectation of the facility that bed-hold policy documents are reviewed/signed by staff during emergent transfers, that calls are made to the Responsible Parties to review the documents, and the document is to be sent via certified mail the next day. The DON stated it was the expectation of the facility that review of the bed hold policy with the Resident/Representative be documented in the progress notes. Review of Resident 184's clinical record documented diagnoses that included diabetes mellitus (the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine), congestive heart failure (CHF - the heart doesn't pump blood as well as it should), and left and right above the knee amputations. Review of Resident 184's clinical record documented Resident was transferred to the hospital on January 16, 2024, payor source was Medicaid, the bed hold notice wasn't signed by the Resident or Resident Representative, and the progress notes didn't reflect bed-hold notice was discussed with the Resident or the Resident Representative. During an interview on April 10, 2024, at 11:02 AM with NHA, it was revealed that if the transfer is emergent, staff will call the Resident Representative to inform them of the bed-hold, and bed-hold should be mailed via certified letter. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.14(a) Responsibility of Licensee

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46253 Based on clinical record review and staff interviews, it was determined that the facility failed to ensure the resident assessment accurately reflected the resident status for two of 26 residents reviewed (Residents 77 and 87). Findings Include: Review of Resident 77's clinical record revealed diagnoses that included vascular dementia (brain damage caused by multiple strokes which causes memory loss in older adults), delusional disorder (type of psychotic disorder; a delusion is an unshakable belief in something that is untrue), and depression. Review of Resident 77's Quarterly MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) with the assessment reference date (ARD-last day of the assessment period) of September 2, 2023, revealed in Section N. Medications at subsection N0450. Antipsychotic Medication Review that the Resident was receiving an antipsychotic medication on a routine basis, had not had a gradual dose reduction, and that their physician had not documented that a gradual dose reduction was clinically contraindicated. Review of Resident 77's Quarterly MDS with the ARD of October 18, 2023, revealed in Section N. Medications at subsection N0450. Antipsychotic Medication Review that the Resident was receiving an antipsychotic medication on a routine basis, had not had a gradual dose reduction, and that their physician had not documented that a gradual dose reduction was clinically contraindicated. Review of Resident 77's clinical record revealed a Consultation Report completed by the pharmacist dated July 17, 2023, with a recommendation for their physician to review their antipsychotic medication for a dose reduction. This recommendation was reviewed and signed by Resident 77's physician on August 4, 2023, with documentation noted that the recommendation was contraindicated because Resident 77 was still experiencing behaviors; which confirmed that their physician had documented that a gradual dose reduction was clinically contraindicated. The date of this documentation was not included in Resident 77's aforementioned MDSs. Review of Resident 77's clinical record revealed a consultation note from PsychoGeriatric Services dated December 8, 2023, that indicated in section titled Treatment Plan/Recommendations recommending no gradual dose reduction and that the benefits of the medication outweighed the risks. This recommendation was initialed by Resident 77's primary care physician on December 11, 2023. Review of Resident 77's Quarterly MDS with the ARD of January 18, 2024, revealed in Section N. Medications at subsection N0450. Antipsychotic Medication Review that the Resident was receiving an antipsychotic medication on a routine basis, had not had a gradual dose reduction, and that their physician had not documented that a gradual dose reduction was clinically contraindicated although the aforementioned consultation note indicated that a gradual dose reduction had been documented as clinically contraindicated. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on April 10, 2024, at 1:40 PM, the NHA confirmed that the aforementioned MDS for Resident 77 were coded inaccurately, that modifications were completed, and that she would expect the MDS to have been coded accurately. Review of Resident 87's clinical record revealed she was admitted to the facility on [DATE], with diagnoses that included: Post-Traumatic Stress Disorder (PTSD - a mental and behavioral disorder that develops from experiencing a traumatic event, such as sexual assault, warfare, traffic collisions, child abuse, domestic violence, or other threats on a person's life or well-being), anxiety (a feeling of worry, nervousness, or unease), and bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). Review of Resident 87's clinical record revealed a hospital referral signed by a medical doctor on July 26, 2023, noting a past medical history of PTSD related to a prior intentional medication overdose, that she was hospitalized three weeks prior for an overdose, she was seen by psychology and neurology, and the Resident denied intentional harm to herself prior to being discharged . Review of Resident 87's clinical record revealed a PsychoGeriatric Services Evaluation dated July 28, 2023, noting her PTSD diagnosis and plan for psychology services to continue to follow with her. Review of Resident 87's Admission MDS with the assessment reference date of August 2, 2023, failed to indicate that Resident 87 had a diagnosis of PTSD. Review of Resident 87's Discharge Return Anticipated MDS with ARD of September 21, 2023, failed to indicate that Resident 87 had a diagnosis of PTSD. Review of Resident 87's Quarterly MDS with ARD of November 2, 2023, failed to indicate that Resident 87 had a diagnosis of PTSD. Review of Resident 87's Quarterly MDS with ARD of January 9, 2024, failed to indicate that Resident 87 had a diagnosis of PTSD. During an interview with the NHA on April 10, 2024, at 9:21 AM, she revealed the four MDS assessments were now modified to reflect Resident 87's diagnosis of PTSD, and she would expect Resident assessments to be coded accurately. 28 Pa. Code 211.12(d)(3)(5) Nursing services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46253 Based on facility policy review, observations, clinical record review, and staff interviews, it was determined that the facility failed to ensure the care plan was reviewed and revised for seven of 29 residents reviewed (Resident 20, 36, 42, 59, 77, 81, and 97). Findings include: Review of facility policy, titled Comprehensive Care Planning Policy, with a revision date of March 2, 2021, revealed F) The Comprehensive Care Plan is reviewed and updated at least every 90 days by the interdisciplinary team. J) 2. Residents who have returned from the hospital in the past week. Their previous MDS and Care Plan must be reviewed and updated and section W) Care Plans are to be maintained with the current Medical Record. Review of Resident 20's clinical record revealed diagnoses that included chronic systolic congestive heart failure (a specific type of heart failure that occurs in the left ventricle, and the ventricle cannot contract normally when the heart beats), chronic obstructive pulmonary disease (COPD - a type of progressive lung disease characterized by long term respiratory symptoms and airflow limitations), and dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning). Observation of Resident 20's room on April 8, 2024, at 11:20 AM, revealed the presence of bilateral enabler (assistive device) bars. Review of Resident 20's clinical record physician orders revealed an order for Bilateral assistive handrails to aid in repositioning, with an original order date of February 15, 2024. Review of Resident 20's care plan revealed a care plan problem for limited physical mobility related to weakness. The care plan failed to include bilateral assistive handrails as an intervention. During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on April 9, 2024, at approximately 1:45 PM, the care plan concern was shared. A follow-up review of Resident 20's care plan on April 10, 2024, at 10:00 AM, revealed that the bilateral assistive handrails were added to the care plan on April 9, 2024. During a follow-up interview with the DON on April 11, 2024, at 10:20 AM, she confirmed that Resident 20's bilateral assistive handrails should have been care planned prior to April 9, 2024. Review of Resident 36's clinical record revealed diagnoses that included COPD and heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs). Review of Resident 36's physician orders revealed an order for Xarelto (rivaroxaban) tablet; 15 milligrams; one tab once a day every evening with dinner for atrial flutter, with an original start date of December 6, 2023. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 36's comprehensive person-centered care plan on April 9, 2024, at 1:32 PM, failed to include a focus area relating to Resident 36 being on an anticoagulant medication, as well as to monitor for bleeding. Review of Resident 36's comprehensive person-centered care plan on April 11, 2024, at 9:09 AM, revealed a focus area was added on April 10, 2024, to include the following: Resident 36 is on anticoagulant therapy related to atrial flutter, with an approach area to include: observe for signs of active bleeding (nosebleeds, bleeding gums, petechiae, purpura, ecchymotic areas, hematoma, blood in urine, blood in stools, hemoptysis, elevated temperature, pain in joints, abdominal pain, epistaxis). During an interview with the NHA and DON on April 11, 2024, at 12:27 PM, they revealed they would have expected an anticoagulant care plan to have been added to Resident 36's comprehensive person-centered care plan prior to April 10, 2024. Review of Resident 42's clinical record revealed diagnoses that included atrial fibrillation and the presence of a cardiac pacemaker. Review of Resident 42's cardiology consult dated December 28, 2023, indicated that the Resident was to have remote testing of their pacemaker on April 4, 2024; July 11, 2024; and October 17, 2024. The consult also indicated that the Resident would be seen in the cardiology office on January 21, 2025, at 7:45 AM. Review of Resident 42's care plan revealed a care plan category for cardiovascular, which indicated that Resident 42 had a pacemaker, but the care plan failed to include safety interventions associated with the presence of the pacemaker, any routine testing of the pacemaker, or cardiology follow-up visits. During an interview with the NHA and DON on April 9, 2024, at 1:55 PM, the aforementioned care plan concern for Resident 42 was shared. A follow-up review of Resident 42's care plan on April 10, 2024, at 10:18 AM, revealed that the care plan had been revised to include all appropriate safety measures, pacemaker testing, and cardiology follow-up. During a follow-up interview with the DON on April 10, 2024, at 12:23 PM, she indicated that she had updated the care plan to reflect the safety measures for Resident 42's pacemaker and their cardiology follow-up. She confirmed that she would have expected these items to have been included on Resident 42's care plan prior to April 9, 2024. Review of Resident 59's clinical record on April 9, 2024, at 12:03 PM, revealed diagnoses that included end stage renal disease (condition in which kidneys cease functioning), dependence on renal dialysis (treatment that removes extra fluid and waste products from the blood when the kidneys are not able to), and urinary tract infection (UTI - an infection caused by bacteria in any part of the urinary system). Further review of Resident 59's clinical record revealed the Resident was hospitalized [DATE], through February 4, 2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 59's hospital discharge summary dated February 4, 2024, revealed Resident 59 was ordered an antibiotic for a UTI, had a hemodialysis catheter inserted, was started on renal dialysis, and was ordered continue outpatient dialysis. Review of Resident 59's physician orders revealed an order for outpatient hemodialysis on Tuesday, Thursday, and Saturday. Further review of Resident 59's physician orders revealed an order for doxycycline monohydrate (antibiotic medication), with a start date of February 9, 2024, and an end date of February 19, 2024. Review of Resident 59's comprehensive care plan revealed the facility failed to update Resident 59's comprehensive care plan post-hospitalization to include a focus area for hemodialysis. Further review of Resident 59's comprehensive care plan revealed the facility failed to resolve the focus area for the UTI with an intervention for administer antibiotics as ordered. During a staff interview on April 9, 2024, at 2:12 PM, with the NHA and DON, the aforementioned care plan concerns were addressed and additional information was requested. During an additional staff interview on April 10, 2024, at 9:10 AM, with the NHA and DON, it was revealed Resident 59's care plan had been updated to include a focus area for dialysis with interventions for the dialysis center and access site monitoring, and the focus area for UTI had been resolved. The DON stated it was the facility's expectation that care plan revisions be made timely. Review of Resident 77's clinical record revealed diagnoses that included vascular dementia (brain damage caused by multiple strokes which causes memory loss in older adults), delusional disorder (type of psychotic disorder; a delusion is an unshakable belief in something that is untrue), and depression. Observation of Resident 77 on April 8, 2024, at 10:42 AM, revealed that their hair was combed, down, and appeared oily. The Resident also had visible presence of facial hair noted on their chin. Observation of Resident 77 on April 9, 2024, at 10:10 AM, revealed that their hair was combed, up in pony tail, and appeared oily. The Resident also still had visible presence of facial hair noted on their chin. Review of Resident 77's care plan revealed a problem for resident is limited in ability to maintain grooming/personal hygiene R/T [related to] dementia and resident is limited in ability to bathe self R/T dementia. Interventions included, but were not limited to, provide assistance for grooming hair and assist for daily bathing and weekly showers. Review of Resident 77's activities of daily living (ADLs) documentation for April 2024, revealed the Resident had a complete bed bath on April 6, 7, and 8, 2024. During an interview with the NHA and DON on April 9, 2024, at 2:00 PM, the observations of Resident 77 were shared as well as the ADL documentation for further follow-up. Observation of Resident 77 on April 10, 2024, at 10:28 AM, revealed that their appeared clean and no facial hair was noted on their chin. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up interview with the NHA and DON on April 10, 2024, at 11:00 AM, the NHA indicated that Resident 77's family came in last evening and provided hair care and shaving. She further indicated that staff shared that Resident 77 can be resistive to care and are particular about who provides their care. It was discussed during this interview that this information was not reflected on Resident 77's care plan. The NHA confirmed that Resident 77's care plan should have included this information. Review of Resident 81's clinical record revealed diagnoses that included pressure ulcer of sacral region (wounds that occur from prolonged pressure on the skin), sepsis (an infection of the blood stream), and chronic kidney disease (CKD - a condition characterized by a gradual loss of kidney function). Review of Resident 81's clinical record revealed physician orders for a urinary foley catheter (a medical device that can be inserted in the body) related to her pressure ulcer, with a start date of March 12, 2024. Review of Resident 81's care plan on April 9, 2024, at approximately 9:00 AM, failed to reveal notation of a urinary foley catheter. During an interview with the DON on April 9, 2024, at 1:42 PM, the surveyor revealed the concern that Resident 81's care plan failed to reveal notation of a urinary foley catheter. Review of Resident 81's care plan on April 10, 2024, at approximately 9:00 AM, revealed she had a care plan focus area for her indwelling urinary catheter, with a start date of April 9, 2024. Follow-up interview with the NHA on April 10, 2024, at 1:58 PM, revealed she would expect Resident 81's care plan to be updated to reflect she has a urinary catheter. Review of Resident 97's clinical record on April 10, 2024, at 10:55 AM, revealed diagnoses that included bacteremia (bacteria in the bloodstream) and Methicillin -Sensitive Staphylococcus Aureus (MSSA - a type of bacterial infection). Further review of Resident 97's clinical record revealed Resident 97 was hospitalized [DATE], through March 16, 2024, for MSSA bacteremia due to an infected toe wound. Review of Resident 97's hospital discharge summary dated March 16, 2024, revealed Resident 97 had PICC line (peripherally inserted central catheter; a type of long catheter that is inserted through a peripheral vein in the arm, into a larger vein in the body) placed while hospitalized for long term antibiotic treatment and was ordered Cefazolin two grams every eight hours. Review of Resident 97's physician orders revealed orders for intravenous cefazolin (antibiotic medication) two grams every eight hours and intravenous therapy flush with normal saline 10 milliliters before and after each medication. Review of Resident 97's comprehensive care plan revealed the facility failed to update the comprehensive care plan post hospitalization to include Resident 97's PICC line and antibiotic use. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a staff interview April 10, 2024, at 2:05 PM, the NHA and DON were notified of the aforementioned comprehensive care plan concerns. The DON stated it was the facility's expectation that care plan revisions be made timely. 42 CFR 483.21(b) Comprehensive Care Plans 28 Pa. Code 211.11(d)(e) Resident care plan 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 - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49123 Based on observations, policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards for one of 29 residents reviewed (Resident 97). Findings include: Review of facility policy, titled Central Vascular Access Device (CVAD) Dressing Change, with a revision date of June 01, 2021, read, in part, Consideration: 1. Central vascular access devices (CVADs) include: 1.1 Peripherally inserted central catheter (PICC) . Guidance: 1. Perform sterile dressing changes using Standard- ANTT: 1.2 At least weekly, 1.3 If the integrity of the dressing has been compromised (wet, loose, soiled) . 7. Assessment of the vascular access site is performed: 7.3 Before and after administration of intermittent infusion . 24. Documentation in the medical record includes but is not limited to: 24.1 Date and time, 24.2 Site assessment, 24.3 Length of external catheter, 24.4. Arm circumference, 24.5 Reason for dressing change. Review of Resident 97's clinical record on April 10, 2024, at 10:55 AM, revealed diagnoses that included bacteremia (bacteria in the bloodstream) and Meticillin -Sensitive Staphylococcus Aureus (MSSA - a type of bacterial infection). Further review of Resident 97's clinical record revealed Resident 97 was hospitalized [DATE], through March 16, 2024, for MSSA bacteremia due to an infected toe wound. Review of Resident 97's hospital discharge summary dated March 16, 2024, revealed that Resident 97 had a PICC line (peripherally inserted central catheter; a type of long catheter that is inserted through a peripheral vein in the arm, into a larger vein in the body) placed while hospitalized for long term antibiotic treatment and was ordered Cefazolin 2 grams every eight hours. Review of Resident 97's physician orders revealed orders for intravenous cefazolin (antibiotic medication) 2 grams every eight hours, and intravenous therapy flush with normal saline 10 milliliters before and after each medication. Further review of Resident 97's physician orders failed to revealed orders for PICC line dressing changes and site monitoring. Review of Resident 97's progress notes and medication administration record failed to reveal documentation that Resident 97's PICC line dressing was being changed weekly and that assessment of the access site was being documented. During a staff interview on April 10, 2024, at 2:05 PM, with the Nursing Home Administrator (NHA) and Director of Nursing (DON), additional information regarding Resident 97's PICC line dressing changes and site assessment documentation were requested. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an additional interview on April 11, 2024, at 12:30 PM, with the NHA and DON, it was revealed that no additional information was available, and physician orders had been added for weekly PICC line dressing changes and PICC line site assessments. The DON stated it was the expectation of the facility that PICC line dressing changes be done and documented weekly and as needed, and access site assessments be completed and documented. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 47966 Based on clinical record review and staff interview, it was determined the facility failed to develop a discharge summary to anticipate resident needs for one of three residents reviewed (Resident 132). Findings Include: Review of Resident 132's clinical record revealed diagnoses that included hypertension (high blood pressure) and Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination). Continued review of Resident 132's clinical record revealed he was discharged home with his daughter on February 10, 2024. Continued review of Resident 132's clinical record revealed no documentation of staff documenting a recapitulation of the Resident's stay, a final summary of the Resident's status, a reconciliation of all pre-discharge medications with the Resident's post-discharge medications, a post-discharge plan of care developed with Resident participation to assist Resident 132 to adjust to his living environment, or documentation of arrangements to be made for his follow-up care and post-discharge medical and non-medical services. During an interview with the Nursing Home Administrator and Director of Nursing on April 11, 2024, at 12:30 PM, revealed an expectation of a discharge summary to have been completed for Resident 132 to include the information aforementioned above. 28 Pa. Code 201.25 Discharge policy 28 Pa. Code 211.5(d)(f) Clinical records

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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 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. 37817 Based on clinical record review, observations, and resident and staff interviews, it was determined that the facility failed to implement resident-directed care and treatment consistent with the resident's physician orders and care plan for two of 26 residents reviewed (Residents 41 and 92). Findings include: Review of Resident 41's clinical record revealed diagnoses that included Pneumonia (An infection of the air sacs in one or both the lungs. Characterized by severe cough with phlegm, fever, chills and difficulty in breathing), asthma (a long-term inflammatory disease of the airways of the lungs), and vitamin D deficiency. Review of Resident 41's physician orders revealed an order for an antibiotic amoxicillin-pot clavulanate tablet; 875-125 mg; Amount to Administer: 1 tablet; oral, with a start date of March 13, 2024, and a completed date of March 22, 2024. Further review of Resident 41's physician orders revealed an order for a prednisone tablet once a day by mouth every morning for seven days, with a start date of March 22, 2024, and a completed date of March 28, 2024. Review of Resident 41's clinical record revealed a progress note written by Employee 10 (Registered Nurse) on March 22, 2024, that stated new orders from Employee 9 (Certified Registered Nurse Practitioner) for repeat lab work, orders to extend her antibiotic treatment for three days, and add prednisone medication for seven days. Review of Resident 41's March 2024 MAR (Medication Administration Record- documentation for treatments/medication administered or monitored), failed to reveal the antibiotic treatment was extended after March 22, 2024, and that the prednisone was only given for six days, from March 23, 2024, to March 28, 2024. During an interview with the Director of Nursing (DON) on April 10, 2024, at 1:52 PM, she revealed the prednisone was only given for six days due to a transcription error when the order was entered, it should have been ordered for seven days, but since the order didn't start until March 23, 2024, it was only completed for six days. Documentation provided to the surveyor on April 11, 2024, at 8:45 AM, revealed a lab report with handwritten orders from Employee 9 to extend Resident 41's antibiotic treatment for three days, signed on March 22, 2024, it was also signed by Employee 10 on March 22, 2024. During a follow-up interview with the DON on April 11, 2024, at 12:34 PM, she revealed she reached out to Employee 9, and she confirmed she gave the verbal and written order to Employee 10 on March 22, 2024, the DON further revealed she would expect physician orders to be followed and transcribed as written. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 92's clinical record documented diagnoses that included hemiplegia and hemiparesis (paralysis of one side of the body) following cerebral infarction (stroke) affecting left non-dominant side and contracture (shortening and hardening of muscles, tendons, or other tissue) left elbow. Review of Resident 92's Physician orders included left resting hand splint on in AM and off at bedtime, as Resident allows/tolerates. Remove for care and check skin integrity every shift; twice a day 7:00 AM - 3:00 PM, 3:00 PM - 11:00 PM, start date June 25, 2023. Observation April 8, 2024, at 11:48 AM, Resident 92's left wrist was contracted in a downward position. It was also observed that there was a light blue wrist splint on a chair against the wall, out of Resident's reach. During an interview with Resident 92 on April 8, 2024, at 11:48 AM, it was revealed that he does wear the wrist splint at times. Observation April 9, 2024, at 10:40 AM, Resident 92 was dressed, lying without the left hand splint on. The splint was observed to be out of Resident's reach on the dresser. Observation April 10, 2024, at 12:03 PM, Resident 92 was dressed, lying without the left hand splint on. The splint was observed to be out of Resident's reach on the dresser. During an interview on April 10, 2024, at 12:13 PM with Employee 3 (Licensed Practical Nurse), Employee 4 (Licensed Practical Nurse), and Employee 5 (Nursing Assistant), it was revealed that, at times, Resident 92 refuses to wear the left hand splint. It was also confirmed that Resident 92 wasn't able to self-ambulate or transfer from bed. Review of Resident 92's care plan included a focus area for activities of daily living, functional status limited in ability to dress/undress self-related to stroke and muscle weakness, edited February 28, 2023. Interventions included left resting hand splint on in AM off in PM, check skin integrity every shift, created September 22, 2023. Further review of resident care plan failed to document refusal for care, restorative nursing program, or splinting program. Review of Resident 92's care plan on April 11, 2024, at 9:18 AM, documented the focus area for behavioral symptoms was edited on April 10, 2024, to include refused to wear resting hand splint in the AM; and the approach for the focus area for activities of daily living functional status was edited on April 10, 2024, to include Resident occasionally refuses to have splint applied. On April 10, 2024, at 12:39 PM, review of restorative nursing program log for April 8th through 10th, 2024, documented unanswered for day shift. On April 10, 2024, at 12:57 PM, review of Medication Administration Record documented for April 8th and 9th, 2024, the left resting hand splint check skin integrity every shift on. During an interview with the DON on April 10, 2024, at 2:00 PM, it was revealed that the restorative nursing program log should be completed and documented as a refusal if the Resident refused to have the splint applied. It was also revealed that the care plan should've reflect if the Resident refuses use of the splint. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 46253 Based on facility policy review, observations, clinical record reviews, and resident and staff interviews, it was determined that the facility failed to provide respiratory care/oxygen services consistent with professional standards of practice for four of four residents reviewed for respiratory care/oxygen services (Residents 7, 34, 41, and 45). Findings include: Review of Resident 7's clinical record revealed diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and hypertension (high blood pressure). Review of Resident 7's physician orders revealed an order to administer oxygen 2 LPM (liters per minute) via nasal cannula PRN (as needed) for shortness of breath, every shift, with a start date of March 26, 2024. Further review of Resident 7's physician orders also revealed an order to clean oxygen concentrator and filter, change tubing weekly on Sunday, with a start date of March 26, 2024. Further review of Resident 7's physician orders revealed an order for CPAP unit at bedtime as needed for obstructive sleep apnea, with a start date of March 26, 2024. Observations of Resident 7's room on April 8, 2024, at 10:05 AM, revealed that they had an oxygen concentrator dated March 31, 2024, and their oxygen tubing was laying on their nightstand, not bagged or dated. Further observation of Resident 7's room on April 8, 2024, at 10:05 AM, revealed a CPAP (continuous positive airway pressure) mask on their nightstand, not bagged or dated. Observation of Resident 7's room on April 9, 2024, at 11:07 AM, revealed their oxygen tubing was bagged and dated April 7, 2024, and their CPAP mask was bagged and dated April 8, 2024. During an interview with the Nursing Home Administrator (NHA) on April 9, 2024, at 1:49 PM, they revealed they would have expected Resident 7's oxygen tubing to have been bagged and dated, as well as their CPAP mask to have been bagged and dated. Review of facility policy, titled Nebulizer Administration Policy, with a last revision date of August 10, 2023, revealed 15. Empty nebulizer cup, rinse with sterile water/sterile saline and air dry. Wipe mask with alcohol wipe and store the neb set in a plastic bag labeled with the patient's name when dried. A nebulizer is a machine used to change medication from a liquid to a mist, allowing it to be inhaled into the lungs. Review of Resident 34's clinical record revealed diagnoses that included chronic obstructive pulmonary disease (COPD - a type of progressive lung disease characterized by long term respiratory symptoms and airflow limitations) and chronic diastolic congestive heart failure (heart failure that occurs when the heart does not relax properly between beats, causing the heart to be unable to pump an adequate amount of blood to the body). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations of Resident 34's room on April 8, 2024, at 10:49 AM and at 1:04 PM, revealed that the Resident had a nebulizer machine with the tubing and mask attached laying out on a metal tray/lid on a nightstand. The mask was not bagged or dated, nor was the tubing dated. Review of Resident 34's physician orders revealed an order for albuterol sulfate solution for nebulization; 2.5 milligrams (mg)/ 3 milliliters (ml) 0.083 % give one vial (3ml) every six hours for shortness of breath or wheezing, with an original ordered date of August 24, 2023. Review of Resident 34's April 2024 Medication Administration Record revealed that the Resident last received a dose of their nebulizer medication on April 1, 2024. During an interview with the NHA and Director of Nursing (DON) on April 9, 2024, at 1:45 PM, the aforementioned observations were shared for further follow-up. The DON indicated that the tubing should be dated and that the mask should be bagged when not in use. A follow-up observation of Resident 34's room on April 10, 2024, at 10:31 AM, revealed that the nebulizer machine and mask had been removed from their room. During a follow-up interview with the NHA and DON on April 10, 2024, at 1:42 PM, the DON confirmed that the mask should have been bagged and the tubing should have been dated. Review of Resident 41's clinical record revealed diagnoses that included Pneumonia (An infection of the air sacs in one or both the lungs. Characterized by severe cough with phlegm, fever, chills and difficulty in breathing), asthma (a long-term inflammatory disease of the airways of the lungs), and vitamin D deficiency. Review of Resident 41's physician orders revealed an order for ipratropium-albuterol solution for nebulization; 0.5 mg-3 mg(2.5 mg base)/3 mL; amt: 3 ml; Inhalation Special Instructions: inhale 1 unit dose via nebulizer three times a day for wheezing shortness of breath Three Times A Day, with a start date of July 1, 2023. Further review of Resident 41's physician orders failed to reveal orders for changing her nebulizer mask. Observation in Resident's room on April 8, 2024, at 10:26 AM, revealed her nebulizer mask was laying on a small dresser in her room, it was dated March 23, 2024, and the table was dirty with crumbs. Observation in Resident's room on April 8, 2024, at 1:49 PM, revealed her nebulizer mask was laying on a small dresser in her room, it was dated March 23, 2024, and the table was dirty with crumbs. Interview with Resident 41 on April 8, 2024, at 1:50 PM, revealed that she gets her breathing treatments through the mask, and she had just had one after lunch. Observation in Resident's room on April 9, 2024, at 10:15 AM, revealed her nebulizer mask was laying on a small dresser in her room, and it was dated March 23, 2024. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON on April 9, 2024, at 1:40 PM, the surveyor brought to her attention the observations of the mask on the dresser. The surveyor questioned how staff would know when to change the mask and how the mask should be stored. The DON revealed the masks should be changed weekly, the Resident should have an order for changing the masks weekly, and the masks should be cleansed and stored in a bag after each use. During a follow-up interview with the DON on April 10, 2024, at 1:44 PM, the surveyor revealed the concern with the observations of the nebulizer mask laying out on a dirty table and not changed within one week. The DON revealed she would expect the mask to be cleaned and stored per facility policy and changed weekly. Review of Resident 45's clinical record revealed diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and COPD. Observation of Resident 45's room on April 8, 2024, at 9:53 AM, revealed their nebulizer sitting on their nightstand, with the tubing not bagged or dated. Review of Resident 45's physician orders revealed an order for ipratropium-albuterol solution for nebulization; 0.5 milligrams - 3 milligrams per 3 milliliters' inhalation, with special instructions to include: inhale 3 milliliters via nebulizer three times a day related to shortness of breath, with a start date of February 5, 2024. Observation of Resident 45's room on April 9, 2024, at 12:31 PM, revealed their nebulizer mask was bagged, and dated April 8, 2024. During an interview with the NHA on April 9, 2024, at 1:49 PM, revealed an expectation for the nebulizer mask to have been bagged and dated while not in use. 28 Pa code 211.12(d)(1)(2) Nursing Services

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49123 Based on review of facility policy, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure that residents who require dialysis receive such services consistent with professional standards of practice for one of one resident reviewed for dialysis (Resident 59). Findings include: Review of facility policy, titled Central Vascular Access Device (CVAD) Dressing Change, with a revision date of June 01, 2021, read, in part, Consideration: 1. Central vascular access devices (CVADs) include: 1.3 Tunneled catheters . 7. Assessment of the vascular access site is performed: 7.4 At least once every shift when not in use. Review of Resident 59's clinical record on April 9, 2024, at 12:03 PM, revealed diagnoses that included end stage renal disease (condition in which kidneys cease functioning) and dependence on renal dialysis (treatment that removes extra fluid and waste products from the blood when the kidneys are not able to). During an interview with Resident 59 on April 8, 2024, at 9:48 AM, Resident 59 revealed he was currently receiving dialysis services on Tuesdays and Saturdays. Resident 59 reported he had previously been receiving dialysis on Tuesdays, Thursday, and Saturdays, but it had changed a few weeks ago due to his condition improving. Further review of Resident 59's clinical record revealed Resident 59 was hospitalized [DATE], through February 4, 2024. Review of Resident 59's hospital discharge summary dated February 4, 2024, revealed Resident 59 had a hemodialysis tunneled catheter inserted, was started on renal dialysis, and was ordered continue outpatient dialysis. Review of Resident 59's physician orders revealed an order for outpatient hemodialysis on Tuesday, Thursday, and Saturday, with a start date of February 5, 2024, and an order for document post-dialysis weight once a day on Tuesday, Thursday, and Saturday, with a start date of February 7, 204. Further review of Resident 59's physician orders failed to reveal orders for dialysis access site monitoring. Review of Resident 59's progress notes and medication administration record failed to reveal documentation that Resident 59's hemodialysis tunneled catheter was being assessed at least once every shift. Review of a physician progress note dated March 22, 2024, read, in part, .dialysis is going well and he is now down to going on Tuesdays and Saturdays. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a staff interview on April 9, 2024, at 2:12 PM, with the Nursing Home Administrator (NHA) and Director of Nursing (DON), additional information was requested regarding documentation of dialysis access site monitoring and the accuracy of Resident 59's physician orders for dialysis and post-dialysis weights. During an additional staff interview on April 10, 2024, at 2:05 PM, with NHA and DON it was revealed that Resident 59's physician orders had been updated to include dialysis access site monitoring every shift, to accurately reflect Resident 59's dialysis on Tuesday and Saturday, and document post-dialysis weight Tuesday and Saturday. The DON stated it was the expectation of the facility that physician orders would be updated and accurate, and that orders would be in place to monitor dialysis access sites. 28 Pa Code 211.5(f) Clinical records 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48484 Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for one of 26 resident's reviewed (Resident 87). Findings include: Review of facility policy, titled Social Services Policy, last revised March 1, 2024, read, in part, The facility provides social services to assure that each resident can attain or maintain his/her highest practicable physical, mental, and/or psychosocial well-being .[Social services is] responsible for assessing and ensuring residents who are trauma survivors receive culturally competent, trauma-informed care/approaches. Including: Psychiatric referrals as needed, identifying triggers and implementing approaches/interventions to help reduce risk of re-traumatization, considering resident's experiences and cultural preferences, values and practices. Review of Resident 87's clinical record revealed she was admitted to the facility on [DATE], with diagnoses that included Post-Traumatic Stress Disorder (PTSD - a mental and behavioral disorder that develops from experiencing a traumatic event, such as sexual assault, warfare, traffic collisions, child abuse, domestic violence, or other threats on a person's life or well-being), anxiety (a feeling of worry, nervousness, or unease), and bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). Review of Resident 87's clinical record revealed a hospital referral signed by a medical doctor on July 26, 2023, noting a past medical history of PTSD related to a prior intentional medication overdose, that she was hospitalized three weeks prior for an overdose, she was seen by psychology and neurology, and the Resident denied intentional harm to herself prior to being discharged . Review of Resident 87's clinical record revealed a PsychoGeriatric Services Evaluation dated July 28, 2023, noting her PTSD diagnosis and plan for psychology services to continue to follow with her. Review of Resident 87's care plan revealed categories for pain and psychotropic drug use (drugs that affect the brain chemicals involved in mental health disorders) related to a diagnosis of PTSD, but failed to reveal a comprehensive care plan for the PTSD that indicates the source of her PTSD or any known triggers or current interventions. Review of Resident 87's clinical record revealed a Psychotherapy Progress Note on August 4, 2023, that read, in part, [Resident 87] was referred to psychological services to address concerns related to her mood (history of bipolar, PTSD, anxiety) .Chart review indicates she was admitted to theER on [DATE] after she was found unconscious in her home .records indicate prior intentional overdose with her most recent overdose attempt hospital admission being June 2023. Further review of the Psychotherapy Progress Note on August 4, 2023, revealed the Resident had experienced other past trauma. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 87's clinical record revealed Psychotherapy Progress Notes on August 17, 2023, and September 8 and 28, 2023; all noting Resident 87's diagnosis of PTSD. Further review of Resident 87's Psychotherapy Progress Notes on September 28, 2023; revealed [Resident 87] is interested in continued psychotherapy appointments in the future and will schedule appointments once they are made available to her. Terminated sessions with [Resident 87]. During an interview with Employee 1 (Social Services Director) on April 9, 2024, at 12:03 PM, the surveyor inquired if she could provide information related to Resident 87 having a diagnosis of PTSD, in which Employee 1 replied no. During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on April 9, 2024, at 1:44 PM, the surveyor inquired about Resident 87's diagnosis of PTSD, such as the source of the PTSD and any known triggers or current interventions. Follow-up interview with the NHA and DON on April 10, 2024, the surveyor again inquired about Resident 87's diagnosis of PTSD and the lack of a comprehensive care plan that identifies the source of the PTSD and any known triggers or current interventions. The DON replied that she is aware that Resident 87 overdosed on medications prior to admission. The surveyor inquired as to why psychotherapy services were terminated on September 28, 2023, and the DON revealed that it was because that psychotherapy group was no longer providing services to the facility after that date. During an interview with the NHA on April 11, 2024, at 12:36 PM, she revealed they are actively looking for other psychotherapy services to take over, and their Social Services Director has graduate level education with qualifications to implement other interventions until they get those services in place. 28 Pa Code 201.18 Management (b)(1)(3) 28 Pa Code 211.12 (c)(d)(3)(5) Nursing services

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 46253 Based on review of facility policy, employee files review, and staff interviews, it was determined that the facility failed to ensure that nursing staff with the appropriate competencies and skills sets to provide nursing and related services was provided to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for three of three nursing staff reviewed (Employees 6, 12, and 13). Findings include: Review of facility policy, titled Nursing Staff Orientation Process, last revised July 14, 2021, revealed, in part, Licensed nurses and certified nursing assistants will receive general orientation and complete skills and competency checklists prior to assuming an independent assignment. 1a. Certified nursing assistants will receive 1-3 days of general orientation (including skills and competencies checklist. 1b. Licensed nurses will receive 1-5 days of general orientation (including skills and competencies checklist). 3. Certified nursing assistants will receive a minimum of 2-3 days orientation on the floor/unit before being permitted to accept an independent assignment. 4. Licensed nurses will receive a minimum 3-4 orientation on the floor/unit before being permitted to accept an independent assignment. 5. Licensed nurse and certified nursing assistant orientation and skills and competency checklist will be completed by approved mentor/ trainer and staff member by the end of the last floor orientation day and turned into the Director of Nursing or designee to review for completeness. The checklist will then be placed in the new employee's file. Review of Employee 6's (Registered Nurse) employee file revealed that they were hired and completed general orientation on January 15, 2024. Further review of Employee 6's employee file failed to reveal a completed skills and competencies checklist. Review of Employee 12's (Nurse Aide) employee file revealed that they were hired and completed general orientation on December 11, 2023. Further review of Employee 12's employee file failed to reveal a completed skills and competencies checklist. Review of Employee 13's (Licensed Practical Nurse) employee file revealed that they were hired on March 19, 2024, and that they attended general orientation on March 16, 2023. Further review of Employee 13's employee file failed to reveal a completed skills and competencies checklist. During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on April 11, 2024, at 12:23 PM, the concern was shared that that the skills and competencies checklists were not located in Employees 6, 12, or 13's employee files. She indicated that they were still looking for these items. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a final interview with the NHA and DON on April 11, 2024, at 1:15 PM, the NHA confirmed that they had not been able to locate the skills and competencies checklists for the employees above. She confirmed that they should be located in each employee's file. In an email communication received from the NHA on April 12, 2024, at 12:53 PM, she confirmed that they had no additional information to offer. 28Pa. Code 201.19(6)(7) Personnel policies and procedures 28 Pa. Code 201.20(a) Staff development 28 Pa. Code 211.12(c)(d)(1)(2)(3)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395395	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River's Bend Health & Rehab Center	800 King Russ Road Harrisburg, PA 17109

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47966 Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation of medications for two of three closed records reviewed (Residents 132 and 133). Findings include: Review of facility policy, titled Disposal/Destruction of Expired or Discontinued Medications, dated 2023, read, in part, Facility should destroy non-controlled medications in the presence of a registered nurse and witnessed by one other staff member, in accordance with facility policy or applicable law. Facility should enter the following information on a drug destruction form when medications are destroyed: Residents name, name and strength of medication, prescription number, amount of medication, date of destruction, signature of staff destroying medications, signature of witnesses, and method of disposition, including donation as permitted by applicable law. Review of Resident 132's clinical record revealed diagnoses that included hypertension (high blood pressure) and Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination). Continued review of Resident 132's clinical record revealed he was discharged home with his daughter on February 10, 2024. Continued review of Resident 132's clinical record revealed no indication of a drug disposition form or any indication of a reconciliation of all pre-discharge medications with the Resident's post-discharge medication being completed upon his discharge. During an interview with the Nursing Home Administrator and Director of Nursing (DON) on [DATE], at 12:30 PM, revealed an expectation of a drug disposition form to have been completed for Resident 132 upon discharge. Review of Resident 133's clinical record revealed diagnoses that included Hypothyroidism (a condition where the thyroid gland doesn't make enough thyroid hormone), glaucoma (a group of eye conditions that damage the optic nerve), and dementia (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders, personality changes, and impaired reasoning). Continued review of Resident 133's clinical record revealed she passed away at the facility on [DATE]. Review of Resident 133's physician orders revealed an order for latanoprost drops; 0.005 %; amt: one drop; ophthalmic (eye) Special Instructions: Administer one drop into both eyes at bedtime related to glaucoma, discontinued on [DATE], that should have been recorded on the drug disposition form. Further review of Resident 133's physician orders revealed an order for levothyroxine tablet; 75 mcg; amt: 75 mcg; oral Special Instructions: for Hypothyroidism, Once A Day, discontinued on [DATE], that should have been recorded on the drug disposition form. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on [DATE], at 10:52 AM, revealed the eye drops and levothyroxine medication should have been recorded on the drug disposition form. Follow-up interview with the DON on [DATE], at 12:37 PM, revealed she would expect the two aforementioned medications to be recorded on Resident 133's drug disposition form. 28 Pa Code 211.12 (c)(d)(1)(5) Nursing services 28 Pa Code 211.19 (j.1)(3)(4)(5) Pharmacy 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. 46253 Based on observations, facility policy review, and staff interviews, it was determined that the facility failed to discard expired medications in one of three medication carts (Cart A); and failed to properly label drugs in one of two medication rooms observed (Station 1). Findings Include: Review of facility policy, titled 5.3 Storage and Expiration Dating of Medications, Biologicals, with a last revised date of August 7, 2023, revealed, in part, 4. Facility should ensure that medications and biologicals that:(1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier; 5) Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to the expiration dates for opened medications. Facility should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened; .5.3 If a multi-dose vial of an injectable medication has been opened or accessed (e.g. needle punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. Review of Omnicare Pharmacy Storage Recommendations for Injectable Diabetes Medications, dated 2023, provided by the facility as their guidelines to follow, revealed: Levemir insulin pen, when opened and stored at room temperature between 59 degrees to 86 degrees Fahrenheit, may be used for 42 days. Observation on Medication Cart A on April 10, 2024, at 8:44 AM, with Employee 11, revealed a Levemir insulin pen that was dated as being opened on February 14, 2024, and a house stock bottle of aspirin that had an opened date recorded of March 1, 2024; but there was no manufacturer expiration date indicated on the bottle. Employee 11 confirmed that the Levemir insulin pen was dated as being opened on February 14, 2024, and that it should have been discarded on March 28, 2024. They also confirmed that the aspirin bottle had no expiration date. Observation of Station 1 Medication Room on April 10, 2024, at 12:10 PM, with Employee 11, revealed two opened bottles of tuberculin 5tu/0.1 ml (milliliters) testing solution that were opened and were not dated with an open date. Employee 11 confirmed that neither vial was dated with an opened date, and indicated that they would discard them. During an interview with the Director of Nursing (DON) on April 10, 2024, at 12:20 PM, the aforementioned concerns were shared. The DON confirmed that the insulin pen was past its expiration date and that the aspirin bottle had no manufacturer expiration date. She indicated that both had been discarded. She further indicated that the aspirin was a bottle that the facility had obtained from a local pharmacy while they were waiting for the medication to be delivered from their medical supplier of over the counter medications. She further confirmed that the tuberculin testing solution should have been dated when opened, and that both vials had been discarded. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(a)(1) Pharmacy 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. 37817 Based on policy review, observations, and staff interviews, it was determined that the facility failed to store and serve food/beverages in accordance with professional standards for food safety for one walk-in refrigerator in the kitchen and one of three nourishment pantries on the nursing units. Findings include: Review of facility policy, Frozen Food Storage, revision date March 9, 2024, read, in part, date pulled from the freezer will be marked on the food item when placed in the refrigerator to thaw. Review of the facility's Use By Guide- Quick Reference, not dated, read, in part, thickened juices must be used within 10 days of opening, thicken milk within three days, and thawed nutritional shakes within 14 days of thawing. Observation in the walk-in refrigerator on April 8, 2024, at 9:30 AM, revealed the following nutritional shakes were thawed and not date marked when pulled from the freezer: 3/4 of a case vanilla shakes, 1/4 of a case orange cream shakes, and 1/4 of a case chocolate shakes. The aforementioned products were good for 14 days once thawed. During an interview with Employee 7 (Food Service Director) on April 8, 2024, at 9:30 AM, it was revealed that when items are pulled from the freezer, they should be date marked. Observation on April 8, 2024, at 9:57 AM, in the second floor nourishment pantry, revealed there were three chocolate nutritional shakes and one vanilla nutritional shake that were thawed and not date marked when pulled from the freezer or marked with a use by date. There was also one container of honey thickened orange juice and once container of nectar thickened milk that was open, with contents partially removed, and not date marked when opened or with a use by date. During an interview with Employee 7 on April 8, 2024, at 10:00 AM, it was revealed that items should be date marked when pulled from the freezer and when opened. During an interview with the Nursing Home Administrator on April 11, 2024, at 12:30 PM, it was revealed that food storage policies should be followed, and that items should be date marked when pulled from the freezer and when beverages are opened. 28 Pa code 211.6(f) - Dietary Services