STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395427	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Home at Hollidaysburg	916 Hickory Street Hollidaysburg, PA 16648

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 48941 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the resident and/or resident representative had an opportunity to develop an advance directive (instructions regarding the provision of health care when the resident is incapacitated) or assist in formulating an advance directive for three of 25 residents reviewed (Residents 22, 27, 35). Findings include: The facility policy regarding advance directives and life sustaining treatment preferences, dated January 11, 2024, indicated that upon admission, the persons served will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. If the persons served indicates that he or she has not established advance directives, the healthcare center staff will offer assistance in establishing advance directives. The persons served will be given the option to accept or decline the assistance, and care will not be contingent on either decision. Nursing staff will document in the medical record the offer to assist, and the persons served decision to accept or decline assistance. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 22, dated July 16, 2024, indicated that the resident was cognitively intact, was able to be clearly understood and clearly able to understand others, and required assistance with care needs. A quarterly MDS assessment for Resident 27, dated June 8, 2024, revealed that the resident was cognitively impaired, was usually understood and usually able to understand others, and required assistance for care needs. A quarterly MDS assessment for Resident 35, dated August 22, 2024, revealed that the resident was cognitively impaired, was rarely/never understood and was rarely/never able to understand others, was dependent for care needs, and had a diagnosis that included dementia. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395427	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical records for Residents 22, 27, and 35 revealed that they did not have advance directives. There was no documented evidence in their clinical records to indicate that the residents and/or their representative were informed of their rights to develop advance directives, no documented evidence that the residents and/or their representatives were provided the opportunity and assistance to formulate an advance directive, and no documented evidence that advanced directives were addressed with the residents and/or resident representatives periodically throughout their course of stay. Interview with the Director of Nursing on September 12, 2024, at 3:12 p.m. confirmed that there was no documented evidence in Resident 22's, 25's and 35's clinical records to indicate that the residents and/or their representatives were informed of their rights to develop advance directives, no documented evidence that the residents and/or their representatives were provided the opportunity and assistance to formulate an advance directive, and no documented evidence that advanced directives were addressed with the residents and/or resident representatives periodically throughout their course of stay. Interview with the Social Service Director on September 12, 2024, at 4:16 p.m. indicated that on admission, if the residents have advanced directives, they are obtained and placed in the medical record. She indicated that if they do not have advance directives, they are given the information on advanced directives and if they decide they do not want to formulate one, the facility does not pursue it any further and the facility does not document in the resident's clinical record the decision to or not to formulate an advanced directive. 28 Pa. Code 201.29(a)(d) Resident Rights.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 19102 Based on clinical record reviews and staff interviews, it was determined the facility failed to provide clearly documented reasons for facility-initiated transfers to the hospital to the resident and resident's representative in language and manner that could be easily understood for five of 25 residents reviewed (Residents 8, 18, 35, 42, 47). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 8, dated August 4, 2024, revealed that the resident was cognitively intact, was independent with personal hygiene care needs, and had diagnosis that included dementia. A nurse's note for Resident 8, dated January 17, 2024, revealed that the resident had a fall in her bathroom and complained of right hip pain. The physician was notified, and the resident was transferred to the emergency room for evaluation. There was no documented evidence that a written notice of Resident 8's transfer to the hospital was provided to the resident or her responsible party regarding the reason for the transfer. A review of the clinical record revealed that Resident 18 was transferred to the hospital on September 2, 2024. There was no documented evidence that a Notice of Transfer letter was issued to Resident 18 or his responsible party. A quarterly MDS assessment for Resident 35, dated August 22, 2024, revealed that the resident was cognitively impaired, was rarely/never understood and was rarely/never able to understand others, was dependent for care needs, and had a diagnosis that included dementia. A nurse's note for Resident 35, dated July 9, 2024, at 11:55 a.m. revealed that the facility received a call from the physician's assistant at Elite Orthopedics indicating that the resident's fracture to her right upper extremity was open and they were sending her to the hospital for intravenous antibiotics. There was no documented evidence that a written notice of Resident 35's transfers to the hospital was provided to the resident's representative regarding the reason for transfer. An admission MDS assessment for Resident 42, dated August 28, 2024, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included diabetes. A nurse's note for Resident 42, dated August 26, 2024, at 9:19 a.m. revealed that the resident had complaints of dizziness and nausea, and was diaphoretic (sweating). The physician was notified, and the resident was transferred to the emergency room for evaluation. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence that a written notice of Resident 42's transfers to the hospital were provided to the resident or the resident's representative regarding the reason for transfer. A nursing note for Resident 47, dated September 4, 2024, at 10:27 a.m. revealed that the resident was admitted to the facility with diagnoses that included dementia. A nursing note, dated September 6, 2024, at 12:00 a.m. revealed the resident had a fall and received a 1.5 centimeter laceration to her forehead. The physician was notified, and the resident was transferred to the emergency room for evaluation. There was no documented evidence that a written notice of Resident 42's transfers to the hospital were provided to the resident or the resident's representative regarding the reason for transfer. Interview with the Director of Nursing on September 12, 2024, at 12:15 p.m. revealed that she was not aware that a written notice must be sent to the resident or their responsible party upon transfer out of the facility and therefore, no such letter was done. 28 Pa. Code 201.29(f)(k)(l)(2) Resident Rights. 28 Pa. Code 201.14(a) Responsibility of Licensee.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48941 Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was developed to reflect the resident's specific care needs for one of 25 residents reviewed (Resident 29). Findings: The facility's policy regarding care plans, dated January 11, 2024, indicated that the care plan is to ensure care and treatment is planned and individualized to the person's served problems/needs, conditions, impairment, disability, and or disease. If a significant change occurs, the care plan is to be reviewed for accuracy and completeness and revised if necessary. If any team member identifies an interim change that does not meet the definition of a significant change, the care plan may be adjusted accordingly. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 29, dated June 14, 2024, revealed that the resident was cognitively impaired, was sometimes understood and sometimes able to understand others, and required assistance with some care needs. A physician's note, dated March 7, 2024, indicated that the resident had a diagnosis of dementia. A physician's order for Resident 29, dated August 23, 2024, indicated that the resident was to receive four milligrams (mg) of Zofran (a medication given for nausea and vomiting) every six hours as needed for nausea and/or vomiting. A nurse's note for Resident 29, dated August 17, 2024, at 2:54 p.m., indicated that the resident had a large emesis at 2:40 p.m. A nurse's note, dated August 21, 2024, at 10:57 p.m., indicated that the resident had a small emesis. A nurse's note, dated August 30, 2024, at 10:48 p.m., indicated that the resident had a small emesis at 3:20 p.m. A nurse's note, dated September 2, 2024, at 2:38 p.m., indicated that the resident had an emesis that a.m. of undigested food, and Zofran was given with no further emesis. There was no documented evidence that a care plan was developed to address Resident 29's risk for dehydration related to her episodes of nausea/vomiting and her order for treatment with Zofran. Interview with the Director of Nursing on September 12, 2024, at 1:46 p.m. confirmed that a care plan to address Resident 29's risk for dehydration related to her episodes of nausea/vomiting and her order for treatment with Zofran was not developed and should have been. 28 Pa. Code 201.24(e)(4) Admission Policy. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 46994 Based on review of facility policies and residents' clinical records, as well as staff interviews, it was determined that the facility failed to review and revise care plans for two of 25 residents reviewed (Residents 15, 29). Findings include: The facility's policy regarding care plans, dated January 11, 2024, indicated that the care plan is to ensure care and treatment is planned and individualized to the person's served problems/needs, conditions, impairment, disability, and or disease. If a significant change occurs, the care plan is to be reviewed for accuracy and completeness and revised if necessary. If any team member identifies an interim change that does not meet the definition of a significant change, the care plan may be adjusted accordingly. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 15, dated July 10, 2024, indicated that the resident was understood and able to understand others, was dependent on staff for personal hygiene care, and had diagnoses that included hemiplegia (paralysis that affects only one side of your body) after having a stroke. Review of the care plan for Resident 15, dated July 29, 2019, revealed that the resident had right-sided hemiparesis (weakness on one side of the body) and hemiplegia and that staff were to encourage the resident to wear an AFO (Ankle Foot Orthosis - a support device intended to control the position and motion of the ankle) brace on his right foot when he was out of bed and wear a resting hand splint (device that supports the hand and wrist in the best position while resting) on his right hand at night and removed in the morning. There was no documented evidence that the resident was wearing an AFO brace or a resting hand splint. Interview with Resident 15 on August 12, 2024, at 9:11 a.m. revealed that the resident had not been wearing an AFO brace or a resting hand splint, and he did not recall if he ever had. Interview with the Director of Rehabilitation on August 12, 2024, at 9:29 a.m. revealed that the resident previously had an order to use a resting hand splint on his right hand; however, the resident refused to wear it, and the order was discontinued. Interview with Physical Therapist 1 on August 12, 2024, at 9:29 a.m. revealed that he was not aware of the resident needing or using an AFO brace in the two years he has been a physical therapist in the facility. The resident does not currently have an issue that would indicate the need for an AFO brace. Interview with the Director of Nursing on August 12, 2024, at 10:02 a.m. revealed that the resident did not use an AFO brace or a resting hand splint and that his care plan should have been revised to reflect that but was not. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An annual MDS assessment for Resident 29, dated June 14, 2024, revealed that the resident was cognitively impaired, was sometimes understood and sometimes able to understand others, required assistance with some care needs, and had a diagnosis of diabetes. A care plan for Resident 29, dated June 23, 2023, indicated that she was to have fingerstick blood sugars obtained per physician's orders. There was no documented evidence in the resident's clinical record that she was ordered to have fingerstick blood sugars obtained. An interview with the Director of Nursing on September 12, 2024, at 1:46 p.m. confirmed that Resident 29's care plan was not revised to reflect that the fingerstick blood sugars were discontinued. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 48941 Based on a review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that ambulation programs to maintain or improve physical abilities were provided as ordered and/or care planned for one of 25 residents reviewed (Resident 2). Findings include: An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated June 11, 2024, revealed that the resident was cognitively impaired, was usually understood and able to usually understand others, and required partial/moderate assistance to walk 10 feet, 50 feet and 150 feet. A care plan for Resident 2, initiated July 28, 2024, indicated that the resident had the potential for decline in abilities and was placed on an ambulation program. Staff was to offer assistance with the program as directed and was to incorporate programs into activities or tasks to improve participation (such as ambulate to/from bathroom and to/from dining room). The original initiation date for her restorative ambulation program was documented as August 25, 2023. A quarterly MDS assessment for Resident 2, dated August 1, 2024, revealed that the resident was cognitively impaired, was usually understood and able to usually understand others, and required partial/moderate assistance to walk 10 feet and 50 feet. The ability to walk 150 feet was not applicable. Clinical record review for Resident 2 revealed that she was on an ambulation program and was to be encouraged to ambulate 75 feet using a gait belt and a front-wheeled walker with assist of one staff and a wheelchair follow to and from the bathroom twice daily in the a.m. and p.m. seven days per week. Review of Resident 2's daily charting documentation for her ambulation program from June 2024 through August 2024, as well as review of nursing notes, revealed that there was no documented evidence that the ambulation program was completed in the a.m. for the following dates: July 12, July 19, August 4, August 22 and August 28. Review of Resident 2's daily charting documentation for her ambulation program from June 2024 through August 2024, as well as review of nursing notes, revealed that there was no documented evidence that the ambulation program was completed in the p.m. for the following dates: June 6, June 7, June 10, July 4, July 10, July 17, July 20, August 1, August 3, August 4, August 10, August 28, August 30, and August 31. An interview with the Director of Nursing on September 12, 2024, at 4:36 p.m. confirmed that there was no documented evidence that Resident 2's ambulation program was completed on the above-mentioned dates. 28 Pa. Code 211.12(d)(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** 46994 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders were followed for one of 25 residents reviewed (Resident 45). Findings include: A review of the clinical record for Resident 45 revealed that the resident was admitted to the facility on [DATE], with diagnoses that included diabetes. Physician's orders for Resident 45, dated September 8, 2024, included an order for the resident to have her blood sugar checked before meals and at bedtime and for staff to administer sliding scale (dose is based on a person's blood sugar) insulin (medication used to lower blood sugar). Review of the Medication Administration Record (MAR) for Resident 8, dated September 2024, revealed no documented evidence that the resident's blood sugar was checked to determine if insulin was required on September 9 before breakfast, on September 10 before breakfast, and on September 10 before supper. Interview with the Director of Nursing on September 12, 2024, at 3:05 p.m. confirmed that there was no documented evidence that Resident 8's blood sugar was checked as ordered by the physician on the above-mentioned dates and times per physician orders. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 48941 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that treatments for pressure ulcers were provided as ordered by the physician for one of 25 residents reviewed (Resident 4). Findings include: The facility's policy regarding treatment/medication administration, dated January 11, 2024, indicated that medications are administered in a safe and timely manner, and as prescribed and recorded on the resident's treatment administration record (TAR). A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated June 29, 2024, revealed that the resident was cognitively impaired, was understood and able to understand others, required assistance with care needs, was dependent for transfers, had two unstageable pressure ulcers (full-thickness pressure injuries in which the base is obscured by slough and/or eschar), and had a diagnosis that included peripheral vascular disease (disease reducing blood flow to the legs). A care plan, initiated on June 25, 2024, revealed that the resident had areas to his bilateral heels with an intervention to administer treatments as ordered. Physician's orders for Resident 4, dated July 13, 2024, included an order for staff to cleanse bilateral heels with normal saline (a sterile solution used for the moistening of wound dressings and wound debridement), pat dry, apply skin prep (creates a barrier to protect skin from irritants like medical adhesives) to the peri wound, allow to dry, apply single layer of xeroform (dressing used to prevent and treat infections and promote wound healing), cover with alleyvn heel (a padded foam dressing for added comfort), wrap with kerlix (wrap used to secure dressing in place) and secure with tape daily and as needed for blister/deep tissue injury (pressure injury that affects the underlying soft tissues and may not be visible until advanced) to bilateral heels. A review of the resident's Treatment Administration Record (TAR) for July 2024 revealed that the resident did not receive the treatment on July 19, 2024, as ordered. Physician's orders for Resident 4, dated August 22, 2024, included an order for staff to cleanse the left heel pressure ulcer with wound cleanser, apply silver alginate (antimicrobial dressing used to prevent infection and absorb drainage) to base of the wound, and secure with border foam every other day and as needed. A review of the resident's Treatment Administration Record (TAR) for August 2024 revealed that the resident did not receive the treatment on August 2, 5, and 14, 2024, as ordered. Interview with the Director of Nursing on September 11, 2024, at 8:49 a.m. confirmed that there was no documented evidence that wound treatments were done to the areas listed above on dates listed above. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46994 Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to provide adequate supervision and failed to ensure that the environment remained as free of accident hazards as possible for three of 25 residents reviewed (Residents 4, 29, 40). Findings include: A facility policy for elopement, dated January 11, 2024, indicated that an elopement is defined as when a resident leaves the facility, or enters an unsafe area, without any team member being aware that the resident has done so. An analysis of each elopement is to be completed by the health care center management team, identifying all possible reasons why safety and security measures were breached. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 40, dated August 9, 2024, indicated that the resident was moderately cognitively impaired, had a history of wandering, was independent with personal hygiene needs and ambulation, and had diagnoses that included dementia. A care plan for Resident 40, dated August 1, 2023, indicated that the resident was at risk for wandering out of the facility. Staff were to discuss and investigate causes of wandering and exit-seeking behaviors, attempt to intervene, and provide interventions, support, and reassurance for her needs and wants. An intervention, dated April 1, 2024, indicated that staff were to complete checks on her whereabouts for safety every 15 minutes when warranted. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nurse's note for Resident 40, dated November 24, 2023, at 9:00 p.m. revealed that the resident went to the first floor using the front elevator. She reported to staff at the time that she knew she was not supposed to use the elevator but did anyway. A nurse's note, dated January 10, 2024, at 3:24 p.m. revealed that the resident was found roaming the front hall on the first floor by housekeeping staff. The resident was given a snack and returned to the second floor. A nurse's note, dated January 15, 2024, at 8:43 p.m., revealed that the resident was found wandering on the first floor near the back hall nurse's station, reporting that she was going to dinner with her family. She was escorted to her room on the second floor. A nurse's note, dated February 11, 2024, at 11:26 a.m., revealed that the resident appeared on the first floor from the front elevator. The nurse aide was not aware that the resident was not on the second floor. A nurse's note, dated April 1, 2024, at 6:24 p.m., revealed that the resident was not on the second floor when staff completed a 15-minute check on the resident. The resident was found on the first floor sitting on the sofa in the lounge and she was assisted upstairs. A nurse's note, dated June 14, 2024, at 2:45 p.m., revealed that the resident was off the unit and returned by staff at 2:40 p.m. A nurse's note, dated July 5, 2024, at 1:30 p.m., revealed that the resident was in her room at 1:15 p.m. and was found on the first floor at 1:22 p.m. The resident reported that she was looking for the bathroom and was redirected to the bathroom on the second floor. A nurse's note, dated July 29, 2024, at 9:13 p.m., revealed that the resident was unable to be located during her 15-minute check and was found on the first floor. She was returned to the second floor without difficulty. A nurse's note, dated August 31, 2024, at 1:21 p.m., revealed that at approximately 11:50 a.m. the resident was observed by staff on the first floor at the rear elevator. She was last seen at 11:45 a.m. in the activity room and returned to the second floor without difficulty. An interview with the Director of Nursing on September 10, 2024, at 11:54 a.m. revealed that resident rooms on the first floor have been empty since March 6, 2024. There was no documented evidence that the facility conducted an investigation or an analysis of Resident 40's repeated elopements from the second floor. An interview with the Director of Nursing on September 10, 2024, at 2:34 p.m. confirmed that Resident 40 left the second floor on the identified dates and times without supervision. An analysis was not completed because the facility did not view the incidents as elopements. Resident 40 was not supposed to leave the floor without supervision, but the facility believed she remained safe because the outside doors were locked preventing her from leaving the facility. The Director of Nursing confirmed that there was potential for the resident to be unsafe when leaving the unit unsupervised. An interview with the Director of Nursing on September 11, 2024, at 10:44 a.m. confirmed that there was a risk for Resident 40 when she eloped from the second floor and administration was not in the facility, but believed the resident remained safe because of the 15-minute checks being completed. The resident and her elopements were discussed at morning meetings, but there was no documentation of it and no formal investigations or analysis were completed. A facility policy for assessments of falls, dated January 11, 2024, indicated that when a resident falls, the following information should be recorded in the resident's medical record: the immediate interventions and appropriate interventions taken to prevent future falls. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Lutheran Home at Hollidaysburg		STREET ADDRESS, CITY, STATE, ZIP CODE: 916 Hickory Street Hollidaysburg, PA 16648	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility policy for managing falls and fall risk, dated January 11, 2024, indicated that if a resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. The attending physician will help the staff reconsider possible causes that may not previously been identified. A significant change MDS assessment for Resident 4, dated June 29, 2024, revealed that the resident was cognitively impaired, was understood and able to understand others, required assistance with care needs, was dependent for transfers, had a fall without injury since his prior assessment, and had diagnoses that included Parkinson's and dementia. A nurse's note for Resident 4, dated August 25, 2024, at 2:42 p.m., indicated that the resident had a fall at 1:30 p.m. when he attempted to transfer himself to the bathroom. The resident was assessed with no apparent visible injuries. Review of the fall investigation revealed that Resident 4 was stated on hourly safety checks beginning August 26, 2024, through August 28, 2024. Review of the hourly safety checks for Resident 4, initiated on August 26, 2024, revealed that there was no documented evidence that the hourly safety checks were completed on August 27, 2024, at 11:00 a.m., 12:00 p.m., and 1:00 p.m. Interview with the Director of Nursing on September 12, 2024, at 1:25 p.m. confirmed that hourly safety checks were not completed for Resident 4 on August 27, 2024, on the above-mentioned times. An annual MDS assessment for Resident 29, dated June 14, 2024, revealed that the resident was cognitively impaired, was sometimes understood and sometimes able to understand others, required assistance with some care needs, and had two or more falls without injury since the prior assessment. A physician's note, dated March 7, 2024, indicated that the resident had a diagnosis of dementia. A nurse's note for Resident 29, dated December 24, 2023, at 11:57 a.m., indicated that at 8:15 a.m. a staff nurse aide notified the nurse that the resident had indicated she had fallen on the floor and hit her head and left shoulder. Upon investigation, the nurse observed a discolored, reddened, raised area to the back of the resident's head with a small circular area in middle that was purple/blue in color and a dark red and purple abrasion to the resident's left upper ear. A nursing assessment to the resident's left shoulder area revealed no changes in skin color and no bruising or open areas. The resident indicated that she was going to go to the bathroom when she slipped on her socks and fell to the floor beside the bed. She indicated that she got herself up and crawled back to bed. The nurse indicated that nonskid slipper socks were applied, and the resident was educated to wear nonskid slipper socks with ambulation. X-ray results to the resident's left shoulder were pending. A nurse's note for Resident 29, dated December 24, 2023, at 1:22 p.m., indicated that Resident 29 complained of pain with range of motion to her left shoulder. The nurse indicated there was no swelling or bruising to the resident's left upper extremity/shoulder. A nurse's note for Resident 29, dated December 24, 2023, at 2:52 p.m., indicated that Resident 29's x-ray results were suspicious for a nondisplaced fracture of the distal fourth shaft aspect of the left clavicle. A nurse's note for Resident 29, dated December 24, 2023, at 3:45 p.m., indicated that Resident 29's neurological checks and safety checks were ongoing. (continued on next page)

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	395427	A. Building B. Wing	09/12/2024

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Lutheran Home at Hollidaysburg	916 Hickory Street Hollidaysburg, PA 16648

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the hourly safety checks for Resident 29, initiated on December 24, 2023, revealed no documented evidence that the hourly safety checks were completed on December 24, 2023, at 4:00 p.m., 5:00 p.m., 6:00 p.m., 7:00 p.m., 8:00 p.m. and 9:00 p.m. and on December 25, 2023, at 3:00 p.m., 4:00 p.m., 5:00 p.m., 6:00 p.m., 7:00 p.m., 8:00 p.m. and 9:00 p.m. Interview with the Director of Nursing on September 12, 2024, at 12:35 p.m. confirmed that hourly safety checks were not completed for Resident 29 on December 24, 2023, and December 25, 2023, on the above-mentioned times. A nurse's note for Resident 29, dated April 26, 2024, at 7:04 a.m., revealed that the resident said she rolled out of bed during the night because she was too close to the edge. She denied hitting her head and indicated that she hit her knees but did not have pain and was able to get back into bed on her own. There were no documented injuries to her head or bilateral knees. Neurological checks and safety checks were initiated. A nurse's note for Resident 29, dated May 16, 2024, at 7:33 p.m., indicated that the resident lost her balance with her walker and fell across her bed with no injuries documented. Interview with the Director of Nursing on September 12, 2024, at 12:35 p.m. revealed that new interventions were not developed after Resident 29's fall on the above-mentioned dates because the facility felt that all of the appropriate interventions were already in place. A nurse's note for Resident 29, dated June 14, 2024, at 10:15 p.m., indicated that the resident reported that she fell in her room and hit the left side of her head. There were no documented injuries. Neurological checks and hourly safety checks were initiated. Review of the hourly safety checks for Resident 29, initiated on June 14, 2024, revealed that there was no documented evidence that the hourly safety checks were completed on June 17, 2024, at 3:00 p.m., 4:00 p.m., 5:00 p.m., 6:00 p.m., 7:00 p.m., 8:00 p.m. and 9:00 p.m. Interview with the Director of Nursing on September 12, 2024, at 12:35 p.m. confirmed that hourly safety checks were not completed for Resident 29 on June 17, 2024, on the above-mentioned times and revealed that new interventions were not developed after Resident 29's fall on the above-mentioned date. A nurse's note for Resident 29, dated August 8, 2024, at 6:28 p.m., indicated that the resident had a fall and was observed lying on her right side with her walker on top of her and head toward the door. The resident denied hitting her head and reported that she was putting her blanket on her bed and got her walker tangled in it. There were no documented injuries. Neurological checks and safety checks were initiated. Review of the hourly safety checks for Resident 29, initiated on August 8, 2024, revealed that there was no documented evidence that the hourly safety checks were completed on August 8, 2024, at 6:00 p.m., 7:00 p.m., 8:00 p.m. and 9:00 p.m. Interview with the Director of Nursing on September 12, 2024, at 12:35 p.m. confirmed that hourly safety checks were not completed for Resident 29 on August 8, 2024, on the above-mentioned times. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nurse's note for Resident 40, dated January 28, 2024, revealed that the resident had an unwitnessed fall in her room. The resident reported that her foot slipped causing her to fall. A nurse's note, dated April 19, 2024, at 4:13 p.m., revealed that the resident had a witnessed fall in her room. The resident lost her balance and fell hitting her head on the footboard and sustained a hematoma to her head and a bruise to her left shoulder. A nurse's note, dated April 20, 2024, at 1:54 p.m., revealed that the resident was observed on the floor in her room. The resident reported sliding off the bed. A nurse's note, dated June 3, 2024, at 8:35 p.m., revealed that the resident was observed on the floor in her room. The resident reported sliding off the bed. A nurse's note, dated June 11, 2024, revealed that the resident was observed on the floor in her room beside her bed. A nurse's note, dated July 15, 2024, at 11:51 p.m., revealed that the resident was observed on the floor in front of the chair in her room. The resident reported sliding off the chair. Interview with the Director of Nursing on August 12, 2024, at 1:40 p.m. revealed that new interventions were not developed after Resident 40's fall on the above-mentioned dates because the facility felt all the appropriate interventions were already in place. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.12(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. 19102 Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure that interventions were in place to prevent urinary tract infections for one of 25 residents reviewed (Resident 13) who had an indwelling urinary catheter. Findings include: A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs), dated August 8, 2024, revealed that the resident had diagnoses that included dementia and obstructive uropathy (when urine cannot drain through the urinary tract) and had an indwelling urinary catheter (a flexible tube inserted and held in the bladder to drain urine). Physician's orders for Resident 13, dated August 6, 2024, included an order for the resident to have an indwelling urinary catheter due to having an obstruction and urinary retention. A care plan, dated August 6, 2024, indicated that the catheter tubing and collection bag were to be kept off the floor. Observations of Resident 13 on September 12, 2024, at 12:31 p.m. and 12:37 p.m. revealed that she was in her recliner chair and her catheter drainage tubing and collection bag were in direct contact with the floor. Interview with Nurse Aide 2 at that time confirmed that the catheter tubing and bag should not be in contact with the floor. Interview with the Director of Nursing on September 12, 2024, at 1:48 p.m. confirmed that Resident 13's catheter tubing and bag should be off the floor. 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. 19102 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that interventions to maintain nutrition were provided as recommended by the dietician for one of 25 residents reviewed (Resident 13). Findings include: A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 13, dated August 8, 2024, revealed that the resident was cognitively intact, required supervision with eating, weighed 106 pounds, and had weight loss. Dietary notes for Resident 13, dated August 26, 2024, at 3:41 p.m., revealed that the resident had a significant weight loss and the dietitian recommended to the physician to add four ounces of magic cup (frozen nutritional supplement) daily with dinner and four ounces of enriched pudding (pudding with additional nutrients) daily with lunch. Observations of Resident 13 during the lunch meal on September 12, 2024, at 12:31 p.m. revealed that the resident was sitting in her room eating her meal, and she did not have enriched pudding. The resident's meal ticket, dated September 12, 2024, indicated that the resident was to have enriched pudding. Interview with Nurse Aide 2 on September 12, 2024, at 12:37 p.m. confirmed that Resident 13 did not receive enriched pudding with her lunch meal. Interview with the Director of Nursing on September 12, 2024, at 2:22 p.m. confirmed that Resident 13 should have received enriched pudding if it was on her meal ticket. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38012 Based on a review of facility job descriptions and personnel files, as well as staff interviews, it was determined that the facility failed to ensure that staff renewed the nurse aide registry to allow individuals to work as a nurse aide for one of six nurse aides reviewed (Nurse Aide 3). This deficiency was cited as past non-compliance. Findings include: The facility's job description for Nurse Aide, undated, revealed that a nurse aide certification was necessary to perform functions of the position. The personnel file for Nurse Aide 3 revealed that her certification on the nurse aide registry expired on [DATE]. The facility was unaware that Nurse Aide 3's certification on the nurse aide registry was expired until it was discovered it on [DATE]. Nurse Aide 3 worked in the facility from [DATE] to [DATE]. Interview with the Nursing Home Administrator on [DATE], at 1:21 p.m. confirmed that Nurse Aide 3's certification on the nurse aide registry expired on [DATE], and should have been renewed prior to expiring and working in the facility. Following the discovery that a nurse aide's certification had expired the following corrective action were taken: The nurse aide was immediately pulled from the schedule, then terminated for not renewing her registry timely. The Director of Nursing immediately upon discovery of the expired registry completed an audit of all registry and licensed staff to verify that there were no other staff with expired status. The Nursing Home Administrator, Director of Nursing, Administrative Assistant, and Human Resources Director will be responsible for checking all registry and license expiration dates for the month. Staff members who have registry or licenses that will expire that month will be given written notice that they must renew within the month. If staff do not renew within two weeks of the written notice, they are pulled from the schedule and will not be scheduled for work until after they renew. The Nursing Home Administrator educated the Director of Nursing, the Administrative Assistant, and the Human Resources Director on the new policy regarding verifying the current status of the employee's registry or license. The review of the facility's corrective actions revealed that they were in compliance with F729 as of [DATE]. 28 Pa. Code 201.29 Personnel Policies and Procedures.

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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. 19102 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure the accountability of controlled medications (drugs with the potential to be abused) for one of 25 residents reviewed (Resident 3). Findings include: A facility policy for medication administration, dated January 11, 2024, indicated that medications were to be poured, administered, and documented by the licensed team member with accountability for the specific medication cart. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated August 9, 2024, revealed that the resident was cognitively impaired, was understood and understands, had pain, and received an opioid (a controlled pain medication). Physician's orders for Resident 3, dated November 29, 2023, included and order for the resident to receive 5-325 milligrams (mg) of hydrocodone-acetaminophen three times a day for chronic arm pain. Review of the controlled drug record (a form that accounts for each tablet/pill/dose of a controlled drug) for Resident 3 for June, July and August 2024 revealed that staff signed out a dose of hydrocodone-acetaminophen for administration to the resident on June 21 at 11:00 p.m., July 19 at 3:00 p.m. , August 6 at 11:00 p.m., August 8 at 11:00 p.m., August 11 at 11:00 p.m., and August 21, 2024 at 11:00 p. m. However, there was no documented evidence in the resident's clinical record, including on the Medication Administration Record (MAR) and nursing notes, that the hydrocodone-acetaminophen was administered to the resident on the above listed dates and times. Interview with the Director of Nursing on September 12, 2024, at 12:15 p.m. confirmed that there was no documented evidence in Resident 3's clinical records to indicate that the signed-out doses of hydrocodone-acetaminophen were administered to the resident on the above-mentioned dates and times. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(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. 19102 Based on review of policies, observations, and staff interviews, it was determined that the facility failed to properly secure and store medications in one of two medication rooms (front hall). Findings include: The facility's policy regarding medication storage, dated January 11, 2024, indicated that all drugs and biologicals were to be stored in a safe, secure, and orderly manner. The nursing staff was responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals were to be locked when not in use. Unlocked medication carts were not to be left unattended. Observations on September 9, 2024, at 10:25 a.m. revealed that the door to the medication room on the second floor (front hall) was left open and unattended. The medication cart was stored inside the medication room and was unlocked. Interview with Licensed Practical Nurse 4 on September 9, 2024, at 10:28 a.m. confirmed that she was down the hallway and the medication room should have been locked Interview with the Director of Nursing on September 9, 2024, at 3:15 p.m. confirmed that the medication cart and room should have been locked when unattended by staff. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(1)Nursing Services.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 19102 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that laboratory specimens were obtained as ordered by the physician for one of 25 residents reviewed (Resident 3). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated August 9, 2024, indicated that the resident was cognitively impaired and was receiving an anticoagulant (blood thinner). A care plan, dated January 20, 2023, indicated that the resident had a history of deep vein thrombosis (blood clot that develops in a deep vein) and pulmonary embolism (blood clot that goes to lung), and Coumadin was to be administered as ordered and laboratory results were to be monitored per physician orders. Physician's orders for Resident 3, dated August 28, 2024, included an order for the resident to receive 6.5 milligrams (mg) of Coumadin (a blood thinner) daily and to check the PT/INR (a test that indicates how much time it takes for the blood to clot) on September 4, 2024. A review of Resident 3's clinical record revealed that staff failed to obtain the PT/INR on September 4, 2024, as ordered. Interview with the Director of Nursing on September 11, 2024, at 1:26 p.m. confirmed that Resident 3 did not have a PT/INR drawn on September 4, 2024, as ordered by the physician and should have. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 19102 Based on review of polices and clinical records, as well as staff interviews, it was determined that the facility failed to maintain clinical records that were complete and accurately documented for two of 25 residents reviewed (Residents 42, 45). Findings include: A facility policy for medication administration, dated January 11, 2024, indicated that medications were to be poured, administered, and documented by the licensed team member with accountability for the specific medication cart. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 42, dated August 28, 2024, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, had diagnoses that included diabetes, and received insulin. Physician's orders for Resident 42, dated August 22, 2024, included an order for the resident to receive Humalog insulin (medication used to lower blood sugar) subcutaneously (beneath the skin) with meals based on a sliding scale (amount of insulin based on blood sugar results). Review of the Medication Administration Record (MAR) for Resident 42, dated August and September 2024, revealed that the amount of insulin administered with meals (7:30 a.m., 11:30 a.m., 4:30 p.m.) according to the sliding scale were not documented on the MAR. Interview with the Director of Nursing on September 11, 2024, at 1:26 p.m. confirmed that there was no documentation of the amount of insulin provided according to the sliding scale and that the amount of insulin administered should be charted on the MAR. Review of the clinical record for Resident 45 revealed that the resident was admitted to the facility on [DATE], with diagnoses that included diabetes. Physician's orders for Resident 45, dated September 8, 2024, included an order for the resident to have her blood sugar checked before meals and at bedtime and for staff to administer sliding scale (dose is based on a person's blood sugar) insulin (medication used to lower blood sugar). Review of the MAR for Resident 8, dated September 2024, revealed that the results of Resident 45's blood sugar testing were not documented before supper on September 8, 2024, or before breakfast, lunch and supper on September 9, 10 and 11, 2024. Interview with the Director of Nursing on September 12, 2024, at 3:05 p.m. confirmed that there was no documented evidence that Resident 8's blood sugar results were documented in her clinical record, and they should have been. 28 Pa Code 211.5(f) Clinical Records. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395427	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER Lutheran Home at Hollidaysburg		STREET ADDRESS, CITY, STATE, ZIP CODE 916 Hickory Street Hollidaysburg, PA 16648	

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.12(d)(5) Nursing Services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395427	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 38012 Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plan of corrections for an annual survey ending October 12, 2023, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending September 13, 2024, identified repeated deficiencies related to a failure to develop and implement comprehensive care plans, failure to revise care plans, failure to protect residents from accidents/hazards, failure to store medications securely,; and failure to ensure that resident's medical records were complete and accurate. The facility's plan of correction for a deficiency regarding developing and implementing care plans, cited during the survey ending October 12, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F656, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure care plans were developed and implemented timely. The facility's plan of correction for a deficiency regarding revision of care plans, cited during the survey ending October 12, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F657, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that resident's care plans were revised timely. The facility's plan of correction for a deficiency regarding safety and accident hazards, cited during the survey ending October 12, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F689, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure residents were free from accidents and hazards. The facility's plan of correction for a deficiency regarding labeling and storing medications, cited during the survey ending October 12, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F761, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that medications were stored securely. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395427	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Home at Hollidaysburg	916 Hickory Street Hollidaysburg, PA 16648

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's plan of correction for a deficiency regarding complete and accurate medical records, cited during the survey ending October 12, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F842, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that resident's medical records were complete and accurate. Refer to F656, F657, F689, F761, F842. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395427	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER Lutheran Home at Hollidaysburg		STREET ADDRESS, CITY, STATE, ZIP CODE 916 Hickory Street Hollidaysburg, PA 16648	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46994 Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that staff used proper infection control techniques during incontinent care for one of 25 residents reviewed (Resident 30). Findings include: The facility's policy regarding hand washing, dated January 11, 2024, indicated that hand washing is the single most important means of preventing infection, and that hands are to be washed after the care of the resident, and after any contact which may contaminate you. Gloves are worn when there is contact with blood and body fluids, secretions, and excretions. Gloves are not a substitute for hand washing, and hands are to be washed even when gloves are worn. A quarterly minimum data set (MDS) assessment (mandated to assess the resident abilities and care needs) for Resident 30, dated August 31, 2024, indicated that she was cognitively intact, was dependent on staff for toileting hygiene, had an indwelling catheter (a thin, hollow tube that is inserted into the bladder to collect and drain urine), was frequently incontinent of bowel, and had diagnosis that included Multiple Sclerosis (a disorder of the central nervous system marked by weakness, numbness, a loss of muscle coordination, and problems with vision, speech, and bladder control). Observations of Resident 30 on August 11, 2024, at 9:26 a.m. revealed that the resident had been incontinent of bowel. With the assistance of another nurse aide, Nurse Aide 5 rolled the resident on her left side and removed bowel movement from the resident's buttocks with disposable wipes, then removed a soiled brief that was under the resident. Without removing the contaminated gloves and washing her hands, Nurse Aide 5 placed a sling under the resident for transfer use, handled the resident's indwelling catheter drainage bag tubing to clamp it, and put the unused disposable wipes in the resident's bed side table. Interview with Nurse Aide 5 on August 11, 2024, at 9:42 a.m. revealed that she should have removed her gloves and washed her hands after providing incontinent care and before touching the resident's sling, indwelling catheter tubing and container of disposable wipes. Interview with the Director of Nursing on August 11, 2024, at 10:44 a.m. confirmed that Nurse Aide 5 should have removed her gloves and completed hand hygiene immediately after providing incontinence care and prior to touching the resident's the personal belongings and catheter tubing. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.