STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395410	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quality Life Services - Sugar Creek	120 Lakeside Drive Worthington, PA 16262

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on clinical record review and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for four out of four residents sampled with facility-initiated transfers (Residents R5, R37, R94, and R108). Findings include: Review of Title 42 code of Federal Regulations (CFR) S483.15(c)(2) Documentation indicated: When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with S483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. Review of the clinical record indicated Resident R5 was admitted to the facility on [DATE]. Review of Resident R5's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/10/24, indicated diagnoses of high blood pressure, chronic pain syndrome, and depression (a constant feeling of sadness and loss of interest). Review of Resident R5's clinical record indicated the resident was transferred to the hospital on 2/17/24, and returned to the facility on [DATE]. Review of Resident R5's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R37 was admitted to the facility on [DATE]. Review of Resident R37's MDS dated [DATE], indicated diagnoses of high blood pressure, dysphagia (difficulty swallowing), and abnormal posture. Review of Resident R37's clinical record indicated the resident was transferred to the hospital on 3/19/24, and returned to the facility on [DATE]. Review of Resident R37's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R94 was admitted to the facility on [DATE]. Review of Resident R94's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes (too much sugar in the blood), and depression. Review of Resident R94's clinical record indicated the resident was transferred to the hospital on 3/11/24, and returned to the facility on [DATE]. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R94's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R108 was admitted to the facility on [DATE]. Review of Resident R108's MDS dated [DATE], indicated diagnoses of dysphagia, heart failure (a progressive heart disease that affects pumping action of the heart muscles), and unsteadiness on feet. Review of Resident R108's clinical record indicated the resident was transferred to the hospital on 3/26/24, where she ceased to breathe on 3/31/24. Review of Resident R108's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, to meet the resident's specific needs at the receiving facility. During an interview on 6/13/24, at 2:01 p.m. the Nursing Home Administrator (NHA) stated, I asked staff and they said they don't typically send care plans with residents when they are transferred to the hospital. During an interview on 6/13/24, at 2:01 p.m. the NHA confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for four out of four residents sampled with facility-initiated transfers (Residents R5, R37, R94, and R108). 28 Pa. Code 201.29 (a)(c.3)(2) Resident rights.

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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** 48546 Based on a review of Resident Assessment Instrument (RAI) User's Manual, clinical records, and staff interviews, it was determined that the facility failed to ensure that MDS assessments accurately reflected the resident's status for two of three residents (Resident R9 and Resident R58). Findings include: Review of facility policy Resident Assessment: RAI/MDS/CAA Process dated 4/8/24, indicated a minimum data set (MDS) will be completed for every resident within 14 days of admission and according to the Medicare and OBRA Guidelines. Refer to the MDS 3.0 manual for the requirements. The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, indicated the following instructions: -Section J - Health Conditions: Current Tobacco Use, Ask the resident if they used tobacco in any form during the 7-day look-back period. If the resident states that they used tobacco in some form during the 7-day look-back period, code 1, yes. Review of the clinical record revealed that Resident R9 was admitted to the facility on [DATE]. Review of Resident R9's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 5/17/24, indicated diagnoses of diabetes (too much sugar in the blood), high blood pressure, and abnormal posture. Review of Resident R9's Admission MDS, Section J: Health Conditions, Question J1300 indicated that Resident R58 does not use tobacco. Review of the facility list of residents that smoke, provided on 6/10/24, included Resident R9. Review of smoking assessment completed on 5/15/24, confirmed that Resident R9 has chosen to smoke cigarettes, Review of the clinical record indicated Resident R58 was admitted to the facility on [DATE]. Review of Resident R58's MDS dated [DATE], indicated diagnoses of diabetes, chronic pain, and ulcerative colitis (a chronic, inflammatory bowel disease that causes inflammation in the digestive tract). Review of Resident R58's Admission MDS, Section J: Health Conditions, Question J1300 indicated that Resident R58 does not use tobacco. Review of the facility list of residents that smoke, provided on 6/10/24, included Resident R58. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of smoking assessments completed on 11/7/23, 2/7/24, and 5/7/24, confirmed that Resident R58 has chosen to smoke cigarettes. During an interview on 6/13/24, at 12:27 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E2 stated, I'm pretty sure Resident R58 arrived to the facility smoking a cigarette. During an interview on 6/13/24, at 12:27 p.m. RNAC Employee E2 confirmed that the facility failed to ensure that a MDS assessment accurately reflected Resident R58's tobacco use status. During an interview on 6/14/24, at 10:57 a.m. the Director of Nursing confirmed that the facility failed to ensure that a MDS assessment accurately reflected Resident R9's tobacco use status. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing Services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to notify the physician of increased Capillary Blood Glucose (CBG) levels as ordered for one of three residents (Resident R82) and obtain physician orders for a resident's wound for one of three residents (Resident R260). Findings include: Review of facility policy Physician Orders- NU 2.18 dated 4/8/24, indicated physician orders are followed in accordance with good nursing principles and practices and are transcribed and carried out by persons legally authorized to do so. It was indicated treatments may not be administered to the resident without the written approval from the attending physician. Review of facility policy Nursing Services - NU 2.15 dated 4/8/24, indicated nursing care includes the provision of all prescribed medications and treatments, and nursing care will be provided within the scope of practice and in accordance with nursing standards of care. Review of facility policy Physician Notification - NU 2.17 dated 4/8/24, indicated upon identification of a resident who has clinical changes, a change in condition, or abnormal lab values, a licensed nurse will perform appropriate clinical observations and data collection and report to the physician as indicated. The Centers for Disease Control defines diabetes as: Diabetes Mellitus is a chronic (long-lasting) health condition that affects how your body turns food into energy. Most of the food you eat is broken down into sugar (also called glucose) and released into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy. If you have diabetes, your body either doesn't make enough insulin or can't use the insulin it makes as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in your bloodstream. Over time, that can cause serious health problems, such as heart disease, vision loss, and kidney disease. People with Diabetes Mellitus may be prescribed injectable insulin to assist in maintaining acceptable levels of CBG's. Hyperglycemia, or high blood glucose, occurs when there is too much sugar in the blood. This happens when your body has too little insulin. Hyperglycemia is blood glucose greater than 125 mg/dL while fasting (not eating for at least eight hours, or a blood glucose greater than 180 mg/dL one to two hours after eating. If you have hyperglycemia and it's untreated for long periods of time, you can damage your nerves, blood vessels, tissues and organs. Damage to blood vessels can increase your risk of heart attack and stroke, and nerve damage may also lead to eye damage, kidney damage and non-healing wounds. Review of the clinical record indicated Resident R82 was admitted to the facility on [DATE]. Review of Resident R82's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/13/24, indicated diagnoses of high blood pressure, diabetes mellitus, and overactive bladder. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review a physician order dated 12/13/23, indicated to check Resident R82's CBG in the morning, call physician if result is less than 60 mg/dL or greater than 400 mg/dL. Review of the clinical record revealed Resident R82's CBGs were as follows: 3/14/24: 415 mg/dL 3/18/24: 458 mg/dL Review of Resident R82's progress notes from 3/14/24 through 3/18/24, failed to include documentation that a physician was notified for Resident R82's abnormal high blood glucose levels on 3/14/24, and 3/18/24, as ordered. During an interview on 6/14/24, at 10:53 a.m. the Director of Nursing (DON) confirmed that the facility failed to notify the physician of Resident R82's abnormal high blood glucose levels on 3/14/24, and 3/18/24, as ordered. Review of Resident R260's admission record indicated the resident was admitted to the facility on [DATE], with the diagnoses of dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), fracture of one rib on right side, and high blood pressure. Review of Resident R260's progress note dated 6/5/24, indicated the resident was admitted from the hospital after a fall. It was documented that the resident had a large abrasion, with dried blood and below right elbow. Review of Resident R260's clinical record from 6/5/24, through 6/10/24, failed to include an order for Resident R260's wound. During an observation and interview on 6/10/24, at 11:45 a.m. Resident R260 was observed with a undated bandage on his right elbow. Resident R260 stated he had a skin tear from falling down the stairs at home. During and observation and interview on 6/12/24, at 10:43 a.m. the Director of Nursing confirmed Resident R260's wound dressing located on his right elbow was undated. The DON confirmed the facility failed to ensure the facility obtained physician orders for Resident R260's wound. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.29(d) Resident Rights 28 Pa. Code 211.10 (c)(d) Resident Care policies 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on facility policy review, clinical record review, resident, and staff interviews, it was determined that the facility failed to provide colostomy care and services consistent with professional standards of practice for two of two residents reviewed (Resident R58 and R262). Findings include: Review of facility policy Ostomy Care dated 4/8/24, indicated ostomy care will be provided for residents who have a urostomy, colostomy, or ileostomy. Ostomy appliances are changed and ostomy pouches are emptied as needed. The purpose of this policy is to maintain integrity of peristomal (around the stoma) skin, monitor condition of stoma (any opening in the body), manage odor, and promote resident's self-esteem. Review of facility policy Care Plan and Interdisciplinary Care Conferences- NU 6.1 dated 4/8/24, indicated an individualized care plan is initiated within 24 hours for each resident as part of the care delivery process. The care plan is a working tool that is reviewed and revised at specific intervals and as needed to reflect response to care and changing needs and goals. Review of the clinical record indicated Resident R58 was admitted to the facility on [DATE]. Review of Resident R58's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/3/24, indicated diagnoses of diabetes (too much sugar in the blood), chronic pain, and ulcerative colitis (a chronic, inflammatory bowel disease that causes inflammation in the digestive tract). Section H indicated a colostomy (a surgical process that diverts bowel through an artificial opening in the abdominal wall) was present. Observation of Resident R58 on 6/10/24, at 10:45 a.m. indicated she had a colostomy. Review of physician order dated 11/7/23, indicated colostomy care every shift and as needed. Review of Resident R58's care plan dated 11/12/23, failed to include the type of appliance, size of the appliance or wafer, and type of collection bag required for colostomy maintenance. During an interview on 6/14/24, at 9:56 a.m. the Director of Nursing confirmed the facility failed to provide colostomy care and services consistent with professional standards of practice for Resident R58. Review of the clinical record indicated Resident R262 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses of diverticulitis of large intestine with perforation and abscess (inflammation of irregular bulging pouches in the wall of the large intestine), peritoneal abscess (a collection of pus or infected fluid that is surrounded by inflamed tissue inside the belly), and dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities). (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R262's Clinician Admission H&P assessment dated [DATE], indicated the resident was admitted from the hospital and had a new colostomy. Review of Resident R262's care plan dated 6/5/24, failed to include care interventions related to resident R262's colostomy. Review of Resident R262's clinical record from 6/5/24, through 6/12/24, failed to include an assessment of Resident R262's stoma to ensure adequate perfusion. During an interview on 6/12/24, at 12:44 p.m. Licensed Nurse Assessment Coordinator (LNAC), Employee E9 confirmed the facility failed to implement a baseline care plan for Resident R262's colostomy. During an interview on 6/12/24, at 1:06 p.m. the Nursing Home Administrator confirmed the facility failed to provide colostomy care and services consistent with professional standards of practice for Resident R262. 28 Pa. Code: 211.11 (a)(c)(d) Resident care plan 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code:211.12(d)(1) Nursing services.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on a review of clinical record, and staff interview, it was determined that the facility failed to ensure a resident was offered sufficient fluid intake to maintain proper hydration and health for one of two residents (Resident R54). Findings include: Review of the Nutrition/Hydration Management- NU 9.9 policy last reviewed 4/8/24, stated residents will receive care and support to enhance potential for attaining the highest level of nutrition and hydration status and the pleasure of eating. It is the facility's policy to provide safe and effective care to manage residents' nutrition and hydration needs. Review of the clinical record revealed that Resident R54 was admitted to the facility on [DATE]. Review of Resident 54's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 5/2/24, indicated diagnoses of dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), anxiety, and muscle weakness. During an observation on 6/10/24, at 11:29 a.m. Resident R54 indicated she asked for water an hour ago. No water was observed at the resident's bedside. The resident was observed with a dry mouth. Resident R54 stated staff do not leave water at her bedside, and she has to ask for it. Resident R54 stated I am always thirsty. During an interview on 6/10/24, at 11:35 a.m. Nurse Aide (NA), Employee E5 stated we are supposed to pass water every shift and in between. NA, Employee E5 confirmed the facility failed to offer sufficient fluid intake to maintain proper hydration and health for Resident R54. During an observation and interview on 6/13/24, at 10:24 a.m. Resident R54 stated she wanted some water. No water was observed at the resident's bedside. During an interview on 6/13/24, at 10:31 a.m. Activity Aide, Employee E6 confirmed Resident R54 did not have any water at bedside. During an interview on 6/13/24, at 10:36 the Director of Nursing and Nursing Home confirmed the facility failed to ensure a resident was offered sufficient fluid intake to maintain proper hydration and health for one of two residents (Resident R54). 28 Pa. Code: 201.18(b)(1)(e)(1) Management 28 Pa. Code: 201.12(d)(1)(3)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on observations, interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care for one of three residents (Residents R75). Findings include: Review of the clinical record indicated that Resident R75 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnosis of obstructive sleep apnea, (occurs when your breathing is interrupted during sleep, for longer than 10 seconds at least 5 times per hour (on average) throughout your sleep period), high blood pressure, and heart failure (a progressive heart disease that affects pumping action of the heart muscles. This causes fatigue, shortness of breath.) Review of Resident R75's care plan dated 5/4/22, indicated the resident receives oxygen therapy for ineffective gas exchange. Review of Resident 75's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 5/8/24, indicated the resident receives oxygen therapy while a resident. Review of Resident R75's physician's order dated 4/29/24, indicated to change and date oxygen tubing weekly for prevention. Review of Resident R75's physician's order dated 4/29/24, indicated to change oxygen tubing for CPAP (Continuous Positive Airway Pressure machine that delivers pressurized air to your nose and mouth to treat sleep apnea) weekly for prevention. During an observation on 6/10/24, at 11:14 a.m. Resident R75 CPAP oxygen tubing was observed not in use and on the ground. During an observation on 6/12/24, at 9:07 a.m. Resident R75 nasal cannula oxygen tubing was observed not in use and on the ground. During an interview on 6/12/24, at 9:10 a.m. Registered Nurse Employee E7 confirmed Resident R75's oxygen tubing was not stored properly when not in use and was on the ground. The facility failed to provide appropriate respiratory care for one of three residents (Residents R75). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48546 Based on review of facility policy, observation, and staff interviews, it was determined that the facility failed to date opened medications in one of three medication carts (Willow Medication Cart). Findings include: Review of facility policy Storage of Medications dated 4/8/24, indicated when the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. Drugs dispensed in the manufacture's original container will carry the manufacturer's expiration date. Once opened, these will be good to use until the manufacturer's expiration date is reached unless the medication is in a multi-dose injectable vial, an ophthalmic medication, or an item for which the manufacturer has specified a usual life after opening. During an observation on 6/12/24, at 8:42 a.m. of the [NAME] Medication Cart indicated the following medications not dated upon opening: - Resident R41's TobraDex eye drops, no date opened. - Resident R41's Muro 128 eye drops, no date opened. - Resident R58's Lantus (prefilled pen to inject long acting insulin under the skin) pen, no date opened. - Resident R58's Dorzolamide HCl-Timolol Maleate eye drops, no date opened. During an interview on 6/12/24, at 8:48 a.m. Licensed Practical Nurse Employee E1 confirmed the above findings. During an interview on 6/12/24, at 12:34 p.m. the Nursing Home Administrator confirmed that the facility failed to date opened medications in one of three medication carts (Willow Medication Cart). 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1)(e)(1) Management. 28 Pa. Code: 211.9 (a)(1) Pharmacy services. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395410	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quality Life Services - Sugar Creek	120 Lakeside Drive Worthington, PA 16262

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 46167 Based on staff interviews, and employee file review, it was determined that the facility failed to employ a full-time qualified Food Service Director for ten of ten months (August 2023 through December 2023, and January 2024 through June 2024). Finding include: During an interview conducted at initial tour on 6/10/24, at 10:29 a.m. Food Service Director (FSD) Employee E3, stated that he was not a Certified Dietary Manager (CDM) and did not have any formal education or certificates in food service management. FSD Employee E3 stated that the facility employs a Registered Dietitian, but that he comes in building only two days per week. During an interview on 6/10/24, at 2:29 p.m. Nursing Home Administrator (NHA) confirmed that FSD Employee E3 did not possess the appropriate qualifications as required. Review of FSD Employee E2's employee file, revealed that he did not possess qualifications for Food Service Director, and had been employed at the facility since 8/9/23. During an interview on 6/11/24, at 11:05 a.m. Registered Dietitian (RD) Employee E4 stated that he works in the facility two days per week and that he is only responsible for clinical duties. RD Employee E4 confirmed that the facility failed to employ a qualified FSD for ten of ten months 28 Pa. Code: 211.6(c)(d) Dietary services.

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 46167 Based on facility policy, observation, and staff interview it was determined that the facility failed to properly contain and dispose of garbage in one of one outside dumpsters to prevent the potential for rodent and insect infestation. Findings include: Review of facility policy Waste Disposal, dated 4/8/24, indicated that trash will be deposited into a sealed container outside the premises. During an observation of the facility's outdoor trash receptacle on 6/10/24, at 11:00 a.m. revealed approximately five empty boxes piled up outside of the dumpster. During an interview on 6/10/24, at 11:00 a.m. Food Service Director Employee E93 confirmed that the facility failed to properly contain and dispose of garbage in the outside trash receptacles to prevent the potential for rodent and insect infestation. 28 Pa. Code 201.18(b)(3) Management. 28 Pa. Code 207.2(a) Administrator's responsibility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395410	A. Building B. Wing	06/14/2024

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that clinical records were complete and accurate for one of six residents reviewed (Resident R260). Findings include: Review of the facility policy Medical Records-The Medical Record date 12/12/23, indicated that the medical record will contain complete and accurate documentation, which clearly identifies the resident, justifies the diagnoses, condition, treatment, care approaches, and responses to the care provided. Review of Resident R260's admission record indicated the resident was admitted to the facility on [DATE], with the diagnoses of dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), fracture of one rib on right side, and high blood pressure. Review of Resident R260's progress note dated 6/5/24, indicated the resident was admitted from the hospital after a fall. It was documented that the resident had a large abrasion, with dried blood and below right elbow. Review of Resident R260's Non-Pressure Wound Tool: B-Shoulder/Arm V 5 report dated 6/5/24, indicated the resident's affected area was the left elbow. A description of the location of the wound stated skin tear to left elbow with wide steri strips on, unable to measure skin tear. The facility failed to accurately document the anatomical location of Resident R260's skin tear. During an observation and interview on 6/10/24, at 11:45 a.m. Resident R260 was observed with a bandage on his right elbow. Resident R260 stated he had a skin tear from falling down the stairs at home. During and observation and interview on 6/12/24, at 10:43 a.m. the Director of Nursing confirmed Resident R260's wound was located on his right elbow confirmed the facility failed to ensure that clinical records were complete and accurate for one of six residents reviewed (Resident R260). 28 Pa. Code 211.5(f) Clinical Records 28 Pa. Code 211.12(d)(1)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337 Based on observation, staff interviews, resident interviews, it was determined the facility failed to maintain patient care equipment in a safe operating condition for one of three residents (Resident R11). Findings include: Review of the clinical record revealed that Resident R11 was admitted to the facility on [DATE]. Review of Resident 11's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 5/10/24, indicated diagnoses of dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), morbid obesity, hemiplegia following cerebral infarction affecting left nondominant side (paralysis of left side of body following a stroke), and muscle weakness. Review of facility provided documentation, it was indicated the facility initially reached out to the resident's wheelchair manufacturer to repair Resident R11's wheelchair on 3/14/24. Resident R11's order for her wheelchair part was not confirmed until 6/6/24, 84 days since the facility was aware Resident R11's wheelchair needed repaired. During an interview on 6/11/24, at 11:59 a.m. Resident R11 indicated the right arm on her wheelchair has been broken for six weeks. Resident R11's right arm wheel chair was observed broken and easily disconnected if pulled. During an interview on 6/12/24, at 11:19 a.m. and 12:21 p.m. the Nursing Home Administrator confirmed she was aware Resident R11's wheelchair needed repaired and failed to maintain patient care equipment in a safe operating condition 28 Pa. code 207.2(a) Administrator's responsibility. 28 Pa. Code 207.4 Ice containers and storage.