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	03/27/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and 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 obtain information from previous employers and/or current employers for five of five employee files reviewed (Employees 2, 3, 4, 5, and 6). Findings include: Review of facility policy, titled Pennsylvania Resident Abuse, with a last review date of April 9, 2024, revealed that the The facility will do the following prior to hiring a new employee: generally, attempt to obtain references from 2 prior employers for an applicant. Review of personnel file of Employee 2 revealed that the Employee was hired on January 2, 2025. Further review of their personnel filed failed to reveal any reference checks from previous and/or current employers. Review of personnel file of Employee 3 revealed that the Employee was hired on December 23, 2024. Further review of their personnel filed failed to reveal any reference checks from previous and/or current employers. Review of personnel file of Employee 4 revealed that the Employee was hired on January 15, 2025. Further review of their personnel filed failed to reveal any reference checks from previous and/or current employers. Review of personnel file of Employee 5 revealed that the Employee was hired on January 15, 2025. Further review of their personnel filed failed to reveal any reference checks from previous and/or current employers. Review of personnel file of Employee 6 revealed that the Employee was hired on November 25, 2024. Further review of their personnel filed failed to reveal any reference checks from previous and/or current employers. During a staff interview with Employee 1 (Regional [NAME] President of Operations) on March 27, 2025, at 9:00 AM, she indicated that the facility had no documentation of reference checks to provide for Employees 2, 3, 4, 5, and 6. (continued on next page)

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

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing on March 27, 2025, at 10:36 AM, the NHA confirmed that he would expect reference checks to be attempted and/or completed during the hiring process. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (b)(1)(e)(1) Management 28 Pa. Code 201.29 (a) Resident rights 28 Pa. Code 211.10(d) Resident care policies

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33879 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 30 residents reviewed (Residents 85 and 125). Findings Include: Review of Resident 85's clinical record revealed diagnoses that included dysphagia (difficulty swallowing), gastro-esophageal reflux disease (when stomach acid backs up into your esophagus, the tube connecting your stomach to your mouth), and hypertension (high blood pressure). Review of Resident 85's clinical record revealed she had a weight measure of 202.8 pounds on October 7, 2024, that reflected a significant weight loss from the previous weight measure. Review of Resident 85's Quarterly MDS (Minimum Data Set- assessment tool utilized to identify residents' physical, mental and psychosocial needs) with ARD (assessment reference date- last day of the assessment period) of October 7, 2024, revealed Section K - Swallowing/Nutrition Status, did not reflect her most current weight that was obtained on October 7, 2025, and did not reflect her significant weight loss. Review of Resident 85's clinical record revealed a physician assessment note dated November 14, 2024, stating, PCM (protein calorie malnutrition- an imbalance between the nutrients the body needs to function and the nutrients it gets) refusing to eat. Review of Resident 85's Quarterly MDS with ARD of November 15, 2024, revealed under Section I: Active Diagnoses, subsection I5600. Malnutrition (protein or calorie) or at risk for malnutrition, it was not marked to reflect that Resident 85 had a diagnosis of PCM. During an interview with the Nursing Home Administrator (NHA) on March 27, 2025, at 11:01 AM, he revealed the MDS assessments had been corrected, and he would expect MDS assessments to be coded accurately. Review of Resident 125's clinical record revealed diagnoses that included congestive heart failure (disease process of the heart that results in decreased ability of the heart to effectively pump blood through out the body) and dementia (irreversible, progressive degenerative brain disease that results in decreased contact with reality and decreased ability to perform activities of daily living). Review of Resident 125's clinical record revealed that Resident 125 was admitted to the facility on [DATE]. Review of Resident 125's weight assessments revealed the following: On August 16, 2025 Resident 125 weighed 165.2 pounds. On October 3, 2024, Resident 125 weighed 151.6 pounds. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On November 5, 2024, Resident 125 weighted 143.6 pounds. The weight of 143.6 pounds on November 5, 2024, indicated that Resident 125 had weight loss of 13% since admission, and 5.2% since October 3, 2024. Review of Resident 125's Quarterly MDS with ARD of November 6, 2024, revealed that Section K - Swallowing/Nutrition Status, subsection K0300 - Weight Loss (loss of 5% or more in the last month or loss of 10% or more in the last six months) was coded as, No or unknown, and did not reflect Resident 125's weight loss accurately. During a staff interview on March 27, 2025, at 11:01 AM, the NHA revealed it was the facility's expectation that resident's Minimum Data Set assessments are coded accurately. 28 Pa. Code 211.5(f) Medical records 28 Pa. Code 211.12(d)(3)(5) Nursing Services

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33879 Based on clinical record review, staff interviews, and facility policy review, it was determined that the facility failed to provide the resident and/or resident representative with a summary of the baseline care plan in a format and location developed by the facility for one of three residents reviewed for care planning (Resident 72). Findings include: Review of facility policy, titled Comprehensive Care Planning Policy, last revised March 20, 2025, revealed the policy's statement was, An interdisciplinary plan of care will be established and updated as indicated for every resident in accordance with state and federal regulatory requirements. The aforementioned policy's Procedures section included, The comprehensive care plan will be developed within seven (7) days after completion of the comprehensive assessment (MDS). The comprehensive care plan will be prepared by an interdisciplinary team that includes but is not limited to: The attending physician; A registered nurse with responsibility for the resident; A nurse aide with responsibility for the resident; A member of the food and nutrition services staff; To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not to be practicable for the development of the resident's care plan; Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident .The presence of all Resident Care Conference staff/attendees, and their relationship to the resident, will be documented. Further, the facility's policy, titled Advance Care Planning Meeting Protocol, last revised October 1, 2024, revealed the procedure for advance care planning meetings included that a representative from social services, nursing (Director of Nursing or Unit Manager) Business Office Manager, and the MDS/Case Manager should meet with the resident and/or resident representative, within a reasonable timeframe, 3-5 days from admission, to discuss pertinent information regarding the patient's wishes . Review of Resident 72's clinical record revealed diagnoses that included general anxiety disorder (excessive worry or fear) and intermittent explosive disorder (mental health disorder characterized by episodes of impulsive, aggressive, or violent behavior). Review of Resident 72's clinical record revealed that Resident 72 was admitted to the facility on [DATE]. Review of Resident 72's clinical record revealed that as of March 26, 2025, no initial care plan meeting was held for Resident 72 to provide the Resident and/or Resident Representative with the baseline or comprehensive plan of care, nor give the Resident and/or Resident Representative the ability to participate in the care planning process with the interdisciplinary team. On March 27, 2025, Employee 1 (Regional [NAME] President of Operations) confirmed that Resident 72 did not have an initial care plan meeting after admission to the facility. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a staff interview on March 27, 2025, Director of Nursing revealed it was the facility's expectation that an initial care plan meeting would be conducted in accordance to the facility's policy. 28 Pa code 211.12(d)(1)(3)(5) Nursing services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46253 Based on facility policy review, observations, clinical record review, as well as resident, resident representative, and staff interviews, it was determined that the facility failed to invite a resident and/or their representative to care plan meetings and failed to have required members of the interdisciplinary team participate in the care plan conference for two of 30 residents reviewed (Residents 14 and 58); and failed to review and revise the resident plan of care for one of 30 residents reviewed (Resident 49). Findings include: Review of facility policy, titled Care Plan Invitation Letter Policy, with a last reviewed date of April 9, 2024, revealed The Executive Director or Administrator will designate a staff member who will be responsible for completing the Care Planning Invitations, for delivering an invitation to the resident prior to the conference date (unless he/she has been legally deemed incompetent), and for mailing an invitation or calling to notify the family/responsible party/representative, within 7 days of the conference date. Review of facility policy, titled Comprehensive Care Planning Policy, with a last reviewed date of April 9, 2024, revealed The care plan is reviewed on an ongoing basis and revised as indicated by the resident's needs, wishes, or a change in condition. At a minimum, this will occur with each comprehensive and quarterly assessment in accordance with the Resident Assessment Instrument (RAI) requirements. The presence of all Resident Care Conference staff/attendees, and their relationship to the resident, will be documented. Review of Resident 14's clinical record revealed diagnoses that included hypertension (high blood pressure) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest in things). During an interview with Resident 14 on March 24, 2025, at 10:54 AM, Resident 14 stated the the facility does not hold care plan meetings for him, and if they do, he is not invited to them. Review of Resident 14's clinical record revealed that a care conference meeting was held on February 25, 2025. The documentation failed to reveal that Resident 14 was in attendance or declined to attend. In addition, the note indicated that only two members of the interdisciplinary team attended the care plan meeting: the Licensed Practical Nurse Assessment Coordinator and the dietician. Further review of Resident 14's clinical record revealed that a care conference meeting was held on September 25, 2024. The documentation failed to reveal that Resident 14 was in attendance or declined to attend, and there were no care plan meetings documented between the meetings in September 2024 and February 2025. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Employee 1 (Regional [NAME] President of Operations) on March 25, 2025, at 10:54 AM, revealed they are working on fixing the facility process for care plan meetings, the meetings should be held at least quarterly, and documentation should reflect that the resident was invited to participate. During a follow-up interview with the Nursing Home Administrator (NHA) on March 26, 2025, at 1:40 PM, he revealed his expectation that care plans meetings are held quarterly and residents are invited to attend. Review of Resident 49's clinical record revealed diagnoses that included heart failure (when the heart muscle doesn't pump blood as well as it should) and vascular dementia (a type of cognitive decline caused by damage to the blood vessels in the brain). Review of Resident 49's comprehensive care plan on March 24, 2025, at 1:25 PM, revealed a focus area that Resident 49 required oxygen therapy related to altered respiratory status, with a start date of February 21, 2024; and an approach to administer oxygen per physician's order and nursing assessment, with a start date of February 21, 2024. Review of Resident 49's clinical record on March 25, 2025, at 11:05 AM, revealed no active physician's order for oxygen. Review of Resident 49's physician's order history revealed an order to administer oxygen (O2) via nasal cannula at 1 liter at night shift for desaturation, with a start date of February 14, 2024, and end date of October 7, 2024. Interview with the NHA on March 27, 2025, at 10:41 AM, revealed that oxygen was removed from Resident 49's care plan and would have expected her care plan to have been revised prior to now. Review of Resident 58's clinical record revealed that she was admitted to the facility on [DATE], with diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), severe protein-calorie malnutrition (nutritional status in reduced availability of nutrients leads to changes in body composition and function), and Parkinson's disease (long term degenerative disorder of the central nervous system that mainly affects the motor system). During an interview with Resident 58's Representative on March 24, 2025, at 11:35 AM, Resident 58's Representative indicated that she had not been invited to any care conferences since the first one that was held within 2 weeks of Resident 58's admission to the facility. Review of Resident 58's clinical record revealed that a care conference meeting was held on December 4, 2024, and that Resident 58 declined to attend, and that Resident 58's family did not respond to the invitation. In addition, it was noted that only three members of the interdisciplinary team attended the care plan: the Licensed Practical Nurse Assessment Coordinator, the Dietician, and the Social Worker. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 58's clinical record revealed that a care conference meeting was held on February 26, 2025. The documentation failed to reveal that Resident 58 or her Representative were invited to attend or attended. The note indicated that only two members of the interdisciplinary team attended the care plan meeting: the Licensed Practical Nurse Assessment Coordinator and the dietician. During a staff interview with the Director of Nursing (DON) on March 26, 2025, at 10:31 AM, he indicated that he spoke with the Resident 58's Representative yesterday to discuss if they had any care concerns. The DON confirmed that Resident 58's Representative was not invited to attend the care conference meeting held in February 2025. He further indicated that he would expect care conference invitations to be given to residents and/or their representatives, and he would expect all members of the interdisciplinary team to participate in a resident's care conference. 42 CFR 483.21(b)(2) Comprehensive Care Plans 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.12(d)(2)(3)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33879 Based on clinical record review and staff interviews, it was determined that the facility failed to ensure a physician's discharge summary was completed for two of four residents reviewed for discharge (Residents 57 and 137). Findings include: Review of Resident 57's clinical record revealed diagnoses that included congestive heart failure (disease process of the heart that results in a decreased ability of the heart to effectively pump blood throughout the body) and type two diabetes mellitus (decreased ability of the body to produce and/or utilize insulin for the transport of glucose from the blood stream into the cells for nourishment). Review of Resident 57's clinical record revealed that Resident 57 was admitted to the facility on [DATE], for rehabilitation after increased weakness. Resident 57 was subsequently discharged to home on February 5, 2025, after reaching rehabilitation goals for activities of daily living and strength. Review of Resident 57's clinical record revealed that as of March 26, 2025, no physician's summary was completed for Resident 57's stay at the facility from January 16, 2025, to February 5, 2025. During a staff interview on March 27, 2025, at approximately 1:50 PM, the Director of Nursing revealed it is the facility's expectation that physician summaries are completed for residents that are discharged . Review of Resident 137's clinical record revealed diagnoses that included dysphagia (difficulty swallowing), chronic kidney disease (a condition characterized by a gradual loss of kidney function), and hypertension (high blood pressure). Review of Resident 137's clinical record revealed that she was admitted to the facility on [DATE], for rehabilitation after a hospital stay. Resident 137 was discharged from the facility after she was sent directly to the hospital following an outside appointment on January 10, 2025. Review of Resident 137's clinical record revealed that as of March 26, 2025, no physician's summary was completed for Resident 137's stay at the facility from December 2, 2024, to January 10, 2025. During a staff interview on March 27, 2025, at 11:01 AM, the Nursing Home Administrator revealed they were unable to locate a physician discharge summary for Resident 137, and it is the facility's expectation that physician summaries are completed for resident's that are discharged . 28 Pa code 211.5(d) Medical records

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46253 Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure care and services are provided in accordance with professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for two of 30 residents reviewed (Residents 61 and 105). Findings include: Review of Resident 61's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), generalized osteoarthritis (degeneration of joint cartilage and the underlying bone, causing pain and stiffness, especially in the hip, knee, and thumb joints), and hypertension (high blood pressure). Review of Resident 61's clinical record physician orders revealed an order for Resident to be out of bed to low Broda chair (a tilt-in-space positioning chair which prevents skin breakdown through reducing heat and moisture) with padded back support, pressure reducing cushion, dycem (a non-slip pad) underneath cushion, right arm trough, bilateral elevating leg rests and padded covers for bilateral leg rests with calf support, dated March 21, 2024; and an order for bilateral heel boots while in bed, dated March 23, 2025. Review of Resident 61's care plan revealed that the bilateral heel boots had been added to her care plan as intervention on March 21, 2024. Observation of Resident 61 on March 24, 2025, at 1:37 PM, revealed that she was in bed with no heel boots in place. Review of Resident 61's clinical record nurse aide point of care documentation revealed that her bilateral boots when in bed had been signed as Done on March 24, 2025, for day shift, at 2:24 PM, by Employee 16 (Nurse Aide). Review of Resident 61's March Medication Administration Record revealed that Employee 12 (Licensed Practical Nurse) had signed that the heel boots were in place on March 24, 2025, day shift. Observation of Resident 61 on March 25, 2025, at 9:27 AM, revealed that she was in bed with no heel boots in place and Employees 10 and 11 were present in the room. During an immediate staff interview with Employees 10 and 11 (Nurse Aide Students) revealed that they were not aware Resident 61 was to have on boots when in bed and indicated that they were getting ready to get Resident 61 out of bed. Employee 10 completed a search of the room and could not locate any heel boots. Review of Resident 61's clinical record nurse aide point of care documentation revealed that her bilateral boots when in bed had been signed as Done on March 25, 2025, for day shift at 8:02 AM, by Employee 16 (Nurse Aide). (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 61's March Medication Administration Record revealed that Employee 12 (Licensed Practical Nurse) had signed that the heel boots were in place on March 25, 2025, day shift. During a staff interview with Employee 12 (Licensed Practical Nurse) on March 25, 2025, at 9:31 AM, she indicated that Resident 61 normally wears them and that maybe they were in the laundry. Observation of Resident 61 on March 25, 2025, at 11:21 AM, revealed that she was seated in her Broda chair, no leg rests were present on the chair, and only her toes were touching the floor. During a staff interview with the Director of Nursing (DON) on March 25, 2025, at 11:40 AM, the DON observed Resident 61 in her Broda chair. He indicated that he would investigate the chair and the bilateral boot concerns. Observation of Resident 61 on March 26, 2025, at 9:45 AM, revealed that she was seated in her Broda chair, no leg rests were present on the chair, and only her toes were touching the floor. During a staff interview with the DON on March 26, 2025, at 10:24 AM, he indicated that he when he spoke to staff about Resident 61's bilateral heel boots, they indicated that Resident 61 frequently kicks them off. He indicated that he could not answer as to why they were not found in Resident 61's room when searched. He further stated that he would expect staff to complete accurate documentation and not sign for care items that were not completed. He confirmed that he would expect to follow a resident's care plan and physician orders. During this interview, the observation was shared of Resident 61 not having leg rests present on her Broda chair at 9:45 AM. The DON said that he put in a therapy referral March 25, 2025, regarding the leg rests because he was not sure where that intervention had generated. During a staff interview with the Nursing Home Administrator (NHA) and DON on March 26, 2025, at 2:03 PM, the DON indicated that he had made a referral to therapy for Resident 61's seating on March 25, 2025, and therapy was looking to place Resident 61 in a lower chair to allow her feet to touch the floor. The DON confirmed that since leg rests were care planned, they should have been in place and that he would expect staff to follow each resident's care plan. Review of Resident 105's clinical record revealed diagnoses that included congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest in things), and hypertension. Review of Resident 105's clinical record physician orders revealed an order for TED Hose (compression stockings to prevent fluid accumulation due to heart failure) to bilateral lower extremities as tolerated: on in AM and off at bedtime every morning and at bedtime for edema (fluid accumulation), with a start date of June 30, 2023. Observation of Resident 105 in her room on March 25, 2025, at 12:40 PM, revealed she did not have TED hose on her lower extremities. Review of Resident 105's clinical record on March 25, 2025, at 12:42 PM, revealed it was documented to indicate that her TED hose were in place. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident 105 in her room on March 26, 2025, at 1:51 PM, revealed she did not have TED hose on her lower extremities. Review of Resident 105's clinical record on March 26, 2025, at 1:54 PM, revealed it was documented to indicate that her TED hose were in place. During a staff interview with the NHA on March 27, 2025, at 11:02 AM, revealed the TED hose should have been placed per physician order, and not documented that they were in place when they were not. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 37817 Based on observation, policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure resident with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility for one of 33 residents reviewed (Residents 79). Findings include: Review of facility policy, Splint Issuance, last revised March 11, 2022, read, in part, splints shall be issued with a provider's order and therapist must evaluate patient to determine need for splint, fit and issuance. Splint schedule will be communicated to the multidisciplinary team and documented in the care plan. Clinical record review for Resident 79 documented diagnoses that included contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity, and rigidity of joints) of multiple muscles, depression (feelings of severe despondency and dejection), dementia (a condition characterized by progressive loss of intellectual functioning, impairment of memory, and abstract thinking), dysphagia (difficulty swallowing), 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), and metabolic encephalopathy (the brains function is impaired due to an imbalance in the body's metabolism). Review of Resident 79's March 2025, physician orders included: left wrist cock up splint (a splint that securely and comfortably immobilize and protect one's wrist, as needed for treating a variety of wrist conditions), on in the morning and off at night. Remove for care and check skin integrity at every shift. Twice a day scheduled 8:00 AM and 5:00 PM, with a start date January 23, 2025. Also, left edema glove on in the morning and off at night. Remove for care and check skin integrity at every shift. Twice a day scheduled 8:00 AM and 5:00 PM, with a start date January 23, 2025. Review of Resident 79's care plan approaches included to apply left wrist cock up splint and left edema glove, on in AM and off in PM, remove for cares, with a start date of January 27, 2025. Review of Resident 79's Occupational Therapy discharge summary dated January 23, 2025, read, in part, recommendations for a splint and edema glove. Interventions provided included: passive range of motion, orthotic caregiver education and use, to prevent further contracture. Instructed patient and primary caregivers in splinting/orthotic schedule to facilitate increased opportunities for participation in activities of choice/hobbies with 100% carryover demonstrated by primary caregivers. Observation March 27, 2025, at 10:07 AM, revealed the Resident was in his wheelchair in the common area and was not wearing the wrist splint or edema glove. During an interview with Employee 14 (Licensed Practical Nurse) on March 27, 2025, at 10:11 AM, it was revealed he should have them on. Employee 14 assisted Resident 79 by placing the splint on the left wrist and the edema glove on the right hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Employee 8 (Clinical Quality Coordinator), and Employee 6 (Director of Nursing) on March 27, 2025, to 10:40 AM, it was revealed that the Resident should've been wearing the splint and edema glove. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 33879 Based on observation, clinical record review, facility document review, and resident and staff interviews, it was determined that the facility failed to ensure residents receive adequate supervision and assessment after an accident for one of five residents reviewed for falls (Resident 72). Findings include: Review of facility policy, titled Neurological Checks Policy, last revised July 9, 2024, revealed the policy stated, Neurological checks are indicated to monitor for potential irregularities in neurological status in the event of a known or unknown head trauma as the result of a resident event, change in resident condition, or physician's order. Review of the procedures section of the policy revealed it included, A licensed clinician will perform an initial neurological check for all residents who have sustained a witnessed, unwitnessed, alleged, reported, or suspected head trauma following an unusual occurrence or change in resident neurological condition .When triggered by a qualifying event, a neurological check observation in the electronic health record will be initiated to conduct periodic checks and to document the results of the neurological checks. If the EHR is down, neurological checks will be completed on paper. Unless otherwise ordered by the physician, the frequency of neurological assessments will be once every shift for 72 hours post occurrence or change. Elements of the observation include: Level of consciousness; mental status; ability to communicate; movement/coordination; reflexes; change in behavior; vital signs: [blood pressure], pulse, respirations. Review of Resident 72's clinical record revealed diagnoses that included general anxiety disorder (excessive worry or fear) and intermittent explosive disorder (mental health disorder characterized by episodes of impulsive, aggressive, or violent behavior). During a resident interview on March 25, 2025, at approximately 9:50 AM, Resident 72 was observed with a bruise, measuring approximately one half inch wide, by one and one half inch long above the outer aspect of Resident 72's right eye. The bruise was observed to be purple in color with well defined edges. When asked about the bruise, Resident 72 stated that it was caused when he struck his head on his bed foot board during a fall a few days prior. Review of Resident 72's clinical record revealed Resident 72 sustained a witness fall on March 19, 2025; however, review of the fall investigation/incident report revealed no injuries were noted (including bruising) in the assessment at the time of the fall. Review of Resident 72's clinical record revealed staff did not document the presence of a bruise above Resident 72's right eye after the March 19, 2025, fall, until after the Director of Nursing (DON) was informed of the bruise by the surveyor on March 26, 2025. During a staff interview on March 27, 2025, at approximately 1:50 PM, the DON revealed it was the facility's expectation that staff would have identified, assessed, and documented Resident 72's bruise. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the incident investigation report for Resident 72's March 19, 2025, witnessed fall, revealed that Employee 13 (Registered Nurse) was the witness to Resident 72's fall. Review of the incident investigation report revealed it was not created until March 21, 2025, two days after Resident 72's fall. Further, review of Resident 72's interdisciplinary progress notes revealed that Employee 13 did not enter a progress note regarding Resident 72's fall until March 26, 2025. Review of the incident investigation revealed it was reviewed by the DON and the interdisciplinary team on March 23, 2025. Review of submitted education and disciplinary action towards Employee 13 for failing to complete a fall event report on at the time of the fall, revealed it was dated March 26, 2025, with signatures dated March 27, 2025. During a staff interview on March 27, 2025, at approximately 1:50 PM, the DON confirmed that it was the facility's expectation that fall investigation/incident reports are completed directly after a fall has occurred. Finally, review of Resident 72's clinical record revealed no documentation that neurological assessments were conducted per facility policy at anytime after Resident 72's March 19, 2025 fall. During a staff interview on March 27, 2025, at approximately 1:50 PM, the DON confirmed that it was the facility's expectation that neurological assessments are conducted after a witness or unwitnessed fall. 211.12(d)(1)(3)(5) 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. 47966 Based on clinical record review, facility policy review, and staff interview, it was determined that the facility failed to maintain complete and accurate records related to dialysis communication for one of one resident reviewed for dialysis (Resident 54). Findings Include: Review of facility policy, titled Hemodialysis Care Policy, with an effective date of June 16, 2017, and a last reviewed date of April 9, 2024, revealed the Pre-dialysis process: Document assessment in the Dialysis Communication Tool. Assessment includes vital signs, pre-treatment weight (unless performed at dialysis), medications administered before treatment, time of last meal, fluid intake, any additional information. Print the tool and send with resident to dialysis (if off-site). Review of Resident 54's clinical record revealed diagnoses that included Parkinson's disease (a movement disorder of the nervous system that worsens over time) and end stage renal disease (a condition where the kidneys have permanently lost most of their ability to function). Review of Resident 54's current physician orders revealed an order for dialysis (process of removing waste products and excess water from the body) on Tuesdays, Thursdays, and Saturdays. Review of Resident 54's physician orders also revealed an order for the dialysis communication tool to be completed and sent to dialysis with the Resident on Tuesdays, Thursdays, and Saturdays, with an active date of January 25, 2025. Review of Resident 54's current care plan revealed a dialysis care plan with an intervention to monitor and record weight on dialysis days, notify medical director of weight gain and/or fluid volume excess, with a start date of April 23, 2024. Review of Resident 54's clinical record revealed a dialysis communication form to be completed each day of dialysis to include Resident 54's pre-dialysis vital signs and assessment as well as Resident 54's post-dialysis vital signs and assessment, which is to be completed by the facility. The form also includes a place for the dialysis unit to document their assessment findings and/or any pertinent information. Review of Resident 54's dialysis forms revealed that the facility did not complete the dialysis communication form for Resident 54 on February 4, 8, and 13, 2025; and March 15, 18, 20, and 22, 2025. During an interview with the Director of Nursing (DON) on March 27, 2025, at 10:54 AM, revealed they were unable to provide dialysis communication forms for Resident 54 for the dates listed above. DON revealed he would expect dialysis communication forms to be completed on dialysis days for Resident 54. 28 Pa Code 211.5(f) Clinical records 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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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. 48484 Based on clinical records review and staff interview, it was determined that the facility failed to provide documentation of actual disposition of medications and method of disposition for one of three residents reviewed (Resident 136). Findings include: Review of Resident 136's clinical record revealed diagnoses that included end stage renal disease (a condition where the kidneys have permanently lost most of their ability to function) and hypertension (high blood pressure). Review of Resident 136's clinical record revealed a discharge summary completed on February 15, 2025, that Resident 136 was found unresponsive and passed away on that day due to cardiac arrest. Further review of the discharge summary revealed Resident 136's disposition of medications went with the Resident. Review of Resident 136's clinical record revealed there was no medication disposition form completed or any progress notes indicating a disposition of medications has been completed for Resident 136. During an interview with the Director of Nursing on March 27, 2025, at 10:34 AM, revealed they were unable to provide a medication disposition form for Resident 136, and would have expected one to have been completed. 28 Pa. Code 211.9(j)Pharmacy services

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 37817 Based on clinical record review, facility policy review, and staff interviews, it was determined that the facility failed to ensure Medication Regimen Reviews were completed by a consultant pharmacist and responded to in a timely manner by the attending physician or prescriber in a timely manner for four of 33 residents reviewed (Residents 49, 62, 70, and 119). Findings include: Review of facility policy, titled Medication Regimen Review, revised June 1, 2024, revealed, 1. If an irregularity is not time-sensitive but should be addressed before the consultant pharmacist's next monthly MMR, the facility staff and the consultant pharmacist will confer on the timeliness of attending physician/prescriber responses to identified irregularities based on the specific resident's clinical condition. 2. The attending physician/prescriber should address the consultant pharmacist's recommendation no later than their next scheduled visit to the facility to assess the resident per facility policy, or applicable state and federal regulations. Review of Resident 49's clinical record revealed diagnoses that included heart failure (when the heart muscle doesn't pump blood as well as it should) and vascular dementia (a type of cognitive decline caused by damage to the blood vessels in the brain). Review of Resident 49's September 2024 monthly medication regimen review revealed the following recommendation made by the consultant pharmacist: Please discontinue PRN (as needed) lorazepam. If the medication cannot be discontinued at this time, please document the indication for use, the intended duration of therapy, and the rationale for the extended time period. Further review of the September 2024 monthly medication regimen review revealed that the attending physician or prescriber failed to provide a response to the pharmacy recommendation, sign, or date the medication regimen review form. Review of Resident 49's October 2024 monthly medication regimen review revealed the following recommendation made by the consultant pharmacist: Please reevaluate the continued need for Omeprazole and consider discontinuation, while monitoring for recurrence of symptoms. If step down therapy is indicated, please consider Famotidine 20 milligram (mg) daily. Further review of the October 2024 monthly medication regimen review revealed that the attending physician or prescriber failed to provide a response to the pharmacy recommendation, sign, or date the medication regimen review form. Review of Resident 49's November 2024 monthly medication regimen review revealed the following recommendation made by the consultant pharmacist: Please attempt a gradual dose reduction (GDR), while monitoring for a return of symptoms. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the November 2024 monthly medication regimen review revealed that the attending physician or prescriber failed to provide a response to the pharmacy recommendation, sign, or date the medication regimen review form. Review of Resident 49's January 2025 monthly medication regimen review revealed the following recommendation made by the consultant pharmacist: Please reevaluate the continued need for Omeprazole and consider discontinuation, while monitoring for recurrence of symptoms. If step down therapy is indicated, please consider Famotidine 20 mg daily. Further review of the January 2025 monthly medication regimen review revealed that the attending physician or prescriber failed to provide a response to the pharmacy recommendation, sign, or date the medication regimen review form. During an interview with the Director of Nursing (DON) on March 27, 2025, at 10:35 AM, revealed he would have expected pharmacy recommendations to have been responded to in a timely manner, as well as signed and dated by the attending physician or prescriber. Review of Resident 62's electronic medical record revealed medication regimen review completed by the pharmacist on January 29, 2025, where recommendations were made and the physician responded on March 26, 2025. Further review of the medical record revealed the pharmacist made a recommendation on October 31, 2024, however, the facility was unable to locate the recommendation. During an interview with the DON on March 26, 2025, at 1:45 PM, revealed that they would expect that the attending physician or prescriber respond to pharmacy recommendations within two to four weeks of when the recommendation is made, and the pharmacy recommendations requested for Residents 62 and 119 that weren't provided, weren't able to be found. Review of Resident 70's clinical record revealed diagnoses that include post-traumatic stress disorder (a mental health condition caused by an extremely stressful or terrifying event) and anxiety disorder (group of mental health conditions characterized by excessive and persistent fear or worry, significantly impacting daily life and functioning). Review of Resident 70's electronic medical record revealed medication regimen reviews completed by the pharmacist on June 27, 2024; July 28, 2024; and October 30, 2024, where recommendations were made. The attending physician or prescriber failed to respond to these recommendations. Clinical record review for Resident 119 documented diagnoses that included anxiety (a feeling of worry, nervousness, or unease), dementia (a condition characterized by progressive loss of intellectual functioning, impairment of memory, and abstract thinking), and delusional disorder (a serious mental illness that causes people to have unshakable false beliefs for at least a month). Review of Resident 119's electronic medical record revealed medication regimen review completed by the pharmacist on August 29, 2024, however, the facility was unable to locate the recommendation. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DON on March 27, 2025, at 11:45 AM, revealed that they would expect that the attending physician or prescriber respond to pharmacy recommendations within two to four weeks of when the recommendation is made. 28 Pa. Code 211.10(c) Resident care policies

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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 observations, review of facility policy, and interviews, it was determined that the facility failed to clean and store dishes in accordance with professional standards for food safety in the dish machine area in the kitchen area for one of one meal observed. Findings include: Review of facility policy, Dish Machine Use, last revised May 17, 2021, read, in part, prior to use confirm chemical dispensers are filled and have enough product for the shift. Prior to use verify temperature and/or chemical sanitizer concentration are within specifications provided by dish machine manufacturer. If requirements are not met, immediately discontinue use of the dish machine and notify the person in charge. During use, operator will monitor temperature gauge frequently, if requirements are not met, immediately discontinue use of the dish machine and notify person in charge. The person loading dirty dishes into the dishwasher will not handle the clean dishes unless they wash hands thoroughly before moving from dirty to clean dishes. Observation on March 24, 2025, at 9:44 AM, in the dish room, revealed the dish machine was already in use and the final rinse cycle temperature registered 142 degrees Fahrenheit (F). The bucket of sanitizer was not connected to the dish machine via tubing; the tubing was noted to be out of the bucket and on the floor. Additional observation revealed Employee 7 (Dietary Aide), with gloved hands, put clean dishes away then loaded dirty dishes into the dish machine, and returned to the clean side to put the clean dishes away without changing glove and completing hand hygiene. During an interview with Employee 9 (Registered Dietitian) on March 24, 2025, at 9:50 AM, it was revealed that there should be sanitizer solution entering the machine, and the tubing was placed into the sanitizer bucket. Employee 9 spoke with Employee 7 about changing gloves and washing her hands each time she is finished loading the machine and prior to putting away the clean dishes. During an interview with the Employee 15 (Food Service Director) on March 25, 2025, at 11:30 AM, it was revealed that the dish machine is a hot temperature dish machine, and it requires that a few cycles need to be run before the dish machine reaches acceptable temperature levels. If the appropriate temperature is not met, the sanitizer solution needs to be connected to the machine. Staff education had been initiated for hand hygiene in the dish room as well as rinse temperature requirements and use of sanitizer as needed. During an interview with the Nursing Home Administrator, it was revealed that the machine should've been run through several cycles to ensure the final rinse temperature reached appropriate temperature. 28 Pa code 211.6(f) - Dietary Services