STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395433	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Tunkhannock	30 Virginia Drive Tunkhannock, PA 18657

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records and staff interviews, it was determined that the facility failed to afford a resident and their designated representative the right to participate in the development of the resident's plan of care for five residents out of five interviewed during a resident group interview (Residents 19, 30, 37, 61, and 73). Findings include: A clinical record review revealed that Resident 19 was admitted to the facility on [DATE], with diagnoses that included osteoarthritis (a degenerative joint disease in which the tissues in the joint break down over time). A review of the quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 7, 2024, revealed that Resident 19 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognitively intact). A clinical record review revealed that Resident 30 was admitted to the facility on [DATE] with diagnoses that include chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe). A review of the MDS assessment dated [DATE] revealed that Resident 30 was cognitively intact with a BIMS score of 13. A clinical record review revealed that Resident 37 was admitted to the facility on [DATE], with diagnoses to include dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A review of the quarterly MDS assessment dated [DATE] revealed that Resident 37 was moderately cognitively impaired with a BIMS score of 11 (a score of 8-12 indicates moderate cognitive impairment). A clinical record review revealed that Resident 61 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease. A review of the quarterly MDS assessment dated [DATE], revealed that Resident 61 was severely cognitively impaired with a BIMS score of 7 (a score of 0-7 indicates severe cognitive impairment). (continued on next page)

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

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A clinical record review revealed that Resident 73 was admitted to the facility on [DATE], with diagnoses that included cerebral infarction (brain damage that results from a lack of blood). A review of a quarterly MDS assessment dated [DATE] revealed that Resident 73 is cognitively intact with a BIMS score of 15. During the resident group interview on May 20, 2024, at 10:00 AM, all residents in attendance (Residents 19, 30, 37, 61, and 73) stated that the facility did not provide them the opportunity to participate in their care plan meetings. A clinical record review revealed a multidisciplinary care conference form dated May 9, 2024, indicating that a care plan meeting occurred for Resident 61 and was attended by a representative from Social Services and a licensed nurse representative. There was no information entered in the field regarding the resident's response to the care conference invitation or the resident's representative's response to the care conference invitation. There was no documentation that Resident 61 or Resident 61's resident representative was afforded the opportunity to participate in the review and revision of her care plan. Further review revealed no evidence that the plan of care was provided to the resident or resident representative for review following the meeting. A clinical record review revealed a multidisciplinary care conference form dated May 7, 2024, indicating that a care plan meeting occurred for Resident 30 and was attended by a representative from social services and a licensed occupational therapist. The form had no information entered in the field regarding the resident's response to the care conference invitation or the responsible party's {resident representative} response to the care conference invitation. There was no documentation that Resident 30 was afforded the opportunity to participate in the review and revision of his care plan. Further review revealed no evidence that the plan of care was provided to the resident for review following the meeting. A clinical record review revealed a multidisciplinary care conference form dated May 15, 2024, indicating that a care plan meeting occurred for Resident 73 and was attended by a representative from social services and a licensed nurse representative. The form had no information entered in the field regarding the resident's response to the care conference invitation or the responsible party's response to the care conference invitation. There was no documentation that Resident 73 or Resident 73's resident representative was afforded the opportunity to participate in the review and revision of her care plan. Further review revealed no evidence that the plan of care was provided to the resident or resident representative for review following the meeting. A clinical record review revealed a multidisciplinary care conference form dated May 9, 2024, indicating that a care plan meeting occurred for Resident 19 and was attended by a certified dietary manager and a licensed occupational therapist. The form had no information entered in the field regarding the resident's response to the care conference invitation or the responsible party's response to the care conference invitation. There was no documentation that Resident 19 or Resident 19's resident representative was afforded the opportunity to participate in the review and revision of her care plan. Further review revealed no evidence that the plan of care was provided to the resident or resident representative for review following the meeting. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A clinical record review revealed a Multidisciplinary Care Conference form dated May 9, 2024, indicating that a care plan meeting occurred for Resident 37 and was attended by a certified dietary manager, a licensed occupational therapist, and the activities director. The form had no information entered in the field regarding the resident's response to the care conference invitation or the responsible party's response to the care conference invitation. There was no documentation that Resident 37 or Resident 37's resident representative was afforded the opportunity to participate in the review and revision of her care plan. Further review revealed no evidence that the plan of care was provided to the resident or resident representative for review following the meeting. During an interview on May 20, 2024, at approximately 1:00 PM, the Nursing Home Administrator (NHA) indicated that letters are provided to residents and resident representatives inviting them to participate in care plan meetings. The DON and NHA were unable to explain why Residents 19, 30, 37, 61, and 73 indicated that they had not been afforded the opportunity to participate in care plan meetings. During an interview on May 20, 2024, at approximately 1:20 PM, Resident 30 stated that he was never provided a letter inviting him to a care plan meeting. During an interview on May 21, 2024, at approximately 9:30 AM, Resident 19 stated that she was never provided with a letter inviting her to a care plan meeting. During an interview on May 21, 2024, at approximately 10:30 AM, the NHA confirmed that it is the facility's responsibility to ensure that residents are afforded an opportunity to participate in the development of their plan of care. 28 Pa. Code 201.29 (a) Resident rights

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 48276 Based on a review of select facility policy, the minutes from resident council meetings, grievance logs, and resident and staff interviews, it was determined that the facility failed to demonstrate timely action to resolve resident grievances raised at resident group meetings and keep the residents apprised of the status of the facility's decisions and efforts toward grievance resolution, including concerns expressed by five of the five residents interviewed during a resident council group interview (Residents 19, 30, 37, 61, and 73). Findings include: A review of facility policy titled Grievance Policy and Guidelines, last reviewed by the facility in July 2023, indicated that all employees are responsible for ensuring customer satisfaction. The policy indicates that when concerns arise, a grievance system is in place to resolve the issues to the satisfaction of all parties involved. The policy also indicates that response to the grievance should be as soon as possible, but within ten working days of receipt of the grievance form. A review of resident council meeting minutes dated February 16, 2024, revealed residents in attendance had concerns indicating that their food and coffee were not being served hot. The residents in attendance suggested snack flyer postings so residents would know what snacks are available and suggested more filling snacks. The meeting minutes indicated that a grievance was filed on behalf of the residents regarding cold food and coffee temperatures. A review of grievances filed revealed no grievance form or actions taken to resolve the grievance. The concern was recorded on a February 2024 grievance log and indicated that all residents at the resident council had concerns that the temperature of the food and coffee was not hot. The log did not indicate actions taken by the facility to resolve the residents' concern. A review of resident council meeting minutes dated March 15, 2024 revealed that the grievance regarding the temperatures of the hot food and coffee was resolved. The meeting minutes indicated that a resident in attendance indicated that the coffee was hotter than usual. A review of resident council meeting minutes dated April 12, 2024, revealed that all residents in attendance indicated that their snacks were not being offered. The meeting minutes indicated a grievance was filed regarding the resident's concern. A review of grievances filed with the facility failed to reveal a grievance was filed on behalf of residents' regarding snacks offered. The facility grievance log dated April 2024 did not include any information regarding residents' concerns about not being offered snacks. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the resident group interview on May 20, 2024, at 10:00 AM, all residents in attendance (Residents 19, 30, 37, 61, and 73) indicated that they have concerns that snacks are not being offered, that the facility sometimes runs out of snacks, and that the temperature of food and coffee is cold. Residents 19, 37, 61, and 73 stated that they often wait 15 minutes for staff to respond to their call bell rings for assistance. The residents stated that if they need care, then the wait is even longer because the nursing staff will turn off the bell and then not come back for another 10 or 15 minutes to provide the care that's needed, on top of the 15 minutes they already waited. All residents in attendance stated that the facility does not have enough staff, which affects how quickly they can pass out meals and respond to residents calls for care or assistance. The residents in attendance stated that the facility has not resolved their concerns they have brought up regarding food temperatures, snacks, or call bell wait times. The residents in attendance confirmed that they continuously bring up these issues with facility staff and during resident council meetings. During the resident group interview on May 20, 2024, at 10:00 AM, the residents explained that the food trays are delivered hot, but the food often sits in the hall for 30 minutes or longer because there is not enough staff to distribute the meals and provide care that residents need. During an interview on May 21, 2024, at approximately 10:00 AM, the Nursing Home Administrator (NHA) confirmed that it is the facility's policy to demonstrate timely action to resolve resident grievances raised at resident group meetings and keep the residents apprised of the status of the facility's decisions and efforts toward grievance resolution. The NHA was not able to provide evidence that the facility made efforts to identify and address the cause of the resident's grievances. NHA was not able to explain why all residents interviewed during the resident group interview (Residents 19, 30, 37, 61, and 73) indicated that the facility has not addressed their concerns brought up at resident group meetings regarding food and coffee temperatures, snacks, and call bell wait times over the last few months. Refer F809 28 Pa. Code: 201.18 (e)(1)(4) Management. 28 Pa. Code: 201.29 (a) Resident Rights.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460 Based on observation, clinical record review, and resident and staff interviews, it was determined that the facility failed to provide housekeeping and maintenance services to maintain a clean and safe resident environment on two of two occupied resident care units. Findings include: An observation on May 18, 2024, at 11:10 AM in resident room [ROOM NUMBER] revealed a ceiling block with a large brown and tan stain above the resident's mirror. In the resident's bathroom, cracks in the floor were observed extending around the edge of the floor. The bathroom wall to the left of the sink, revealed multiple areas of scraped paint, gray and black scuff marks, and exposed drywall. An observation on May 18, 2024, at 11:14 AM in the Nursing [NAME] Hall shower room revealed that the sink faucet continuously flowed water when in the off position. The shower room vent was observed to have a thick layer of gray dust. A gray bucket under a shower chair was observed to contain a brown and black substance. A toilet with cardboard covering the tank and a missing tank lid. The resident shower stall was observed to have brown and black discoloration stains along the shower floor grout. An observation on May 18, 2024, at 9:36 AM in resident room [ROOM NUMBER] revealed a wall to the right of the resident's bathroom with a four-foot by one-foot area of scrapped wall exposing white plaster. Black scuffs were observed across the floor molding and bathroom door. Observation of resident room [ROOM NUMBER] on May 19, 2024, at 9:31 AM revealed that the top right dresser drawer was missing, and the top dresser drawer on the left side was unable to be opened/closed properly. Observation of resident room [ROOM NUMBER] on May 19, 2024, at 9:37 AM revealed that the second drawer on the resident's dresser was broken. The drawer was unable to be opened/closed properly. The ceiling tile around the vent in the resident bathroom was stained brown. Observation of resident room [ROOM NUMBER] on May 19, 2024, at 9:37 AM revealed that the second drawer on the right-hand side of the dresser was broken and would not open/close properly. Observation of resident room [ROOM NUMBER] on May 19, 2024, at 9:42 AM revealed the dresser was heavily soiled with food and dried liquid. Observation of the medication/treatment supply room on the [NAME] Wing on May 20, 2024, at 9:34 AM revealed the sink was heavily soiled and stained with a greenish-blue substance. There was thick brown sludge-like substance coating the faucet and each water turn on knob. The base of the sink was coated with the same brown/black sludge-like substance. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Beneath the sink there was a pink plastic wash basin setting beneath the sink pipe. The basin was coated with a thick layer of brown/black substance. The cabinet frame was heavily soiled with a brown/tan substance. Ceiling tiles above where the medication cart is stored when not in use were heavily water stained. An observation on May 20, 2024, at 9:41 AM revealed the medication/treatment supply room on the Blue Wing had a large hole in the wall next to the heating/ac unit that was covered with plastic and secured with blue painter's tape. The cabinet beneath the sink was heavily stained/soiled with a rust-colored substance, dirt, and debris. Interview with Employee 6, licensed practical nurse, revealed that there were dead animals in the wall that had to be removed. At the time of the observation, the air conditioning was set on high, and there were air fresheners placed on the air conditioning unit. Observation of the Blue Wing resident care unit on May 20, 2024, at 9:49 AM revealed multiple water-stained ceiling tiles outside the resident kitchenette and resident shower room. Ceiling tiles next to the vents in the same area were heavily soiled with black dust/lint. Interview with NHA on May 20, 2024, at approximately 10 AM, confirmed that there were dead squirrels in the wall that needed to be removed. According to the NHA, the facility was waiting on supplies to repair the hole. The NHA further stated that purchase orders were submitted for new drawers/dressers for the resident rooms yet was unable to provide evidence to surveyors that replacement items were on order or that the need for repairs had been identified and/or addressed prior to survey. An observation on May 20, 2024, at 11:08 AM in the Nursing Blue Hall resident laundry room revealed a sink with multiple rust spots and a faucet that continued to run when in the off position. Repeat observation of the Blue Wing medication/ treatment supply room at 1:20 PM, revealed that the hole in the wall was repaired. The plastic had been removed and was replaced with an electrical outlet and outlet cover. Interview with the Nursing Home Administrator on May 21, 2024, at approximately 2 PM confirmed that the residents' environment was to be maintained in a clean and sanitary manner. Refer F867 28 Pa. Code 201.18 (e)(2.1) Management

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on observation, a review of clinical records and select incident reports, and staff interviews it was determined that the facility failed to consistently provide individualized resident care, consistent with professional standards of practice, to prevent the development of an avoidable mucosal membrane pressure injury, with pain for one resident out of two sampled residents (Resident 23). Findings: According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, Standardized pressure ulcer risk assessment and care planning and implementation to address the areas of risk. The American College of Physicians (ACP) is a national organization of internists, who specialize in the diagnosis, treatment, and care of adults. The largest medical-specialty organization and second-largest physician group in the United States) Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i. e. support surfaces, repositioning and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement and wound cleansing; using adjunctive therapies; and considering possible surgical repair. A review of Resident 23's clinical record revealed he was admitted to the facility on [DATE], with diagnoses including cerebral infarction, protein - calorie malnutrition, left hip pressure ulcer, and contracture of left, and right knee, and right upper arm. A quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated November 15, 2023, revealed that the resident was severely cognitively impaired with a BIMS score of 03 (the Brief Interview for Mental Status a tool to assess the resident's attention, orientation, and ability to register and recall new information, a score of 0-7 equates to being severely cognitively impaired). The resident had functional impairment of both the left and right upper and lower extremity, and was dependent on staff for lower body dressing. A review of a Quarterly Braden Scale (a tool used to determine/predict pressure sore development) dated November 16, 2023, revealed that Resident 23 scored a 15, indicating that the resident was at mild risk for pressure sore development. The resident had a current physician orders for suprapubic catheter (a suprapubic catheter is a medical device that helps drain urine from your bladder. It enters your body through a small incision in your abdomen) care, initially dated October 7, 2022, to monitor the suprapubic catheter site for any changes or signs/symptoms of infection, an order initially dated October 9, 2022, and renewed on November 11, 2022. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The resident's care plan, dated January 13, 2022, indicated that the resident has pressure ulcer stage 4 to left hip and a mucosal membrane pressure injury to underside of penis and the potential for more pressure ulcers related to decreased mobility, foley catheter use, and history of stage 4 pressure area left distal medial foot, as per revision March 4, 2024. The resident's care plan noted the resident's use of the suprapubic catheter 14 fr 30 cc related obstructive uropathy secondary to benign prostatic hyperplasia (BPH) [enlargement of the prostate gland] and failed voiding trial date-initiated June 16, 2022, with an intervention to provide catheter care as per physician order also initiated June 16, 2022. An eINTERACT SBAR Summary for Providers note (Situation, Background, Assessment, and Recommendation (or Request), is a structured communication framework that can help teams share information about the condition of a patient or team member or about another issue your team needs to address) dated November 16, 2023, 0230 hrs (2:30 AM) revealed that the resident had a change in skin condition. A fluid filled blister on the resident's right thigh had developed. Recommendations were to apply skin prep to right thigh blister every shift (QS) until resolved. The SBAR note failed to identify the blister's appearance including its size, measurements, color, and surrounding tissue's appearance. A review of Resident 23's Treatment Administration Record (TAR) for November 2023, revealed on November 16, 2023, apply skin prep to right thigh intact blister QS until resolved every shift, discontinued November 24, 2023. A medication administration note dated November 24, 2023, 0259 (2:59 AM) indicated that the area had resolved. At the time of the survey, on May 19, 2024, at approximately 9:10 AM, the survey team requested any evidence that the facility had to describe the description of the blister including size, color, the surrounding tissue's appearance and potential causative factor. During interview of May 19, 2024, at approximately 10:15 AM, the Director of Nursing (DON) stated that no further information was available. A review of a weekly skin review - V3 document dated February 14, 2024, indicated that the resident's skin was intact, no new skin issues noted, but to see existing wound sheets. A nurses note dated February 17, 2024, at 11:34 AM, indicated that the nurse called the resident's responsible party (RP) and left a brief message that the resident had a new skin issue and to please return call. A review of facility incident report dated February 17, 2024, at 11:02 AM, entitled skin integrity, revealed open area noted along underside of penis, area cleansed and covered with non-adhesive dressing. Resident has a suprapubic catheter. Resident unaware of injury. MD and RP aware. RN assessment performed, peri guard in place. Will monitor until resolved. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a wound evaluation flow sheet V-5, dated February 17, 2024, week 1, revealed that this wound was not continuing documentation of a wound currently being tracked as noted in weekly skin review dated February 14, 2024. The resident was noted with open area on underside of penis from meatus to midway down shaft. Tunneling noted at meatus side approximately 0.3 cm at 12 o'clock. Resident expresses pain as tunnel is assessed, denies pain otherwise. Able to visualize resident's urethra. Open area measures 5 centimeter (cm) length x 2 cm width x 0.5 cm depth. A small, serous, thin amount, without odor of exudate (fluid that leaks out of blood vessels into nearby tissue) was noted. The wound bed is 100 % granulation tissue, and the wound margins are defined, with the surrounding tissue intact, without redness or swelling. Treatment cover with dressing until wound care evaluate. A nurses note dated February 18, 2024, at 10:56 AM, noted day 1, open area to underside of penis, area appears healed. Resident denies pain/discomfort. However, a wound evaluation flow sheet V-5, dated February 20, 2024, week 2, revealed that the resident's open area on the penis was mostly unchanged (from February 17, 2024). A review of consultant wound specialist note dated February 27, 2024, revealed the initial evaluation of the penis as, its etiology (cause) is pressure related, mucosal membrane pressure injury measuring 4 cm x 4.8 cm, 0.1 cm epithelial wound bed, with the edges intact, scant serous exudate without odor. Treatment recommendations cleanse with normal saline, apply Mupirocin ointment to base of the wound leave open to air (OTA) twice daily (BID) and as needed (PRN). Wound was likely sustained from catheter use with hypospadias (congenital condition in which the opening of the penis is on the underside rather than the tip). A physician order was noted February 28, 2024, for Mupirocin external ointment 2 % (topical antibiotic) apply to penis topically every day and evening shift for treatment. Cleanse underside to penis, pat dry, apply Bactroban (antibiotic) and leave OTA. Notify MD if sign/symptom of infection present. A physician progress note dated February 29, 2024, noted a evaluation of the penis revealed the ventral surface of the penile shaft has erythema (redness), without evidence of significant infection. No significant open areas are noted. No obvious drainage. Suprapubic catheter in place. The suprapubic catheter was underneath his penis abutting and rubbing up against the area of irritation. Assessment/Plan, penile irritation, continue with Mupirocin. We will ensure that the suprapubic catheter is on the outside of the brief so that it can not irritate the ventral surface of the penile shaft. Wound care to follow. The facility failed to assure appropriate positioning of the suprapubic catheter tubing to prevent the development of a pressure sore on the resident's penis. After the development of the avoidable pressure sore, a physician order dated February 29, 2024, was noted ensure suprapubic tubing is out of brief so it can not irritate under surface of penis every shift. A review of consultant wound notes dated March 5, 2024, revealed that the stage of the pressure sore was noted as Mucosal Membrane Pressure injury that measures 14 sq cm. (Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue, these injuries cannot be staged).Wound notes dated March 12, 19, 26, 2024, and April 2, 2024, revealed that the resident's wound remained mostly unchanged. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On April 9, 2024, the consultant revealed the wound was improving despite its measurements. The area was pressure related, mucosal membrane pressure injury measuring 3.7 cm x 3.5 cm, 0.1 cm epithelial wound bed, with the edges intact, no exudate. Treatment recommendations cleanse with normal saline, apply Mupirocin ointment to base of the wound leave (OTA) twice daily (BID). Wound notes dated April 16, 23, 30, 2024, revealed the wound remained mostly unchanged. A wound note dated May 7, 2024, revealed the pressure wound is stable measuring 3.5 cm x 2.5 cm, 0.1 cm epithelial wound bed, with the edges intact, without exudate. Treatment recommendations cleanse with normal saline, apply Mupirocin ointment to base of the wound leave (OTA) twice daily (BID). The most recent wound note dated May 14, 2024, revealed the pressure wound was stable, measuring 3.5 cm x 2.2 cm, 0.1 cm epithelial wound bed, with the edges intact, without exudate. Treatment recommendations cleanse with normal saline, apply Mupirocin ointment to base of the wound leave (OTA) twice daily (BID). Observation of the resident's penile pressure injury on May 20, 2024, at approximately 1:45 PM, with the resident's approval, in the presence of the Director of Nursing (DON), revealed a clean, superficial oval shaped wound on the penile shaft, without drainage or odor. The wound bed appeared moist, pinkish red. The wound measured 3.8 cm x 1.7 cm x 0.2 cm, (as measured by the DON) without tunneling/undermining. During this observation the resident appeared comfortable without any signs of discomfort. During an interview with the Director of Nursing May 20, 2024, at approximately 1:50 PM, confirmed that the facility failed to ensure that the tubing from the resident's suprapubic catheter was positioned in a manner that did not create pressure on the resident's penis resulting in a pressure sore, that the caused the resident pain. 28 Pa. Code 211.12 (d)(3)(5) Nursing services.

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F 0689 Level of Harm - 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** 41460 Based on a review of clinical records, select incident reports and facility policy, and staff interview it was determined that the facility failed to provide necessary supervision of a resident with known unsafe behaviors to prevent a fall resulting in serious injuries, a fracture left humeral head and fracture of the left nasal bone, for one out of 20 sampled residents (Resident 12). Findings include: A review of a facility policy entitled Falls Management System that was provided by the facility on May 21, 2024, indicated that each resident is assisted in attaining or maintaining their highest practicable level of function through providing the resident adequate supervision, assistive devices, and functional programs, as appropriate, to prevent accidents. It is the policy of this center to provide each resident with appropriate evaluation and interventions to prevent falls and minimize complications if a fall occurs. A review of Resident 12's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included vascular dementia [is a condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain that causes problems with reasoning, planning, judgment, and memory], cognitive communication deficit [are problems with communication caused by impaired cognitive processes, such as attention, memory, perception, and language], symbolic dysfunction [refers to the breakdown in communication that occurs when symbols, such as words, gestures, or facial expressions, are misinterpreted or misunderstood], anxiety [fear characterized by behavioral disturbances], and dysphasia (difficulty swallowing). An admission Nursing Assessment - Section 6. Fall Risk dated March 4, 2024, at 1:21 p.m., revealed that Resident 12 was assessed as a high fall risk. Nursing documentation in the resident's clinical record following the resident's admission on March 4, 2024, revealed that the resident required assistance of one staff with activities of daily living and assist of two with transfers out of bed to the wheelchair daily daily. Employee 1, LPN noted that the resident was oriented to self but had confusion to location and situation. The resident was able to resident able to make needs known to staff but was non-compliant with alarms. Staff had observed the resident ambulating around room and pushing her bed side table and stated to this author {Employee 1} I went to college, how much money do you make? Safety device in place and functioning and will continue to monitor, call bell within reach. Additionally, a nurse progress behavior note completed by Employee 1, a LPN, dated March 8, 2024, at 10:58 a.m., revealed that the resident was continuously standing up from her wheelchair and was non-compliant with safety devices. Resident was standing up in lobby and attempting to walk around during activities and stated, I want to go home, I need to go home to my mother for supper. what do you want me to do, do you want me to hit you or slap it out of you. You just need to leave me alone, goodbye. The resident continued standing up out of chair, post therapy and one-to-one, fluids, toileting, and activities were ineffective, and the resident was grabbing at other people's hand as they walked by and yelled [NAME]. Safety devices were in place and functioning and will monitor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A Minimum Data Set assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated March 11, 2024, revealed that the resident had severe cognitive impairment, physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually), and other behavioral symptoms not directed toward others (e. g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming or disruptive sounds) behavior of this type occurred 1 to 3 days. The MDS noted that the resident's behaviors significantly put the resident at risk for physical illness or injury and the resident used daily bed and chair alarm [any physical or electronic device that monitors resident movement and alerts the staff when movement is detected]. Resident 12's care plan revised March 15, 2024, identified that the resident was at risk for falls with prevention interventions to anticipate and meet the resident's needs, be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed and provide a prompt response to all requests for assistance, ensure that the resident is wearing appropriate footwear such as nonskid sock when ambulating or mobilizing in wheelchair, and use chair/bed electronic alarm and ensure the device is in place as needed. Progress notes dated March 11, 2024, through March 20, 2024, revealed that the resident displayed behaviors such as combativeness and non-compliance with care, punching, and slapping at staff, crying/weeping, was difficult to console or redirect, and continued to exhibit unsafe behaviors. A review of a SBAR (Situation Background Assessment Recommendation - a communicate tool) completed by Employee 2, a Licensed Practical Nurse (LPN), dated March 20, 2024, at 8:09 p.m., revealed that the resident had a change in condition related to a fall. Vitals were as follows: pulse: 107, respiration rate: 24, temperature: 98.4, pulse oximetry: O2 98.0 % room air, and had pain. Employee 2 noted that she heard crying and found the resident lying on the floor {in the resident's room} with a small amount blood noted from resident's nose. Supervisor {Employee 3} called to room and assessment was performed and the resident's Primary Care Provider responded to send resident to ER (emergency department) for evaluation. An incident report completed by Employee 3, a Registered Nurse (RN), dated March 20, 2024, at 8:38 p.m., revealed that at 7: 45 p.m., Resident 12 was found lying on her back, on the floor in her room, in front of the door. Resident noted to have scant amount of sanguineous (bloody) drainage under her nose and was awake and alert with confusion per norm. This nurse {Employee 3} attempted to ask resident what happened, resident started to say that she got out of bed and then became emotional with incomprehensible speech. Emotional support given. Vitals obtained and as charted. Resident stated that her head hurt and attempted to reposition herself and proceeded to cry out when she moved her left shoulder. Able to move right arm without difficulty. Legs equal in length and no external foot rotation noted with plus two pitting edema (swelling) noted to bilateral lower extremities. Skin was intact. While trying to safely reposition the resident, she became lethargic and less responsive to verbal stimuli than baseline. Noted predisposing situation factors {to the fall} included ambulating without assistance, bare feet or inappropriate footwear, non-compliance with safety instructions, incident during unassisted self-transfer from bed, bed in lowest position, and safety mat(s) at side of the bed. The on-call physician was contacted and ordered to send resident to the ER (emergency room) and the responsible party (RP) was notified with 911 called. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident 21's clinical record revealed that she returned to the facility on [DATE], at 6:56 am, with diagnoses of minimally displaced fracture (broken) left humeral head (bone in the upper arm) and a minimally displaced fracture of the left nasal (nose) bone. The facility was aware of the resident's confusion to location and situation, unsafe behaviors, and non-compliance with safety measures, including alarms, but failed to provide the resident with the necessary supervision, at the level and frequency required, to prevent this fall during which the resident sustained multiple fractures. During an interview with the Director of Nursing (DON) on May 21, 2024, at 12:00 p.m., confirmed that the facility failed to provide adequate supervision of a resident (Resident 12) with known unsafe behaviors to prevent falls and from sustaining major injuries, fractures to the left humeral head and left nasal bone. 28 Pa. Code 211.12 (d)(5) Nursing services. 28 Pa. Code 211.10 (a)(d) Resident care policies

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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. 41460 Based on observation, review of select facility policy and staff interview, it was determined that the facility failed to ensure that medication was stored at the appropriate temperature according to manufacturer's directions in one of three medication storage rooms reviewed. (Blue Wing) Findings include: Observation of the facility's medication storage refrigerator on May 20, 2024, at 9:41 AM in the presence of Employee 6, Licensed Practical Nurse (LPN) revealed that the thermometer read 26 degrees Fahrenheit (6 degrees below freezing). Observation revealed the following medications stored in the medication refrigerator: Lorazepam Intensol 2mg/mL (oral concentrate), Promethazine 25mg suppositories, and the following insulins; Lantus Solostar 100 units/mL (3 mL) pen, Novolog Flexpen 100 units/mL (3 mL) pen, Victoza 18 mg/3 mL (3 mL) pen, Humalog Kwikpen 100 units/mL (3 mL), and Ozempic. Review of the medication room refrigerator temperature log dated May 2024, revealed that refrigerator temp. must be between 36 and 46 degrees Fahrenheit. The staff are to report any malfunctions/fluctuations. According to the refrigerator temperature log, the refrigerator was 36 degrees on May 20, 2024, on the off-going shift (10 PM to 6 AM). Interview with the Director of Nursing confirmed that the medication refrigerator was not at the correct temperature and made pharmacy aware that medications were stored below the instructed 36 degrees Fahrenheit. Review of manufacturer instructions for each insulin revealed that each unopened insulin medication needs to be refrigerated at temperatures between 36 degrees Fahrenheit and 46 degrees Fahrenheit. Further review of manufacturer instructions for insulin revealed that if the medication has been frozen it is not to be used and needs to be discarded. Review of manufacturer instructions for Lorazepam Intensol 2mg/mL revealed that the medication is to be refrigerated at temperatures between 36 degrees Fahrenheit and 46 degrees Fahrenheit. Interview with the Director of Nursing on May 21, 2024, at approximately 1:30 PM confirmed that medications were to be stored at proper temperatures according to manufacturer's directions to maintain integrity of the medication. 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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on observations, a review of facility's planned meal tickets, and resident and staff interviews it was determined that the facility failed to accommodate residents' food preferences, and provide foods planned for oral gratification for one resident of 20 residents reviewed (Resident 32). Findings included: A review of resident 32's clinical record indicated she was most recently admitted to the facility on [DATE], with diagnoses to include chronic obstructive pulmonary disease (COPD), diabetes, and gastroparesis (a condition which affects the stomach muscles and prevents proper stomach emptying). The resident's care plan, dated August 15, 2016, included a focus area of Nutrition, revealing the resident is dependent on tube feeding related to duodenal stricture, gastroparesis with a planned included that the resident is NPO (nothing by mouth, ice chips, clear Gatorade, coffee, and lemon Italian ice allowed) see orders section of medical chart, date revised December 13, 2022. The resident's care plan, also included the problem/need of socialization, date-initiated July 7, 2023, with an intervention that staff is to offer resident lemon Italian ice or coffee during social as alternative due to dietary restrictions, initiated April 26, 2024. A review of current physician orders dated June 30, 2023, revealed that the resident was to receive an enteral tube feeding every shift, give 45 ml/hr of Isosource 1.5 for 20 hrs. via J tube document amount administered each shift and document. Observation of the lunch meal on May 18, 2024, at approximately 12:20 PM, revealed that Resident 32's tray card [is a menu-based document that provides essential information about a resident ' s meal such as diet order, preferences, food allergies, dislikes, dining location, supplements, and adaptive equipment (if required) and helps staff accurately prepare and serve meals to residents based on their individual needs and preferences] indicated that her lunch items were to include 2 lemon ice, and hot coffee, (may have ice chips or Italian ice). During this observation the surveyor observed that the resident's lunch tray revealed that the resident was not served lemon ice, or Italian ice. Interview with the the alert and oriented, cognitively intact resident at that time the resident stated she never gets it (referring to the lemon or Italian ice) According to the resident she is exhausted asking for it, and that staff is well aware of her continued requests/complaints of not receiving it on her meal tray A second observation of the lunch meal on May 19, 2024, at approximately 12:15 PM, revealed that Resident 32's tray card indicated that her lunch items were to include 2 lemon ice, and hot coffee, (may have ice chips or Italian ice). During this second observation the surveyor observed that the resident was again not served lemon ice, or Italian ice on her lunch tray. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Nursing Home Administrator (NHA) on May 19, 2024, at approximately 1:45 PM, the NHA stated that the facility's policy requires Resident 32 to purchase her own Italian lemon ice. The meal ticket for the resident's lunch time indicated that 2 Lemon ice are to be served, and that the resident's care plan indicated staff is to offer lemon Italian ice in activities. The NHA stated that staff are to offer the lemon Italian ice during activities. The surveyor requested the facility policy that indicated the resident is to purchase her own lemon Italian Ice, the NHA replied, it is my policy. 28 Pa. Code 201.29 (a) Resident rights 28 Pa. Code 211.6 (a) Dietary services

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 48276 Based on review of the minutes from Resident Council Meetings, scheduled facility mealtimes, and select facility policy, and resident and staff interviews, it was determined that the facility failed to consistently provide snacks as desired by residents including 3 out of the 20 residents sampled (19, 30, and 37) and experiences reported by residents during a group interview (Residents 61 and 73). Findings include: A review of the facility's policy titled Policy: Frequency of Meals, last reviewed in July 2023, indicated that nourishing snacks will be available for residents who need or desire additional food between meals. The policy indicates that residents will be offered nourishing snacks if the time span between the evening meal and the next day's breakfast exceeds fourteen hours. A review of the facility's scheduled mealtimes revealed that the time between dinner and breakfast the next day exceeds fourteen hours. A review of resident council meeting minutes dated April 12, 2024, revealed that all residents in attendance indicated that they were not receiving snacks. The meeting minutes indicated that a grievance was filed on behalf of the residents in attendance. The facility provided daily water and snack pass forms to be completed and signed by a nurse aide and licensed nurse to indicate that water and snacks were passed. Six of the 13 forms had no signature indicating that water or snacks were passed on the 2:00 PM to 10:00 PM shift (evening shift). Six of the 13 forms reviewed had no date to confirm when the task was completed. During the resident group interview on May 20, 2024, at 10:00 AM, all residents in attendance (Residents 19, 30, 37, 61, and 73) indicated that they were not being offered evening snacks. The residents explained that about once or twice a month they are offered snacks, but the majority of the time they have to ask staff for assistance or get their own snack. The residents indicated that the facility runs out of snacks, and on several occasions, no snacks were available when requested by residents. The residents explained that the facility is aware of this concern; however, the problem has not been resolved. The residents indicated that the facility is often short on nurse staffing and that there may not be enough staff to offer snacks to the residents every evening. During an interview on May 21, 2024, at 10:30 AM, the Nursing Home Administrator (NHA) was unable to explain why Residents 19, 30, 37, 61, and 73 are indicting that the facility is not offering nutritious snacks. The NHA stated that the facility does not evaluate snack inventory level to ensure snacks are consistently available to meet residents needs. Refer F565 28 Pa. Code 211.12 (d)(3)(5) Nursing Services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43944 Based on observation and staff interview, it was determined that the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in the food and nutrition services department and two of three resident pantries. Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). Review of a facility policy titled Food Storage that was provided by the facility on May 20, 2024, indicated that food storage areas shall be maintained in a clean, safe, and sanitary manner. Guidelines for food storage included the following: Food storage areas shall be clean at all times. All packaged food, canned foods, or food items stored shall be kept clean and dry at all times. All foods stored in walk-in refrigerators and freezers shall be stored above the floor on the shelves, racks, dollies, or other surfaces that facilitates thorough cleaning. All food will be dated at time of receipt and be inventoried using the FIFO (first in, first out) method. Bulk items such as flour, sugar, oatmeal, etc. shall be stored in covered plastic bins. These should be labeled and dated clearly and appropriately. The initial tour of the kitchen was conducted on May 18, 2024, at 8:38 AM, that revealed the following unsanitary practices with the potential to introduce contaminants into food and increase the potential for food-borne illness: Observed a rack of clear plastic beverage pitchers that had an accumulation of a white substance coating the surfaces. Above the beverage station, observed a ceiling tile that had tan colored circular staining and the top of the coffee maker had an accumulation of dust adhered to the surface. Also, behind the coffee maker and on the molding of the stainless-steel table there was an accumulation of debris and dust. Observations of another food/beverage preparation station revealed that the shelving had debris present and stained serving trays with dishes on the tray and were not covered. The trays that had thermal cups that were on a tray that was stained. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observations of the walk-in freezer revealed that the door latch was broken and did not make contact with the latch to secure the door closed. Upon entry, the air curtain was ill-fitting, covered in frost, and had icicles hanging off the plastic strips and dripping on to the floor. The entry way floor was covered in a thick coating of ice that was slippery. Additionally, observed that the cases of frozen food were encased in ice crystals and observed three cases of frozen food left in direct contact with the floor. Observed that there was a free-standing black colored fan that was pointed at the walk-in freezer door that was covered with debris and dust. The ceiling tiles near the tray line area were splattered with a brown-colored substance and the ceiling light covers had several dead bugs accumulated on the inside. Further observations of revealed that there was a dirty broom leaning between the wall and kitchen preparation equipment. Observed that microwave, near the tray line, had food splattered on the handle. Additionally, there were two plastic containers of serving utensils placed inside with the handles at the bottom of the container and left uncovered. The cook's sink had a green cutting board that was placed between the wall and faucet and was observed with deep knife marks and worn. In the cook's area, observed a black mobile cart with two eight-quart clear plastic storage containers with cereal inside and were not labeled or dated. Observed that the wall exiting the cook's area was peeling and the tile baseboard behind was crumbling that left a gap between the wall and tile. Observed that ceiling tiles in the dish room area had a tannish-brown colored substance splattered on them. An observation conducted on May 18, 2022, at 9:11 AM, of the green unit resident pantry revealed that the there was a ceiling tile near a vent that had brown circular stains. The top of the refrigerator had debris and dust, an uncovered thermometer, and a blue basket with food remnants. Additionally, observed that the blue unit resident pantry had reddish colored stains on the floor around the perimeter of the refrigerator. During an interview with the Nursing Home Administrator on May 20, 2024, at 10:39 a.m., confirmed the above observations and that dietary department, and dietary equipment, and resident pantry areas should be maintained in a sanitary manner to prevent opportunities for foodborne illness. 28 Pa. Code 201.18 (e) (2.1) Management 28 Pa. Code 211.6 (f) Dietary Services

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 41460 Based on staff interviews, it was determined that the facility failed to conduct a facility wide assessment that reflected the personnel and specific resources presently available and to identify those that are necessary to care for its current resident population. Findings include: At the time of the survey ending May 21, 2024, the facility failed to provide evidence that a facility assessment to determine the specific and unique needs of its resident population and the available and accessible resources to meet these needs on a daily basis and during emergent situations had been developed. During an interview with the Nursing Home Administrator on May 19, 2024, at 1:00 PM, the NHA had indicated that the facility assessment was provided in the survey readiness binder. Additional interview with the NHA on May 21, 2024, at 1 PM indicated that the facility assessment had recently been updated yet failed to provide the survey team with the required document. There was no facility assessment presented to the survey team by survey ending May 21, 2024. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18 (b)(e)(1)(3) Management

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on observation, clinical record review, and staff interview, it was determined that the facility failed to ensure the coordination of hospice services with facility services to meet the resident's needs on a daily basis for one out of 20 residents sampled (Resident 5). Findings include: A clinical record review revealed that Resident 5 was admitted to the facility on [DATE], with diagnoses that included multiple sclerosis (an immune-inflammatory disease that attacks and damages cells in the central nervous system and causes neurological impairment). Further review of the clinical record revealed a physician's order for Resident 5 to be admitted to hospice services related to a malignant neoplasm of the colon initiated on April 26, 2024. A clinical record review revealed a significant change in status comprehensive Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) for Resident 5 dated May 4, 2024. According to the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual User's, Chapter 2: Section 03 Significant Change in Status Assessments (SCSA) dated October 2023, the Care Area Assessment (CAA) completion date must be no later than 14 days after the determination that the criteria for a significant change in status occurred. The care plan completion date must be no later than 7 calendar days after the CAA completion date. The criteria for a significant change of status occurred when Resident 5 was admitted to hospice care on April 26, 2024. The required completion date for Resident 5's CAAs was May 10, 2024. Resident 5's care plan completion date with revisions after assessment and admission to hospice services was May 17, 2024. A clinical record review revealed no evidence that the facility updated Resident 5's care plan to include hospice care. The resident's care plan did not identify measures planned to assure that nursing facility staff coordinate and monitor the delivery of resident care in conjunction with the hospice provider's services to meet the resident's needs. Further review of the clinical record and facility hospice communication documents failed to reveal that a schedule was developed and/or available to the resident, resident's representative, or facility to ensure coordination of resident care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395433	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Tunkhannock	30 Virginia Drive Tunkhannock, PA 18657

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on May 21, 2024, at 10:30 AM, the Nursing Home Administrator (NHA) confirmed that the facility failed to ensure that the implementation of hospice services was included in Resident 5's plan of care. The NHA was unable to provide evidence that a schedule for Resident 5's hospice care was developed to ensure the coordination of hospice services with facility services to meet the resident's needs on a daily basis. At the time the survey concluded on May 21, 2024, the care plan was not updated to include hospice services (5 days overdue). 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (d)(3)(5) Nursing services.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 41460 Based on review of facility policies and staff interview, it was determined that the facility failed to maintain documentation and demonstrate evidence of its ongoing QAPI (Quality Assurance Performance Improvement - a framework utilized to guide an organization's performance improvement efforts) program. Findings include: Review of the facility policy entitled Quality Assurance and Performance Improvement last revised August 29, 2022, revealed, the company is committed to developing, implementing, and maintaining an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility will: 1. Maintain documentation and demonstrate evidence of its ongoing QAPI program which may include but is not limited to: a. systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and b. documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; 2. Present its QAPI plan to the State Survey Agency as requested; 3. Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and 4. Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. Interview with the Nursing Home Administrator on May 21, 2024, at 10:36 AM revealed that the facility had not conducted a QAPI meeting. The NHA could not provide evidence of when the last QAPI meeting had been conducted. According to the NHA, he has had other things to worry about. There was no evidence at the time of the survey ending on May 21, 2024, that the facility had developed, implemented, or maintained an effective QAPI program. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18 (b)(1)(e)(1) Management

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 41460 Based on information provided by the facility, and staff interview it was determined that the facility failed to implement a quality assurance program to identify problems that are opportunities for improvement. Findings include: According to federal regulatory requirements at 42 CFR S483.75 (g)(2) the QAPI committee must: S483.75 (g)(2)(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; S483.75 (g)(2)(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. Interview with the Nursing Home Administrator on May 21, 2024, at 10:36 AM revealed there was no evidence the facility had taken actions aimed at performance improvement since last annual survey completed April 21, 2023. 28 Pa. Code 201.18 (b)(1)(3)(e)(1)(2)(4) Management

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 41460 Based on review of facility documents and staff interviews, it was determined that the facility failed to maintain a Quality Assurance Process Improvement (QAPI) Committee. Findings include: During review of QAPI committee on May 21, 2024, the Nursing Home Administrator was unable to provide evidence of any staff, administration, or Medical Director attendance to meetings. The NHA failed to provide evidence of QAPI Committee meeting sign-in sheets for the period of April 2023 through April 2024. Interview with the NHA on May 21, 2024, at 10:36 AM confirmed that the facility failed to maintain a QAPI committee. 28 Pa. Code 211.2(d)(5)(6)(7)(8)(10) Medical director 28 Pa. Code 201.18 (e)(2)(3)(4) Management.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 43944 Based on observations, and staff interview, it was determined the facility failed to ensure that essential equipment was in safe operating condition in the facility's kitchen. Findings include: Observation of the dietary department on May 18, 2024, at 8:38 a.m., revealed that the door latch to the facility's walk-in freezer was broken and did not make contact with the latch on the door jamb to secure it closed and left a gap around the perimeter of the door. Additionally, observed that the seal around the freezer door was ill-fitting. Upon entering the walk-in freezer, observed that the air curtain was ill-fitting, covered in frost, and had icicles hanging off the plastic strips and dripping on to the floor. The freezer entry way floor was covered in a thick coating of ice and was slippery. Additionally, observed that the cases of frozen food were encased in ice crystals and the wire metal shelves were encased in ice. At the time of the survey ending May 21, 2024, the Nursing Home Administrator (NHA) could not provide documented evidence that that the facility had acted upon the on-going issues with the walk-in freezer to maintain resident food in a safe and sanitary manner. Refer F812 28 Pa. Code 201.18 (e)(2)(3)(4) Management