STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395434	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wecare at MT Lebanon Rehabilitation and Nrsg Ctr	350 Old Gilkeson Road Pittsburgh, PA 15228

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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 - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43725 Based on review of facility policy, clinical records and staff interview, it was determined that the facility failed to provide the opportunity to formulate an advance directive (a written instruction such as a living will or durable power of attorney for health care for when the individual is incapacitated) for six of nine residents reviewed (Resident R27, R39, R42, R50, R55, and R67). Findings include: A review of the facility Advance Directives 12/29/23 and 4/9/24, indicated the resident has the right to formulate an advance directive, including the right to accept or refuse medial or surgical treatment. A review of the medical record indicated Resident R27 was readmitted to the facility on [DATE], with diagnoses that included diabetes, depression, and anxiety. A review of the clinical record failed to reveal an advanced directive or documentation that Resident R27 was given the opportunity to formulate an Advanced Directive. A review of the medical record indicated Resident R39 was readmitted to the facility on [DATE], with diagnoses that included diabetes, depression, and high blood pressure. A review of the clinical record failed to reveal an advanced directive or documentation that Resident R39 was given the opportunity to formulate an Advanced Directive. A review of the clinical record indicated Resident R42 was readmitted to the facility on [DATE], with diagnoses that included Huntington ' s Disease (inherited disorder that causes nerve cells in the brain to gradually break down and die), depression, and anxiety. A review of the clinical record failed to reveal an advanced directive or documentation that Resident R42 was given the opportunity to formulate an Advanced Directive. A review of the clinical record indicated Resident R50 was admitted to the facility on [DATE], with diagnoses that included cancer, high blood pressure, and congestive heart failure ((progressive heart disease that affects pumping action of the heart muscles). (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the clinical record failed to reveal an advance directive or documentation that Resident R50 was given the opportunity to formulate an Advance Directive. A review of the clinical record indicated Resident R55 was admitted to the facility on [DATE], with diagnoses that included obesity, depression, and difficulty swallowing. A review of the clinical record failed to reveal an advance directive or documentation that Resident R55 was given the opportunity to formulate an Advance Directive. A review of the clinical record indicated Resident R67 was admitted to the facility on [DATE], with diagnoses that included diabetes, chronic pain, and high blood pressure. A review of the clinical record failed to reveal an advance directive or documentation that Resident R67 was given the opportunity to formulate an Advance Directive. During an interview on 9/18/24, at 9:40 a.m. Social Worker Employee E6 confirmed that the clinical record did not include documentation that Resident R27, R39, R42, R50, R55, and R67 were afforded the opportunity to formulate Advanced Directives. 28 Pa. Code: 201.29(b)(d)(j) Resident rights.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 49646 Based on review of facility policy, clinical records, and interviews with staff, it was determined that the facility failed to complete a Level II evaluation by a state Preadmission Screening and Resident Review (PASARR) representative to determine if the resident has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate for one of three residents (Resident R15). Findings include: A review of the facility policy titled Policy Interpretation and Implementation dated April 9, 2024, revealed that it was the responsibility of the facility to assure that all residents admitted to the facility receive a screening (Level I) and referral for Level II in accordance with State and Federal Regulations. Review of Resident R15's clinical record indicated the PASARR form for this resident was accurately completed and revealed the resident needed a Level II evaluation. The resident had a diagnosis of Schizophrenia and bi-polar disorder. During an interview with Social Services Employee E6, at 1:34 p. m., on September 18, 2024 confirmed the lack of referral and completion of the Level II evaluation by a state PASARR representative for Resident R15. 28 PA. Code 211.5(f)(iv)(vii) Medical records. 28 PA. Code 201.14(a) Responsibility of licensee.

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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 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** 43725 Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to notify physicians of increased and decreased Capillary Blood Glucose (CBG) levels and failed to assess residents for hyperglycemia (high blood glucose) and hypoglycemia (low blood glucose), for two of seven residents reviewed (Residents R39, and R78). Findings include: The Centers for Disease Control defines diabetes as: Diabetes Mellitus is a chronic (long-lasting) health condition that affects how your body turns food into energy. Most of the food you eat is broken down into sugar (also called glucose) and released into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy. If you have diabetes, your body either doesn't make enough insulin or can't use the insulin it makes as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in your bloodstream. Over time, that can cause serious health problems, such as heart disease, vision loss, and kidney disease. Hypoglycemia is a condition that occurs when blood glucose is lower than normal, usually below 70 milligrams per deciliter (mg/dl). If left untreated, hypoglycemia may lead to weakness, confusion, unconsciousness, arrhythmias and even death. People with Diabetes Mellitus may be prescribed injectable insulin to assist in maintaining acceptable levels of CBG's. Hyperglycemia, or high blood glucose, occurs when there is too much sugar in the blood. This happens when your body has too little insulin. Hyperglycemia is blood glucose greater than 125 mg/dL while fasting (not eating for at least eight hours, or a blood glucose greater than 180 mg/dL one to two hours after eating. If you have hyperglycemia and it ' s untreated for long periods of time, you can damage your nerves, blood vessels, tissues and organs. Damage to blood vessels can increase your risk of heart attack and stroke, and nerve damage may also lead to eye damage, kidney damage and non-healing wounds. Review of the facility policy Diabetes - Clinical Protocol reviewed 12/29/23 and 4/9/24, indicated staff will identify and report issues that may affect the resident ' s diabetes management such as hypoglycemia. Review of the facility policy Nursing Care of the Older Adult with Diabetes Mellitus reviewed 12/29/23 and 4/9/24, indicated to call provider immediately if resident is hypoglycemic (less than 70). Follow the provider orders for blood glucose monitoring. Review of the facility policy Management of Hypoglycemia reviewed 12/29/23 and 4/9/24, indicated for blood glucose less than 70, but greater than 54, give resident oral form of rapidly absorbed glucose, notify the provider immediately, remain with resident, recheck blood sugar in 15 minutes. For blood sugar less than 54, administer glucagon, notify provider immediately, remain with resident, monitor vital signs, and recheck blood glucose in 15 minutes. Document the resident ' s blood glucose before interventions. Record resident ' s level of consciousness. Document provider instructions. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Change in Resident ' s Condition or Status reviewed 12/29/23 and 4/9/24, indicated the nurse will notify the resident ' s attending physician on call when there has been a significant change in the resident ' s condition, a need to alter the resident ' s medical treatment significantly, or specific instruction to notify the physician of changes in the resident ' s condition. The nurse will record in the resident ' s medical record information relative to changes in the resident ' s condition. Review of the facility policy Charting and Documentation reviewed 12/29/23 and 4/9/24, indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident ' s medical, physical, functional, or psychosocial condition, shall be documented in the resident ' s medical record. Documentation of procedures and treatments will include care-specific details, including date and time, assessment data and/or any unusual findings, notification of family, physician, or other staff. Review of the clinical record indicated Resident R39 was readmitted to the facility on [DATE], with diagnoses that included diabetes, high blood pressure, and depression. Review of Resident R39' s Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated 8/17/24, indicated the diagnoses remain current. Review of a physician ' s order dated 3/6/24, indicated to inject Lispro (fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours) per sliding scale, call MD (doctor) if less than 80 and greater than 400. Review of the clinical record electronic Medication Administration Record (eMAR) revealed that the resident's CBG's were as follows: On 9/12/24, at 8:43 a.m. the CBG was noted to be 53. On 8/23/24, at 3:02 p.m. the CBG was noted to be 477. Review of the care plan dated 2/14/24, indicated the following interventions: -Accuchecks as ordered, call MD per order. -Monitor resident for signs and symptoms (s/s) of hypoglycemia. -Provide insulin coverage as per resident ' s individual order. -Provide medication/juice to increase blood sugar below 60 as per resident ' s individual order. -Sliding scale coverage as ordered. Review of Resident's eMAR and clinical progress notes indicated the resident was not assessed for hyper-/hypoglycemia, the blood glucose was not monitored for effectiveness of treatment, failed to follow interventions of the care plan, and the physician was not notified of abnormal results on the above listed dates. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a clinical record indicated Resident R78 was admitted to the facility on [DATE], with diagnoses that included diabetes, cancer, and congestive heart failure (progressive heart disease that affects pumping action of the heart muscles). Review of the MDS dated [DATE], indicated the diagnoses remain current. Review of physician ' s orders dated 10/16/23, indicated Accuchecks two times a day. Further review of a physician ' s order dated 2/15/24, indicated Trulicity (injectable medicine that helps control blood sugar levels), one time every seven days. Review of Resident R78's eMAR revealed that the resident's CBG's were as follows: On 6/9/24, at 6:12 a.m. the CBG was noted to be 62. On 3/13/24, at 3:44 p.m. the CBG was noted to be 416. A review of Resident R78's care plan dated 6/10/23, indicated the following interventions: -Accuchecks as ordered, call MD per order. -Monitor/Observe for s/s of hypo and hyper-glycemia. Review of Resident R78's eMAR and clinical progress notes indicated the resident was not assessed for hyper-/hypoglycemia, failed to follow interventions of the care plan, blood sugar was not rechecked, and the physician was not notified of abnormal results. During an interview on 9/19/24, at 10:00 a.m. Licensed Practical Nurse (LPN) Employee E12 stated if the blood glucose was under 50, they would call the doctor. If the blood glucose was greater than 400, they would notify the supervisor and call the doctor. They would document in the MAR and progress notes. During an interview on 9/19/24, at 10:05 a.m. LPN Employee E14 stated if the blood glucose was less than 70, they would give glucose gel, notify the supervisor, recheck blood glucose in 15 minutes, and call the doctor. If blood glucose was over 400, they would administer the ordered insulin and call the doctor. They would document in the progress notes. During an interview on 9/19/24, at 1:00 p.m. the Director of Nursing confirmed the facility failed to notify the doctor of a change in condition related to blood glucose for Residents R39, and R78. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.29(d) Resident Rights 28 Pa. Code 211.10 (c)(d) Resident Care policies 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50158 Based on review of facility policies, clinical records, and staff interview, it was determined that the facility failed to provide adequate supervision due to documentation for the bed mobility needs for one of five residents (Resident R8), which resulted in a roll out of bed. Findings include: Review of the Resident Assessment Instrument (RAI) 3.0 User's Manual effective October 2019, indicated that bed mobility is defined as how resident moves to and from lying position, turns side or side, and positions body while in bed or alternate sleep furniture. The RAI further indicated that How a resident turns from side to side, in the bed, during incontinence care, is a component of Bed Mobility and should not be considered as part of Toileting. Review of American Congress of Rehabilitation Medicine - Caregiver Guide and Instructions for Safe Bed Mobility published 4/28/17, indicated bed mobility refers to activities such as scooting in bed, rolling, side-lying to sitting, and sitting to lying down. Resident R8 was admitted to the facility on [DATE]. Review of Resident R8's Minimum Data Set (MDS) assessment (mandated assessment of a resident's abilities and care needs) dated 4/16/24, indicated diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), end stage renal failure (a condition in which the kidneys lose the ability to remove waste and balance fluids), and intellectual disabilities. Review of Resident R1's MDS assessments, Section G - Functional Status, Questions G0110A, ADL Assistance for Bed Mobility, dated, 4/16/24 indicated that Resident R8 required extensive assistance of two or more staff members. Review of Resident R8's physician's orders since admission did not reveal an order that specified bed mobility assistance until 6/4/24. At which time it was changed to two person assist at all times for bed mobility. Review of Resident R8's plan of care for assistance with dressing, personal hygiene, walking, transferring, toileting, changing position in bed initiated 11/7/22, revealed no documented assistance level for bed mobility for Resident R8 until 8/5/24. Review of PT Evaluation and Plan of Treatment documentation on 1/16/24 indicated that Resident R8 required assistance of two or more staff members for bed mobility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note written by Licensed Practical Nurse (LPN) Employee E12 dated 5/26/24, at 6:31 a.m. indicated CNA [certified nursing assistant] reported to this Nurse that resident was lying on floor. Upon entering into room observed face down. Registered Nurse (RN) notified and accessed for injuries. Obtained a Hematoma [bruise] to his RT [right] side head of temporal. Denies any pain at this time. Resident was assisted off the floor with Hoyer x 3[mechanical lift using 3 people] into his bed. Review of a progress note dated 5/26/24, at 6:41 a.m. indicated that Resident R8 exited the facility with emergency services personnel for the hospital. Review of a progress note written by RN Employee E10 dated 5/26/24, at 6:50 a.m. indicated Around 0600, this nurse was notified of a witnessed fall. Per CNA, she turned him towards her to change him. He rolled towards her and caught him but because he was heavy & stiff, the CNA was not able to put him down to the floor so he fell . Noted some blood on his R forehead with a 7 cm x 2. 5cm hematoma. No other bleeding noted on other parts of his body, no skin tear or abrasion. Fistula [dialysis port] intact. Per resident, he rolled out of the bed during change. Review of a progress note written by RN Employee E10 dated 5/27/24, at 12:30 p.m. indicated Resident returned from St. [NAME] ER at approx. 1200, after he was further evaluated r/t [related to] fall causing head injury. CT Brain Unenhanced [brain scan] showed no acute CNS [central nervous system] findings or fracture. Small right frontal hematoma. Review of an employee statement written by NA Employee E13 dated 5/26/24, stated, I was in turning the resident to me to provide a.m. care. The resident became stiff and I couldn't stop the roll. I caught him and lowered him to the floor. He hit his head on the nightstand. NA Employee E13 is no longer employed by the facility and was not able to be contacted. During an interview on 9/19/24, at 2:45 p.m. the Director of Nursing confirmed that the facility failed to provide adequate documentation for the bed mobility needs for one of five residents, which resulted in a roll out of bed for Resident R8. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 201.20(b)(1) Staff Development. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.11(d) Resident care plan.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 49646 Based on employee personnel review and staff interview, it was determined that the facility failed to complete a performance evaluation of each nurse aide at least once every 12 months for five of five nurse aides reviewed (Employees E1, E2, E3, E4, and E5). Findings include: The facility noted the following hire dates for five employees reviewed for performance evaluations: Employee E1's hire date of December 16, 2014 Employee E2's hire date of November 11, 2020 Employee E3's hire date of August 22, 2012 Employee E4's hire date of May 13, 2009 Employee E5's hire date of July 8, 1993 A request to review the annual performance evaluations revealed no documented evidence that the facility is completing the evaluations at least once every 12 months. Interview with the Nursing Home Administrator on September 19, 2024, at 9:18 AM confirmed that performance evaluations were not completed on the five employees. 28 Pa. Code 201.19 (2) Personnel policies and procedures 28 Pa Code: 201.20 (a)(b)(c)(d) Staff development.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50158 Based on observations and staff interviews, it was determined that the facility failed to properly dispose of expired and/or opened medical supplies in one of two medication rooms (First floor). Findings include: During an observation of the facility medication room on [DATE], at 1:15 p.m. of the facility medication room, the following was observed: -19 Medline triple pack povidone iodine swabsticks with expiration date of ,d+[DATE]. -16 Curad oil emulsion dressing with expiration date of [DATE]. -16 Dynarex DynaSorb super absorbent dressing with expiration dates of [DATE]. -25 Brava strip paste coloplast with an expiration dates of [DATE],[DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. -One I Medical Devices IM41000 small bore extension set 7 with an expiration date of [DATE]. During an interview on [DATE], at 10:11 a.m. the Nursing Home Administrator confirmed the facility failed to properly dispose of expired and/or opened medical supplies in one of one medication rooms. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(5) Nursing services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 43725 Based on review of facility policy, observations and staff interviews, it was determined that the facility failed to maintain infection control practices to prevent the potential for cross contamination during a dressing change. Findings include: Review of the facility policy Dry/Clean Dressings dated 4/9/24, indicated to clean the bedside stand before and after dressing change. Place the clean equipment on the clean field. Wash and dry hands thoroughly. Label tape or dressing with date, time, and initials. During an observation on 9/19/24, at 1:30 p.m. with Registered Nurse (RN) Employee E15 the following occurred during a dressing change: - a red biohazard bag was placed in the resident's regular garbage can - clean gloves donned, hands were not washed/sanitized prior - bedside table wiped but was not cleared of resident belongings - clean gloves donned again and hands were not washed/sanitized - personal scissors cleansed - items placed on bedside table (including a box of gloves, bag of cling gauze, and roll of tape) a clean barrier was not used - old bandage removed with scissors - clean gloves donned again and hand were not washed/sanitized - normal saline used to ease bandages from wound - clean gloves donned and hands were not washed/sanitized - wound cleansed with normal saline - collagen dressing cut with scissors these were not cleansed after cutting the dirty dressing - dressing placed on wound, covered with sterile gauze and wrapped with cling gauze. - clean gloves donned again and hands were not washed/sanitized - scissors cleansed, bandage secured with tape without a date and initials placed on bandage. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- red biohazard bag taken to soiled utility - box of gloves, roll of tape, and bag of cling gauze disposed of in the medication room garbage. RN Employee E15 stated these are not soiled, so they can be thrown away in here. - hands washed with soap. During an interview on 9/19/24, at 1:57 p.m. RN Employee E15 stated I washed my hands before I went into the room. There wasn't anywhere in the room to wash my hands. Resident room contained a bathroom with running water and soap. During an interview on 9/19/24, at 2:00 p.m. the Director of Nursing confirmed the facility failed to prevent cross contamination during a dressing change, 28 Pa. Code: 201.20(c) Staff development. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0940 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 49646 Based on the review of the facility policy and staff interviews, it was determined that the facility failed to implement and maintain an effective training program for individuals providing services under contractual agreement, consistent with their expected roles. Finding include: Review of the policy In-Service Training dated 4/9/24, indicated it is the policy of the facility to develop, implement, and maintain an effective training program for all new and existing staff providing services under contractual arrangement, consistent with expected roles. During an interview on 9/18/24, at approximately 1:30 p.m. the Director of Nursing confirmed the previous Human Resource Director did not have accurate and completed training files. During an interview on 9/19/24, at 9:18 a.m. the Nursing Home Administrator confirmed the facility failed to implement, and maintain an effective training program for individuals providing services under contracted arrangement, consistent with their expected roles. 28 Pa. Code 201.20(a)(b)(c)(d) Staff Development

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395434	A. Building B. Wing	09/20/2024

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F 0941 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 49646 Based on review of facility documents and staff interviews, it was determined that the facility failed to provide Communication training to ten of ten direct care facility staff reviewed (Employees E1, E2, E3, E4, E5, E7, E8, E9, E10, and E11). Finding include: Review of facility education documents revealed the facility failed to offer Communication education to direct care staff members. Review of Nurse Aide (NA) Employee E1's facility provided information did not include training on effective communication. Review of NA Employee E2's facility provided information did not include training on effective communication. Review of NA Employee E3's facility provided information did not include training on effective communication. Review of NA Employee E4's facility provided information did not include training on effective communication. Review of NA Employee E5's facility provided information did not include training on effective communication. Review of Activities Aide Employee E7's facility provided information did not include training on effective communication. Review of Dietary Aide Employee E8's facility provided information did not include training on effective communication. Review of Housekeeping Employee E9's facility provided information did not include training on effective communication. Review of Registered Nurse Employee E10's facility provided information did not include training on effective communication. Review of Occupational Therapy Employee E11 facility provided information did not include training on effective communication. During an interview on 9/19/24, at 9:18 a.m. the Nursing Home Administrator confirmed that the facility failed to provide Communication training to direct care facility staff. 28 Pa. Code: 201.14(a) Responsibility of Licensee (continued on next page)

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F 0941 Level of Harm - Potential for minimal harm Residents Affected - Many	28 Pa. Code: 201.20(c) Staff Development

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F 0942 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 49646 Based on review of facility documents and staff interview it was determined that the facility failed to provide training on residents rights for ten of ten staff members (E1, E2, E3, E4, E5, E7, E8, E9, E10, E11). Finding include: Review of the facility education documents revealed the facility failed to offer Resident Rights education to its direct care staff members. Review of Nurse Aide (NA) Employee E1's facility provided information did not include training on resident rights. Review of NA Employee E2's facility provided information did not include training on resident rights. Review of NA Employee E3's facility provided information did not include training on resident rights. Review of NA Employee E4's facility provided information did not include training on resident rights. Review of NA Employee E5's facility provided information did not include training on resident rights. Review of Activities Aide Employee E7's facility provided information did not include training on resident rights. Review of Dietary Aide Employee E8's facility provided information did not include training on resident rights. Review of Housekeeper Employee E9's facility provided information did not include training on resident rights. Review of Registered Nurse Employee E10's facility provided information did not include training on resident rights. Review of Occupational Therapy Employee E11's facility provided information did not include training on resident rights. During an interview on 9/19/24, at 9:18 a.m. the Nursing Home Administrator confirmed that the facility failed to provide Resident Rights training to direct care facility staff. 28 Pa. Code: 201.14(a) Responsibility of Licensee (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0942 Level of Harm - Potential for minimal harm Residents Affected - Many	28 Pa. Code: 201.20(c) Staff Development

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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 0944 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 49646 Based on the review of facility documents and staff interview, it was determined that he facility failed to provide Quality Assurance and Performance Improvement (QAPI) training to ten of ten facility staff reviewed (E1, E2, E3, E4, E5, E7, E8, E9, E10, E11\). Finding include: Review of Nurse Aide (NA) Employee E1's facility provided information did not include training on QAPI. Review of NA Employee E2's facility provided information did not include training on QAPI. Review of NA Employee E3's facility provided information did not include training on QAPI. Review of NA Employee E4's facility provided information did not include training on QAPI. Review of NA Employee E5's facility provided information did not include training on QAPI. Review of Activities Aide Employee E7's facility provided information did not include training on QAPI. Review of Dietary Aide Employee E8's facility provided information did not include training on QAPI. Review of Housekeeping Employee E9's facility provided information did not include training on QAPI. Review of Registered Nurse Employee E10's facility provided information did not include training on QAPI. Review of Occupational Therapy Employee E11's facility provided information did not include training on QAPI. During an interview on 9/19/24, at 9:18 a.m. the Nursing Home Administrator confirmed that the facility failed to provide training on QAPI for Employees E1, E2, E3, E4, E5, E7, E8, E9, E10 and E11. 28 Pa. Code: 201.20(a) Responsibility of Licensee 28 PA. Code: 201.20(c) Staff Development

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F 0946 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide training in compliance and ethics. 49646 Based on review of facility policy and documents and staff interview, it was determined that the facility failed to provide training on compliance and ethics for ten of ten staff members (E1, E2, E3, E4, E5, E7, E8, E9, E10, E11). Findings include: Review of Nurse Aide (NA) Employee E1's facility provided information did not include training on compliance and ethics. Review of NA Employee E2's facility provided information did not include training on compliance and ethics. Review of NA Employee E3's facility provided information did not include training on compliance and ethics. Review of NA Employee E4's facility provided information did not include training on compliance and ethics. Review of NA Employee E5's facility provided information did not include training on compliance and ethics. Review of Activities Aide Employee E7's facility provided information did not include training on compliance and ethics. Review of Dietary Aide Employee E8's facility provided information did not include training on compliance and ethics. Review of Housekeeping Employee E9's facility provided information did not include training on compliance and ethics. Review of Registered Nurse Employee E10's facility provided information did not include training on compliance and ethics. Review of Occupation Therapy Employee E11's facility provided information did not include training on compliance and ethics. During an interview on 9/19/24, at 9:18 a.m. the Nursing Home Administrator confirmed that the facility failed to provide training on compliance and ethics. 28 Pa. Code: 201.14(a) Responsibility of licensee 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.20(a)(c) Staff Development

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49646 Based on review of facility policy and documentation, and staff interview, it was determined that the facility failed to conduct at least 12 hours of in-service education, within 12 months of their hire date anniversary, for nurse aides as required for five of five nurse aides (Employee E1, E2, E3, E4 and E5). Finding include: A review of the facility policy In-Service Training dated 4/9/24 and 12/29/23, indicated all staff (means all new and existing staff), are able to interact in a manner that enhances the resident's quality of life and quality of care and can demonstrate competency in the topic areas of the training. Review of the Facility assessment dated [DATE], indicated that staff are trained on policies and procedures, consistent with their roles. This also includes determining if new or updated policies are needed, and ensuring they are developed or updated. Review of Nurse Aide (NA) Employee E1, E2, E3, E4 and E5's education records with hire date greater than 12 months revealed the following: NA Employee E1 had a hire date of 12/16/14, with 4 hours in-service training between 12/16/22, and 12/16/23. NA Employee E2 had a hire date of 11/20/20, with 4 hours in-service training between 11/20/22, and 11/20/23. NA Employee E3 had a hire date of 8/22/12, with 4 hours in-service training between 8/22/23, and 8/22/24. NA Employee E4 had a hire date of 5/13/09, with 4 hours in-service training between 5/13/23, and 5/13/24. NA Employee E5 had a hire date of 7/8/93, with 4 hours in-service training between 7/8/23, and 7/8/24. During an interview on 9/19/24, at 9:18 a.m., the Nursing Home Administrator confirmed that the required education was completed in the required timeframe, and further confirmed that the facility failed to provide the required 12 hour annual in-service education within 12 months of their hire date anniversary for five of five nurse aides. 28 Pa. Code: 201.14(a) Responsibility of Licensee. 28 Pa. Code: 201.20(c) Staff Development.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 49646 Based on review of facility documents and staff interview, it was determined that he facility failed to provide training on behavioral health for ten of ten staff members (Employees E1, E2, E3, E4, E5, E7, E8, E9, E10, E11). Findings include: Review of Nurse Aide (NA) Employee E1's facility provided information did not include training on behavioral health. Review of NA Employee E2's facility provided information did not include training on behavioral health. Review of NA Employee E3's facility provided information did not include training on behavioral health. Review of NA Employee E4's facility provided information did not include training on behavioral health. Review of NA Employee E5's facility provided information did not include training on behavioral health. Review of Activities Aide Employee E7's facility provided information did not include training on behavioral health. Review of Dietary Aide Employee E8's facility provided information did not include training on behavioral health. Review of Housekeeping Employee E9's facility provided information did not include training on behavioral health. Review of Registered Nurse Employee E10's facility provided information did not include training on behavioral health. Review of Occupational Therapy Employee E11's facility provided information did not include training on behavioral health. During an interview on 9/19/24, at 9:18 a.m. the Nursing Home Administrator confirmed that the facility failed to provide training on behavioral health for Employees E1, E2, E3, E4, E5, E7, E8, E9, E10, E11. 28 Pa. Code: 201.14 (a) Responsibility of licensee 28 Pa. Code: 201.18 (b)(1) Management (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	28 Pa. Code: 201.20(a)(c) Staff Development