STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395413	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wesley Enhanced Living Pennypack Park	8401 Roosevelt Boulevard Philadelphia, PA 19152

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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 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. 39343 Based on observations, reviewof clinical record, review of facility documents and staff interviews, it was determined that the facility failed to revise the care plan for activities of daily leaving for one of 31 residents reviewed (Resident R32). Findings include: Review of Resident R32's clinical record revealed that the Resident R32 was admitted in the facility on January 16, 2024. Resident R32's diagnoses included, Muscle Weakness, Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and judgment), and abnormalities of gait and mobility. Review of physician order for Resident R32, dated March 13, 2024, indicated an order for Physio-Therapy evaluation and treatment as indicated. Review of the care plan for Resident R32, initiated on January 16, 2024, with a target date of September 8, 2024, indicated that Resident R32 would demonstrate an improvement in Activities of Daily living status through skilled therapy intervention. Review of Resident R32's current care plan revealed that the resident's care plan was not updated or revised to reflect the improvement or care plan status related with the Activities of Daily Life Interview conducted on October 24, 2024 at 1:04 p.m. with the Directoof Nursing confirmed that the resident's care plan was not updated to reflect the resident current activities of daily living status. 28 Pa Code 211.11(d) Resident Care Plan

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39343 Based on review of clinical records, review of facility documentation, review ofd facility policies and interviews with staff, it was determined that the facility failed to provide adequate supervision to prevent elopement of one out of 31 residents reviewed (Resident R80). Findings include: Review of facility policy, Elopement of a Resident effective dated December 12, 2016, revealed that it was the policy of the facility to put measures into place to prevent residents room eloping (leave without staff knowledge) from the facility. The policy defined elopement as the ability of a resident, who is not capable of self-preservation to successfully wander away, walk away, run away, escape, or otherwise leave the facility or environment unsupervised, unnoticed, and/or prior to their scheduled discharge and enter into a harmful situation. Review of the clinical record for Resident R80, revealed resident was admitted to the facility on [DATE], with diagnoses including Anxiety Disorder (a mental illness that causes a person to experience excessive and uncontrollable feelings of fear or anxiety. These feelings can be so severe that they interfere with a person's daily life), Abnormalities of Gait and Mobility, Other Symbolic Dysfunction (Other symbolic dysfunction is a language impairment caused by an underlying medical condition, such as brain damage, that affects the brain's ability to recognize symbols, identify sounds, write, or speak), and Alcohol Abuse. Review of Resident R80's Minimun Data Set (MDS- assessment of resident's care needs) dated, April 4, 2024, revealed a BIMS score of 15 (Brief Interview for Mental Status, a cognitive screening tool used to assess mental status in patients), indicating that the resident was cognitively intact (the ability to clearly think, learn, and remember). (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 a nursing progress note of Resident R80, dated April 19, 2024, revealed that at about 4 PM the CNA (Nurse Aide) went to check on resident, but she (Reisdent R80) was not in her room and she (Nurse Aide) reported to the charge nurse. Staff searched for Resident R80 in every room on the floor and around the courtyard, but Resident R80 was nowhere to be found. It was reported to the Supervisor and the Security who joined in the search. A called was made to Resident R80's sister, and her daughter to verify if she was with them, but they said resident was not with them. When got back from the search at the courtyard, found resident in her room dressed up sitting on her bed; asked her where and whom she went out with, she said she went to a party on the third floor and that she told somebody before leaving, and the person promised to tell the nurse; left Resident R80 in her room on her bed; after a while Resident R80 started speaking in a high tone, nurse went in to see what was going on with her, as she was talking I smell alcohol in her breath, the nurse tried to investigate, and called the CNA and the other charge nurse to the room, they as well confirmed that they smell alcohol, so the nurse went through some shopping bags in [Resident R80's] room and on top of her bed, the nurse found a half bottle of [NAME] and a full bottle of wine on her bed, at that point [Resident R80] started forcing and yelling, and scratching the nurse's hand, crying so that the nurse should let go of the [NAME] that she got because she had cold; the nurse called the Supervisor who joined with the nurse to redirect [Resident R80] and she became calm, made her sister and her daughter aware; notified the Physician; placed the resident in her bed with all safety measure in place. Further review of clinical records revealed that, Resident R80 was assessed for any sign of injury, and none found, and Resident R80 denied any discomfort. Resident was Awake, Alert and Oriented; BIMS (Brief Interview for Mental Status, a cognitive screening tool used to assess mental status in patients) of 15 (perfect score); notified and updated emergency contact; care plan was updated with check every two hours for safety and high risk for elopement; notified MD and Security; informed Front Desk Staff and all staff that resident R80 needed to be escorted by family when leaving the facility. Front desk was given updated picture. The staff was able to verify resident had left building by self, no friend or family member was present. Resident did leave via the front desk wearing jeans, sneakers, white top, and jacket in arm, not using cane or walker like she (R80) normally would when leaving with family members. Front desk receptionist was present and did not notice anything out of the ordinary. Picture was not present at the time of elopement because resident had never shown any concern for elopement in the last year she had been in the facility, and R80's original admission was April 2023. The closest store where liquor can be bought was on the other side of the main road in the shopping center where there was a state store for fine wine and good spirits, approximately 10-minute walk according to google maps. Care-plan updated with every 15-minute checks as resident R80 continued to verbally say she would leave, resident refused to wear wander guard; so, wander guard was placed on cane and walker of R80, and resident was completely noncompliant with using safety devices now because of wanderguard places. R80 was also started on Gabapentin to help with alcohol withdrawal/anxiety. Resident 80's behaviors had continued, despite medication and family has been notified that alternative placement needs to be explored at this time. Resident was also seen by psych and during interview R80 told I'm leaving I don't need to be here. Alcohol when found was taken away from resident. R80 did not have an order for alcohol, so it was removed, and daughter was made aware. Resident R80 had not made any comments related to leaving or drinking alcohol before the incident. The daughter is against mother drinking and sister had verbalized to support that, who are R80's most frequent visitors. R80 does not have a P.O.A. Resident does not currently have any order to give or not give alcohol. Resident R80 remained on every 15 minutes checks until the staff received recommendation that psychologist/psychiatrist felt it would be appropriate to discontinue them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On October 21, 2024, 12:10 p.m., , interviewed Resident R80 in her room. R80 was not cooperative to talk about the incident. On October 21, 2024, 12:20 p.m., interviewed the DON, and the DON confirmed the information as mentioned in the clinical notes, as above. On October 22, 2024, 9:57 a.m., interviewed the Unit Manager, a Registered Nurse, Employee E1., who restated the same information as mentioned above, and added that Resident R80 was noted missing around 3 p.m., on April 19, 2024, during room rounds. Employee E10 confirmed that unit staff searched the unit and courtyard, notified security and supervisor; also made phone calls to Resident 80's contact persons and were able to confirm that family did not have resident with them. Resident does frequently go out with family. Then after about an hour and 45 minutes resident was noted returning entering the front desk and Resident R80 stated that she was with a friend. Resident would not elaborate on who the friend was. No one was seen dropping resident off as she walked in by herself. She did return with a black shopping bag with 2 bottles of alcohol, a bottle of wine 750 ml (unopened) and a 375 ml bottle of brandy half full. Resident R80 had stated, this is America, this is a free country, I can do what I want. Resident R80 does have a history of alcohol abuse. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39343 Based on review of facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to ensure that physican orders were followed related to an indwelling urinary catheter for one of five residents reviewed with incontinence concerns (Resident R8). Findings include: Review of Resident R8's clinical record revealed that the resident was admitted to the facility on [DATE]. Diagnoses included Urinary Tract Infection, Cognitive Communication Deficit (a difficulty with communication that's caused by a disruption in cognitive processes. This can affect a person's ability to speak, listen, read, write, and interact socially) and Depression (a common mental health condition that can impact a person's thoughts, feelings, behavior, and sense of well-being. It's more than just feeling down or having a bad day, and it can interfere with daily activities like sleeping, eating, and working). Review of physician order for Resident R8, dated August 23, 2024, indicated an order for an indwelling urinary Foley catheter with size 16FR/10ML for urinary retention. On October 24, 2024, at 8:46 a.m., it was observed that for Resident R8, no 16FR/10ML was marked on the Foley Catheter, to verify the size of the Foley Catheter, which did not enable to confirm whether the facility had followed the physician order. At the time of the finding, confirmed the same with Employee E9, a Registered Nurse. 28 Pa Code 211.12(d)(1) Nursing services 28 Pa Code 211.12(d)(5) 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** 06525 Based on observations of nutritional care and services, interviews with staff, reviews of policies and procedures, it was determined that the facility failed to assess and monitor the nutritional status of one of four residents reviewed to ensure that each resident maintained acceptable parameters of nutritional status related to usual body weight and laboratory values. (Resident R27) Findings include: A review of the policy titled weight management dated July 15, 2029 revealed that if there was a weight change from the previous weight for a resident that was less five pounds the dietitian was to be notified by the nursing staff. The dietitian was then responsible to conduct a nutritional assessment of the resident and provide interventions for the resident to maintain body weight and meet food and fluid needs daily. A review of the policy titled nutritional assessment dated [DATE] revealed that the dietitian in conjunction with the nursing staff and physician were to conduct a comprehensive assessment of each resident upon a change in a residents' condition. The nutritinal assessment was to identify usual meal patterns, snack patterns, food preferences, food form, toleration, texture and flavors for each resident. The clinical record review for Resident R27 revealed a laboratory study that was completed on September 30, 2024 that indicated this resident had a low albumin level. A low albumin level meant that the level of protein in the blood was below normal. A low albumin level was indicative of malnutrition or not eating enough nutritients. The clinical record indicated a physican's progress note dated October 10, 2024 that indicate Resident R27 had an arterial wound located on the left heel and a new sacral pressure sore. Review of the weight summary for Resident R27 indicated that on September 2024, the resident weighted 174 pounds and on October 2024 the resident weight was 167 pounds for a total of 7 pounds in 1 month. The weight record also indicated that Resident R27 lost three pounds during a weekly weight period October 4, 2024- 170 pounds and October 11, 2024 the resident weighted 167 pounds. The weight record indicated a significant twenty-one pound weight loss for Resident R27 over a six month period (May 2024- 188 pounds and October, 2024- 167 pounds.) There was no documentation to indicate that the dietitian had completed a comprehensive nutritional assessment of Resident R27 after a change in status and condition had occurred for this resident on October 10, 2024 with the development of the sacral pressure sore and continuous weight loss since May, 2024 and October, 2024. Observations of Resident R27 during the breakfast meal on October 24, 2024 revealed that this resident was requiring assistance with eating. The resident was enjoying warm cooked cereal with milk. There was no documented evidence that food preferences, nutritional supplementation or adapted utensils were considered to enhance the amount of foods consummed and eating abilities for this resident. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Registered nurse, Employee E5, Nursing aide, Employee E7 and Registered Dietitian, Employee E4 between 9:00 a.m. and 11:00 a.m., on October 24, 2024 confirmed that there was no documented nutritional assessment for the month of October, 2024 related to foods and fluid intake, adaptive equipment or nutritional supplentation for Resident R27. 28 Pa. Code 211.10(c) Resident care policies

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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** 46508 Based on observations, review of clinical records and interview with staff, it was determined that the facility failed to administer oxygen as ordered by the physician for one of 31 residents reviewed. (Resident R22) Findings include: Review of Resident R22's clinical record revealed that Resident R22 was admitted to the facility on [DATE], with diagnoses of Type 2 Diabetes Mellitus without complications, Acute Embolism and Thrombosis of unspecified deep veins of left lower extremity, obesity, Essential Hypertension, Unspecified Fracture of Left Lower Leg. Further review of resident's clinical record revealed a physician's order dated September 26, 2024, for: O2 (oxygen) at 2L via NC (nasal cannula) for Pox (pulse oxygen level) < 92% on room air every shift for Pox < 92% on room air. Observation on Resident R22 conducted during tour of the second-floor unit on October 21, 2024, at 1:04 pm, revealed that Resident R22 was in bed asleep with family member (son) on bedside. Further observation revealed that Resident R22 was on oxygen via nasal cannula connected to an oxygen concentrator machine. Further, observation revealed that the oxygen tubing was not dated. Observation of the oxygen concentrator machine revealed that the oxygen level was at 4.5 liters/minute. Interview with Unit Manager Employee E8 conducted at the time of the observation confirmed that Resident R22's oxygen level was set at 4.5 liters/minute. Interview with Director of Nursing, Employee E2 conducted on October 24, 2024 at 12:25 pm revealed that the frequency of the oxygen tubing change is usually written on the physician's order. Review of the physician's orders for Resident R22 revealed no orders for the frequency of the oxygen tubing change. 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39343 Based on review of facility policy, review of clinical records, and staff interviews, it was determined that the facility failed to ensure provide documentation of a clinical rationale for the continued administration of an antipsychotic medication and failed to ensure that a gradual dose reduction was attempted for a psychoactive drug for one out of two residents reviewed (Residents R32) Findings Include: Review of facility policy Medication Monitoring and Management, effective dated September 6, 2023, revealed if a resident is admitted on an antipsychotic medication or the facility initiates antipsychotic therapy, the facility must attempt a Gradual Drug Reduction (GDR involves the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the medication can be discontinued altogether) in two separate quarters (with at least one month between the attempts) within the first year, unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated. A GDR is considered clinically contraindicated if: Target symptoms returned or worsened after the most recent attempt at a GDR, and the physician documents the clinical rationale for why any additional attempted dose reductions would likely impair the resident's function, increase distressed behavior, or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. Review of Admission Sheet of Resident R32 indicated that the resident was admitted to the facility on [DATE], with diagnoses including Dementia (a chronic condition that causes a gradual decline in cognitive abilities, such as thinking, remembering, and reasoning), and muscle weakness. Review of physician order for Resident R3, dated October 12, 2022, revealed an order for Quetiapine Fumarate Oral Tablet 25, give 2 tablet by mouth at bedtime for psychosis in the absence of dementia. (Quetiapine is an antipsychotic medication that treats several kinds of mental health conditions including schizophrenia and bipolar disorder). Review of Resident R32's clinical record revealed no documented evidence that the physician reviewed the medicine Quetiapine Fumarate for a gradual dose reduction or documented the rationale for the continued administration of the medication. Interview with the Director of Nursing on October 23, 2024 at 10:28 a.m. confirmed the above findings. 28 Pa Code 211.2(a) Physician services 28 Pa Code 211.9(a)(l)(k) 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46508 Based on review of clinical records, observation, and staff and resident interview, it was determined that the facility failed to ensure that all drugs and biologicals were safely stored for one of 31 residents reviewed (Resident R36). Findings include: Review of Resident R36's clinical record revealed that Resident R36 was admitted to the facility on [DATE] with diagnoses of Atherosclerosis Heart Disease, Type 2 Diabetes Mellitus, Occlusion and Stenosis of Bilateral Carotid Artery, Essential Hypertension, Hyperlipidemia, Further review of Resident R36's clinical record revealed the following physician's orders: Aspirin Oral Capsule 81 MG (Aspirin) Give 81 mg by mouth one time a day for CAD (coronary artery disease)-Order Date-September 27, 2023. Lasix Oral Tablet 20 MG (Furosemide) Give 1 tablet by mouth one time a day for LE (lower extremity) edema-Order Date-October 24, 2023. Metoprolol Tartrate Oral Tablet 25 MG (Metoprolol Tartrate) Give 25 mg by mouth one time a day for HTN (Hypertension) hold for sbp systolic blood pressure) below 110 and hr(heart rate) below 60-Order Date-September 27, 2023. Plavix Oral Tablet 75 MG (Clopidogrel Bisulfate) Give 1 tablet by mouth one time a day for CAD (coronary artery disease)-Order Date-October 24, 2023. Metformin HCl ER Oral Tablet Extended Release 24 Hour (Metformin HCl) Give 500 mg by mouth two times a day for DM (diabetes mellitus)-Order Date- December 11, 2023. Review of Resident R36's MAR (medication administration record) revealed that Aspirin Oral Capsule 81 MG (Aspirin) Give 81 mg by mouth one time a day for CAD (coronary artery disease)-Order Date-September 27, 2023 was schedule to be administered every 8am-12pm, Lasix Oral Tablet 20 MG (Furosemide) Give 1 tablet by mouth one time a day for LE (lower extremity) edema-Order Date-October 24, 2023 was schedule to be administered every 8am-12pm Metoprolol Tartrate Oral Tablet 25 MG (Metoprolol Tartrate) Give 25 mg by mouth one time a day for HTN (Hypertension) hold for sbp (systolic blood pressure) below 110 and hr(heart rate) below 60-Order Date-September 27, 2023 was schedule to be administered every 8am-12pm Plavix Oral Tablet 75 MG (Clopidogrel Bisulfate) Give 1 tablet by mouth one time a day for CAD (coronary artery disease)-Order Date-October 24, 2023 was schedule to be administered every 8am-12pm (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Metformin HCl ER Oral Tablet Extended Release 24 Hour (Metformin HCl) Give 500 mg by mouth two times a day for DM (diabetes mellitus)-Order Date- December 11, 2023 was schedule to be administered every 9am Observation on Resident R36 conducted on October 21, 2024, at 10:15 am, during the tour of the second-floor unit revealed that Resident R36 was awake and was sitting on his bed. Observation of Resident R36's surroundings revealed that there was a medication cup on his bedside table. Further inside the medication cup were 1 white oval tablet, 1 round reddish flesh colored tablet, 1 round light flesh colored tablet, 1 small white tablet, 1 large white colored tablet. Interview with Resident R36 conducted at the time of the observation confirmed that that five tablets in the medication cup on his bedside table were his. Further Resident R22 revealed that the nurse came by earlier and left his medications on his bedside table. Further, Resident R36 also revealed that he did not take his medications because the nurse did not explain to him what the medications were. Interview with licensed nurse Employee E9 conducted at the time of the observation confirmed that Resident R36's medications were still on his bedside table and that the medication were left on Resident R36/'d bedside table unattended by a nurse. 28 Pa. Code 201.8(b)(l) Management 28 Pa. Code 211.12(d) Nursing services

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06525 Based on interviews with residents and staff, reviews of policies and procedures, and clinical record reviews, it was determined that the facility failed to provide as needed dental services for one of 31 clinical records reviewed. (Resident R56) Findings include: A review of the facility policy titled dental services dated December 2016 revealed that routine and emergency dental services were provided for all residents to meet their oral health needs. The policy indicated that a dentist provides care to the residents at the facility and was under a contracted agreement to visit the residents monthly and weekly as necessary. The policy indicated the the social worker was responsible for assisting residents with dental appointments and transportation arrangements to a dental office as needed. Clinical record review revealed a comprehensive annual assessment dated [DATE] that indicated Resident R56 was cognitively intact. Interview with Resident R56 at 9:30 a.m., on October 22, 2024 revealed that this resident had mouth pain and discomfort. The resident also reported that her tooth was decaying and she had been waiting for several months for the nursing staff to make arrangements for her to receive as needed dental services for teeth extractions. Clinical record review revealed a dental examination on August 28, 2024 that confirmed Resident R56 need for dental care. The dentists identified moderate peridontal disease and plaque and root extrations for decayed teeth. After the extractions, Resident R56 was to be fitted for upper and lower dentures. Interview with the Registered nurse, Employee E10 and the Social worker, Employee 15, at 10:30 a.m., on October 22, 2024 confirmed the lack of timely dental services for Resident R56. Employees E10 and E15 stated that they were aware of the dental evaluation and follow-up recommended by the dentist for Resident R56 on August 28, 2024. 28 Pa. Code 211.15 Dental services 28 Pa. Code 211.16(a)(1) Social services 28 Pa. Code 211.12(d)(3)(%) Nursing services 28 Pa. Code 211.10(c) Resident care policies

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	395413	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wesley Enhanced Living Pennypack Park	8401 Roosevelt Boulevard Philadelphia, PA 19152

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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. 39343 Based on review of clinical records, observations, and resident and staff interviews, it was determined that the facility failed to ensure that physician orders were accurate for one of 31 residents reviewed (Resident R32). Findings include: Review of physician order dated March 13, 2024, for Resident R32, indicated an order to change oxygen tubing/cannula/plastic bag and inspect filter and clean or replace if soiled, weekly on Saturdays 11-7 shift; place initials and date changed the tubing that are placed in plastic bags; every night shift every Saturday. Check Pulse Ox every shift; Oxygen: 2 Liters/Minute, As Needed, via Nasal Canula for Pulse Ox below 92% Room Air, As Needed. Observation conducted on October 24, 2024, at 9:07 a.m., of Resident R2, in the presence of a Registered Nurse, Employee E9, revealed that Resident R32 had no oxygen devise placed with him as ordered. Interviewed with Resident R32 at the time of observation, revealed that he was not receiving or in need of any oxygen therapy for a long time. Reviewed the Minimum Data Set (MDS, a standardized way to evaluate a resident's health needs and functional abilities, and it helps nursing home staff to identify health issues of residents) of Resident R32, dated September 3, 2024, stated that Resident R32 was not receiving oxygen therapy. At the time of the finding, Employee E9 confirmed that Resident R32's physician orders related to oxygen were not accurate. 28 Pa. Code 211.12(d)(1) Nursing services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 39343 Based on observations, review of facility policies, review of facility documentation, clinical record review and interviews with staff, it was determined that the facility failed to maintain an effective infection control program related to Transmission Based Precautions for one of 13 residents reviewed ((Resident R8). Findings include: Review of facility policy, Infection control Guidelines for all Nursing Procedures, effective dated October 2018, revealed that Transmission Based Precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent the spread of infection. Standard Precautions apply to body fluids. Wear personal Protective Equipment (PPE) to prevent exposure to spills or splashes of body fluids. Observation on October 24, 2024, at 8:46 a.m. revealed that Employee E9, a Registered Nurse (RN) , examined the urinary Foley catheter of Resident R8. Employee E9 did not wear PPE during examinationo of the urinary catheter even though Resident R8 was suggested for Transmission Based Precautions. Employee E9 confirmed not wearing PPE at the time of the observation. 28 Pa Code 211.12(d)(1) Nursing services

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 46508 Based on clinical record review and interviews with staff, it was determined that the facility failed to ensure that residents were provided with education related to the influenza vaccines prior to administration of the vaccine for six of six residents reviewed (Residents R2, R22, R29, R36, R83 and R115) Findings include: Review of clinical records of Resident R2, Resident R29, Resident R83, Resident R36, Resident R115 and Resident R22 revealed that all six residents were offered and received the flu vaccines for the flu season 2024-2025. Further review of Resident R2, Resident R29, Resident R83, Resident R36, Resident R115 and Resident R22's clinical record, revealed no documented evidence that that Resident R2, Resident R29, Resident R83, Resident R36, Resident R115 and Resident R22 were provided with education related to the influenza vaccines such as the benefits and potential side effects of the vaccines prior to administration of the influenza vaccines. Interview with the Director of Nursing (DON) Employee E2 conducted on October 24, 2024, at 12:25 p.m. confirmed that Resident R2, Resident R29, Resident R83, Resident R36, Resident R115 and Resident R22 were offered and received the Influenza vaccine for the 2024-2025 influenza season. Further interview with Employee E2 confirmed that Resident R2, Resident R29, Resident R83, Resident R36, Resident R115 and Resident R22 were not provided with education related to the influenza vaccines such as the benefits and potential side effects of the vaccines prior to administration of the influenza vaccines. 28 Pa Code 201.18(b)(1)(d) Management 28 Pa Code 211.12(c)(d)(1) Nursing services

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 06525 Based on observations of the operations of the main dietary kitchen and the six kitchenettes constructed on the nursing units, reviews of manufactures' specifications for the dish machines and interviews with staff, it was determined that essential mechanical equipment used for the food and nutrition services department was not fully operational and safe. Findings include: Observations of the dish machine area equipment inside the main kitchen revealed a dish machine whose manuafacturer's recommendations for safe operation were for hot water to be used for the cleaning and sanitation of dishes utencils bowls cups and every day china. The director of Dietary Services, Employee E3, reported that the booster heater required mechanical equipment (pressure reducing valve on the booster heater) and repair for the dish machine to be maintained safely and in accordance with manufacturer's specified final rinse temperature of 180 degrees Fahrenheit. Observations of the second floor B wing nursing unit kitchenette revealed a dish machine that was not maintained according to manufacturer's specifications to effectively sanitize the dish ware and utencils. The final water rinse temperature of this dish machine was 86 degrees Fahrenheit. The required temperature for heated water was 180 degrees Fahrenheit. Observations of the first floor A wing nursing unit kitchenette and the first floor C wing nursing unit kitchenette revealed dish machines that were not being maintained according to manuafacturer's specifications to effectively sanitize the dish ware cups, bowls mugs and utencils. The final rinse temperature of the dish machine registered 157 for the A wing nursing unit kitchenette and 165 for the C wing nursing unit kitchenette. The required final rinse water temperature for these dish machines to effectively sanitize the dish ware cups, bowls mugs and utencils was 180 degrees Fahrenheit. The lack of fully operational essential equipment for the food and nutritional services department that was confirmed with the director of dietary services, Employee E3, at 1:00 p.m., on October 22, 2024. 28 Pa. Code 201.18(b)(1)(3)(e)(1)(2)(2.1) Management 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 06525 Based on observations of the physical environment of the food and nutrition services department and reviews of the pest control operator's reports it was determined that the facility failed to maintain an effective pest control program so that the building was free of pest. Findings include: Observations of the main kitchen revealed a set of double doors in hallway outside the kitchen. These doors opened directly onto the concrete dock. Additional observations revealed a large metal dumpster unit just below the concrete dock; where garbage and refuse was held for later disposal. The double doors did not seal completely upon closing; that was an air gap was evident along the threhold of the doors allowing easy access to the building for pests and rodents. Observations on the second floor B wing nursing unit kitchenette revealed a mouse running across the floor into a hole/void underneath the wooden cabinets. There was obvious water damage surrounding these wooden cabinets inside this kitchenette. A dish machine and sink were noted as part of the kitchenette equipment used for residents that were eating in the dining room on this second floor B wing nursing unit. A review of the contracted pest control operator's reports for October 7, 2024 revealed that the inside of the building was treated for common household pests (mice, roaches). A review of the contracted pest control operator's reports for September 12, 2024 revealed that the inside of the building was treated for common household pests (mice). A review of the contracted pest control operator's reports for September 3, 2024 revealed that the inside of the building was treated for common household pests (mice, roaches). The pest control operator indicated that the main kitchen contained food debris on the floors along with excess water. Floor drains needed cleaning for draining purposes. A review of the contracted pest control operator's reports for August 6, 2024 revealed that the inside of the building was treated for common household pests (mice, roaches and flies). A review of the contracted pest control operator's reports for July 15, 2024 revealed that the inside of the building was treated for common household pests (mice) on the second floor nursing unit. A review of the contracted pest control operator's reports for July 10, 2024 revealed that the inside of the building was treated for common household pests (mice, roaches). A review of the contracted pest control operator's reports for June 12, 2024 revealed that the inside of the building with focus especially in the main kitchen was treated for common household pests (mice, roaches). 28 Pa. Code 201.18(b)(1)(3) Management (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.14(a) Responsibility of licensee