STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395442	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
York North Skilled Nursing and Rehabilitation Ctr	1770 Barley Road York, PA 17408

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37817 Based on clinical record review, observations, and resident and staff interviews, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for six of 33 residents reviewed (Resident 3, 10, 67, 111, 118, and 127). Findings Include: Review of the Resident Assessment Instrument, Version 3.0, dated October 2023, Chapter 3, Section L, read, in part, if resident has dentures examine for loose fit. Ask resident to remove denture to examine and complete exam of lips and oral cavity. Review of Resident 3's clinical record revealed diagnoses that included low back pain, depression, and dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning). Review of Resident 3's Quarterly MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) with the assessment reference date (last day of the assessment period) of February 2, 2024, revealed in Section N. Medications that the Resident was coded as not receiving an opioid medication (a class of medications used to treat pain) during the assessment reference period. Review of Resident 3's January 2024 and February 2024 Medication Administration Record, revealed that the Resident had received an opioid medication on January 29, 2024, and February 1 and 2, 2024. During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on March 27, 2024, at 11:40 AM, the MDS coding concern was shared for further follow-up. During an interview with Employee 4 (RNAC - Registered Nurse Assessment Coordinator) on March 27, 2024, at 1:09 PM, Employee 4 confirmed that Resident 3's MDS was coded inaccurately for their opioid medication and that they had completed a modification. During a follow-up interview with the NHA and DON on March 27, 2024, at 1:20 PM, the DON confirmed that she would expect the MDS to have been coded accurately. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 10's clinical record revealed diagnoses that included hemiplegia (paralysis of one side of body) and hemiparesis (muscle weakness on one side of the body) following a cerebral infarction (a stroke - damage to the brain from interruption of its blood supply) affecting left non-dominant side, Alzheimer's dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), and heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs). Review of Resident 10's Annual MDS with the assessment reference date of December 28, 2023, revealed in Section N. Medications that the Resident was not coded as receiving an antiplatelet medication (a medication that helps prevent blood cells from sticking together and forming a blood clot) during the assessment period. Review of Resident 10's December 2023 Medication Administration Record, revealed that the Resident had received an antiplatelet medication daily during the assessment period. Review of Resident 10's Quarterly MDS with the assessment reference date of February 22, 2024, revealed in Section N. Medications that the Resident was not coded as receiving an antiplatelet medication during the assessment period. Review of Resident 10's February 2024 Medication Administration Record, revealed that the Resident had received an antiplatelet medication daily during the assessment period. During an interview with the NHA and DON on March 26, 2024, at 1:15 PM, the MDS coding concern was shared for further follow-up. During an interview with Employee 4 on March 27, 2024, at 11:07 AM, Employee 4 confirmed that both of Resident 10's MDS's were coded inaccurately, that the antiplatelet medication should have been coded, and that they had completed a modification to the assessments. During a follow-up interview with the NHA and DON on March 27, 2024, at 11:38 AM, the DON confirmed that she would expect the MDSs to have been coded accurately. Review of Resident 67's clinical record documented diagnoses that included anxiety (a feeling of worry, nervousness, or unease), chronic obstructive pulmonary disease (COPD - a group of lung disease that block airflow and make it difficult to breathe), and epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures). During an interview with Resident 67 on March 25, 2024, at 11:04 AM, it was revealed that she saw the Dentist several months ago and it was recommended that her full upper denture be replaced and that she be fitted for a partial lower denture, but the dentist never came back and she hasn't heard anything. It was also revealed that her upper denture is loose, and that it didn't hinder her ability to eat. Observation on March 25, 2024, at 11:04 AM, Resident 67's upper denture was noted to be loose. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 67's dental consult dated January 18, 2024, read, in part, full-upper dentures were loose fitting. Recommended full mouth x-ray to evaluate dentition for possible fabrication of a new upper complete denture and partial lower denture, along with a six month dental cleaning, and follow-up with Resident following dental x-ray. Review of Resident 67's quarterly MDS dated [DATE], documented NO for loose fitting full or partial denture. During an interview with the NHA and DON on March 28, 2024, at 10:50 PM, the Surveyor informed them of the concern regarding Resident 67's loose denture not documented on the February 22, 2024, MDS. No further information was provided. During an interview with Employee 4 on March 28, 2024, at 1:00 PM, revealed that the dental assessment portion on the aforementioned quarterly MDS is completed via a clinical record review and a visual dental assessment isn't completed. Clinical record review revealed a dental consult on January 18, 2024, and did reveal loose denture. There was no follow-up from the dentist and the condition was past the look back period; therefore, not coded. Review of Resident 111's clinical record revealed diagnoses that included chronic respiratory failure (when your blood has too much carbon dioxide or not enough oxygen) and dependence on supplemental oxygen (cannot live with supplemental oxygen). Review of Resident 111's quarterly MDS dated [DATE], Section O0100. Special Treatments, Procedures, and Programs, C1. Oxygen Therapy, revealed that Resident 111 did not receive oxygen therapy during the previous 14 days. Review of Resident 111's Treatment Administration Record (TAR) for the month of March 2024, revealed that Resident 111 received supplemental oxygen at 3 liters per minute via nasal canula daily from March 6-11, 2024. Interview with the Employee 4 on March 28, 2024, at 11:35 AM, revealed that the MDS completed on March 11, 2024, should have been coded to reveal that the Resident received oxygen therapy. Review of Resident 118's clinical record on March 27, 2024, at 2:02 PM, revealed diagnoses that included cellulitis (bacterial skin infection) of the left lower limb and open wound (a break in the skin that leaves internal tissue exposed) left lower leg. Review of Resident 118's progress notes revealed Resident 118 had been continuously receiving treatment of an open wound on the left lower extremity since admission on July 26, 2023. Review of Resident 118's quarterly Minimum Data Set, dated dated dated [DATE], revealed that section M1040 other ulcers, wounds, and skin problems, subsection D open lesions(s) other than ulcers, rashes, cuts (e.g., cancer lesion) was coded no. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an additional interview on March 28, 2024 at 1:39 PM, with the DON, it was revealed that section M1040 on Resident 118's MDS dated [DATE], had been incorrectly coded. The DON stated it was the facility's expectation that MDS assessments be completed accurately. Review of Resident 127's clinical record on March 27, 2024, at 9:59 AM, revealed diagnoses that included end stage renal disease (condition in which kidneys cease functioning leading to the need for long-term dialysis) and methicillin resistant staphylococcus aureus infection (MRSA- infection that is difficult to treat because of resistance to multiple antibiotics). Review of Resident 127's physician orders revealed an order for dialysis (treatment that removes extra fluid and waste products from the blood when the kidneys are not able to) on Monday, Wednesday, and Friday. Review of Resident 127's quarterly Minimum Data Set, dated dated dated [DATE], revealed that section O0110. special treatments, procedures, and programs, subsection J1 dialysis was coded no while a resident. Further review revealed section I active diagnosis, subsection I1700 multidrug-resistant organism (MDRO) was coded no. During an additional interview on March 28, 2024 at 10:57 AM, with the NHA and DON, it was revealed that sections O0110 and I1700 on Resident 127's MDS dated [DATE], had been coded incorrectly and a modification had been made. The DON, in the presence of the NHA, stated it was the facility's expectation that MDS assessments be completed accurately. 28 Pa Code 211.12 (d)(3)(5) Nursing Services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33879 Based on clinical record review, observations, facility policy reivew, and staff interviews, it was determined that the facility failed to revise and/or update the resident comprehensive plan of care for six of 30 residents reviewed (Residents 10, 11, 73, 93, 118, and 129). The facility also failed to ensure that care plan meetings included representation from the interdisciplinary team for four of 33 residents reviewed (Residents 10, 11, 93, and 129). Findings include: Review of facility policy, titled Person Centered Care Plan, with a last review date of December 29, 2023, revealed the following: 1) in the section titled Policy, in part, The interdisciplinary team, in conjunction with the patient and/or representative, as appropriate, will establish the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care; 2) in the section titled Purpose that to promote positive communication between patient, patient representative, and team to obtain the patients and resident representative input into the plan of care, ensure effective communication, and optimize clinical outcomes; and 3) in the section titled Practice Standards at 7. 2 Care plans will be reviewed and revised by the interdisciplinary team after each assessment and as needed to reflect the response to care and changing needs and goals. Review of Resident 10's clinical record revealed diagnoses that included hemiplegia (paralysis of one side of body) and hemiparesis (muscle weakness on one side of the body) following a cerebral infarction (a stroke - damage to the brain from interruption of its blood supply) affecting left non-dominant side, Alzheimer's dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), mild intellectual disabilities, and heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs). Review of Resident 10's clinical record revealed Dietician progress note dated October 3, 2023, at 10:09 AM, that the Resident had a confirmed weight loss of 14.6% in one month and a 12% loss in six months. This note further indicated that the current plan would be continued and recommendation was given for weekly weights. Another note dated December 4, 2023, at 10:48 AM, that indicated the Resident was triggering for a significant weight loss of 15.6% in six months, but that their weight had been stable over the past month, and no changes to plan. Another progress note dated March 11, 2024, at 10:33 AM, that indicated the Resident was triggering for significant weight loss of 13.1% in six months and were stable at one month. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 10's care plan revealed that the Resident had a focus for nutritional status: at risk for weight changes, with a date initiated of July 20, 2016, and last revised date on November 22, 2021. The care plan did not reflect Resident 10's actual significant weight loss that started on October 3, 2023. During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on March 27, 2024, at 1:10 PM, the concern was shared regarding Resident 10's actual weight loss was not being care planned. The DON indicated that she would look into the concern. Review of Resident 10's care plan conference notes revealed that their last care plan conference was on October 10, 2023, and that the only attendees were Resident 10 and a representative from Social Services, Employee 13. During an interview with Employee 6 (Social Services Director) and Employee 13 on March 28, 2024, at 11:35 AM, Employee 13 confirmed that she has no social work credentials and indicated that usually the only attendees to the care conferences are the Resident, the Activity Director, and herself. She further indicated that occasionally therapy might attend. Employee 6 indicated that he only attends the care plan meetings for difficult residents, and that nursing staff and therapy occasionally attend. During an interview with the Employee 7 on March 28, 2023, at 12:08 PM, she indicated that they would not have revised Resident 10's care plan to include the actual significant weight loss because he was being followed by the Dietician, and the Dietician indicated that there were no changes in his plan of care. During a final interview with the NHA and DON on March 28, 2024, at 12:48 PM, the DON indicated that she was in agreement with Employee 7 that Resident 10 did not need their care plan revised to reflect the actual significant weight loss because their plan of care had not changed. It was shared that a resident's care plan should be an accurate direct reflection of the resident's current status. It was also shared that Resident 10 had not had a care plan conference since October 10, 2023, and that the only attendees were the Resident and Employee 13. The DON confirmed that she would expect care conferences to occur at a minimum of quarterly and that all members of the interdisciplinary team would attend these conferences. Review of Resident 11's clinical record revealed diagnoses that included cerebral infarction (a stroke - damage to the brain from interruption of its blood supply), dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), and localized infection of the skin and subcutaneous tissue (tissue just under the skin). Observation of Resident 11 on March 25, 2024, at 10:42 AM, revealed a dark colored area to their left great toe. Observation of Resident 11 on March 27, 2024, at 11:10 AM, continued to reveal the dark colored area to their left great toe, as well as a pinpoint dark colored area to the outer aspect of their left second toe. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 11's clinical record progress notes revealed a note dated February 1, 2024, at 1:49 PM, by the Certified Registered Nurse Practitioner (CRNP - a registered nurse who has advanced education and clinical training in a health care specialty area) that indicated they had seen Resident 11 for evaluation of their great toe for a possible infection which was described as great toe red, warm to touch, and very tender. there is an open area with some bleeding and purulent drainage. unable to express anymore drainage at this time. toenails are thick. no other open areas noted at this time. Orders were given for an antibiotic, a local treatment of bacitracin, and a band aide to be administered daily and as needed. Further review of Resident 11's clinical record progress notes revealed a note dated February 1, 2024, at 2:39 PM, by a nurse, which indicated the area was on Resident 11's left great toe, that the CRNP assessed the area and gave treatment orders, that the bacitracin was to be discontinued when the area was resolved, and requested Resident 11 be seen by podiatrist. Review of podiatry visit note dated February 15, 2024, revealed that there was a scabbed lesion to the tip of the left great toe with subungual (situated or occurring under a fingernail or toenail) hematoma (blood clot), that the Resident had been on Keflex, and that the podiatrist questioned if the area was from an injury and that the scab was left intact. No new orders were given by podiatrist. Review of Resident 11's care plan revealed that the Resident was care planned at risk for alteration in skin integrity and potential for skin tears, bruises, abrasions, and pressure ulcers, with a last revision date of May 10, 2023. This review of Resident 11's care plan failed to reveal the presence of the skin issue noted on their left great toe or second toe. During an interview with the NHA and DON on March 27, 2024, at 11:42 AM, observations of Resident 11's toes were shared and that the care plan did not include these identified actual skin concerns. During an interview with Employee 7 (Registered Nurse Unit Manager) on March 27, 2024, at 2:21 PM, she indicated that she reassessed areas on Resident 11's toes and obtained a new treatment order today. She confirmed that the area should have been care planned when originally found. She also provided a copy of revised care plan that included both areas on Resident 11's toes. During an interview with the NHA and DON on March 28, 2024, at 10:43 AM, the DON confirmed that she would expect staff to complete body audits weekly. She indicated that if any skin issues are identified during the body audit completion, it would be documented in the progress notes and all follow-up would be completed as indicated. She further indicated that she would expect documentation to have been completed for this Resident's ongoing toe issue. and that she would expect staff to have care planned the area when it was first identified. Review of Resident 11's care plan conference notes revealed that the Resident had care plan conferences on December 5, 2023, and March 5, 2024. The only attendees at both of these conferences were Resident 11 and Employee 13. During an interview with Employee 6 and Employee 13 on March 28, 2024, at 11:35 AM, Employee 13 confirmed that she has no social work credentials, and indicated that usually the only attendees to the care conferences are the Resident, the Activity Director, and herself. She further indicated that occasionally therapy might attend. Employee 6 indicated that he only attends the care plan meetings for difficult residents, and that nursing staff and therapy occasionally attend. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a final interview with the NHA and DON on March 28, 2024, at 12:49 PM, the DON confirmed that Resident 11's care plan should have been revised when the skin issue was discovered. It was also shared that the only attendees as Resident 11's care conferences on December 5, 2023, and March 5, 2024, were the Resident and Employee 13. The DON confirmed that she would expect all members of the interdisciplinary team to attend these conferences. Review of Resident 73's clinical record documented diagnoses that included diabetes mellitus (the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine), sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts), and Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow imprecise movement). Review of Resident 73's physician orders on March 26, 2024, documented CPAP (Continuous Positive Airway Pressure - a method of respiratory therapy in which air is pumped into the lungs through the nose or nose and mouth during spontaneous breathing): Nasal Mask; Humidifier: every evening and night shift for Sleep Apnea and as needed, order date February 14, 2024, but there were no pressure settings indicated on the order. Further review of Resident 73's physician orders on March 27, 2024, documented a new order CPAP: Nasal Mask; humidifier: yes, pressure settings: RAMP time 0.20, RAMP 4.0, CMh20 4, flex 2 with humidify as needed for sleep and every evening and night shift for sleep apnea, dated March 27, 2024. Review of Resident 73's care plan documented a focus area for at risk for respiratory impairment related to shortness of breath while lying flat, initiated February 8, 2024. Interventions included administer medications/treatments per physician orders, initiated February 8, 2024. Further review of Resident 73's care plan on March 27, 2024, revealed the respiratory impairment care plan contained an intervention for CPAP use per physician order. During an interview with Employee 9 (Registered Nurse Supervisor) on March 27, 2024, at 1:30 PM, it was revealed that Resident 73's care plan should've contain an intervention for the CPAP machine. Clinical record review of Resident 93's revealed diagnoses that included diabetes mellitus, edema (swelling in extremities), and pressure ulcer (an open area of the skin caused by pressure). Review of Resident 93's weight history revealed an 11 pound weight loss between August 2023 and March 2024; greater than 10% in six months. Review of nutrition progress notes documented on November 2, 2023, revealed a significant weight loss of 5% from the previous month, and recommended to re-weigh to verify accuracy of the weight. Review of nutrition note dated November 15, 2023, revealed re-weight obtained and weight loss was confirmed, requested weekly weight monitoring. Nutrition note dated January 5, 2024, documented significant weight loss of 9% in three months and monitoring weekly weights. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On February 12, 2024, nutrition note documented a significant weight loss of 11% in six months. Review of Resident 93's care plan documented a focus area for at nutritional risk related to diabetes, heart disease, hypertension (high blood pressure), and a history of significant weight gain, Now weight is stable. initiated December 9, 2020, revised July 5, 2023. Interventions included to review weights and notify physician and Responsible Party of significant weight change, initiated December 9, 2020. Further review of Resident 93's care plan failed to document significant weight loss. Review of care plan progress notes dated November 28, 2023, and February 22, 2024, read, in part, attendees included Social Services and the Resident. During an interview with the DON on March 28, 2024, at 10:50 PM, it was revealed that it is expected that care plan meetings are attended by Social Services, Activities, Nursing, and Dietary. It was confirmed that Dietary doesn't attend care plan meetings. It was also revealed that Resident 93's care plan should've been updated to include the significant weight loss. During an interview with the NHA and DON on March 27, 2024, at 12:30 PM, it was revealed that the registered Dietitian works remotely and doesn't attend care plan meetings in person or remotely. It was also revealed that the facility has attempted to hire a Registered Dietitian who is willing to work at the facility and hasn't been successful. During an interview with Employee 6 and Employee 9 on March 28, 2024, at 11:45 AM, it was revealed that Employee 9 runs the care plan meeting, Employee 6 doesn't attend routinely, at times a representative from the Activities Department and Therapy Department will attend, and there is no representation from dietary. Review of Resident 118's clinical record on March 27, 2024 at 2:02 PM, revealed diagnoses that included cellulitis (bacterial skin infection) of the left lower limb and open wound (a break in the skin that leaves internal tissue exposed) on left lower leg. An observation made on March 25, 2024, at 2:06 PM, of Resident 118's room, revealed a sign on the door that stated enhanced barrier precautions and a caddy containing personal protective equipment, which included gowns and gloves, in the hallway by the door. Review of the facility's list of residents on transmission-based precautions on March 27, 2024 at 1:52 PM, revealed Resident 118 was on precautions for VRE (vancomycin-resistant enterococci - a type of bacteria resistant to multiple antibiotics) Further review of Resident 118's clinical record revealed an admission progress note dated July 26, 2023, at 5:24 PM, that indicated Resident 118 had a history of VRE. Review of Resident 118's comprehensive plan of care on March 28, 2024, at 1:23 PM, revealed a focus area for infection of urinary tract, history of VRE, initiated March 13, 2024. Further review of Resident 118's resolved care plans a focus area for VRE, with a resolved date of November 21, 2023. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on March 28, 2024, at 1:39 PM, with the DON, the surveyor requested additional information regarding the resolutions of the aforementioned care plan focus area. The DON stated the focus area for VRE should not have been resolved, and it is the facility's expectations that care plan revisions are accurate. Review of Resident 129's clinical record on March 26, 2024, at approximately 9:15 AM, revealed diagnoses including stage 4 pressure injury of the sacral region (wound of the skin caused by pressure over a bony prominence that extends through the layers of skin to the underlying connective tissue and/or bone) and paraplegia (paralysis of both lower limbs). Review of Resident 129's comprehensive plan of care revealed a care plan with a focus of, The Patient is at risk for alteration in nutritional status [related to] increased needs for wound healing, which was initiated on January 10, 2024, and last revised on January 12, 2024. Review of Resident 129's clinical record revealed upon admission to the facility on [DATE], Resident 129 was documented as weighing 220.0 pounds. Review of Resident 129's clinical record revealed weekly weights were not performed upon admission. Review of Resident 129's clinical record revealed that the next documented weight was 24 days later on February 3, 2024. On February 3, 2024, Resident 129's documented weight was 218.0 pounds. On February 16, 2024, Resident 129 was transferred to the hospital due to an emergency medical situation. Resident 129 returned to the facility on [DATE]. Review of Resident 129's clinical record revealed that on February 22, 2024, a weight of 186.6 pounds was documented at 10:31 PM, and again approximately two hours later at 12:32 AM on February 23, 2024, a weight was documented as 186.6. Resident 129 demonstrated a significant weight loss of 14.4% between February 3, 2024, and February 23, 2024. Review of Resident 129's interdisciplinary progress notes revealed that on February 28, 2024, at 2:50 PM, Employee 14 (Registered Dietician) entered a progress note which included, [Current body weight] captured on 186.6 lbs. This [weight] triggers for significant [weight] loss of 15.2% x 1 month. Though unsure of [usual body weight] and no other [weight history] available. Will cont[inue] to monitor weekly [weights] to better assess [weight] trends. Review of the care plan goals and interventions revealed the care plan was not updated to reflect the significant weight loss identified on February 23, 2024. During a staff interview on March 28, 2024, at approximately 11:30 AM, DON revealed she would expect Resident 129's care plan to be updated to reflect an actual significant weight loss. 42 CFR 483.21(b) Comprehensive Care Plans 28 Pa. Code 211.12(d)(5) Nursing services

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37817 Based on observations, clinical record review, and staff interviews, it was determined that the facility failed to maintain adequate personal hygiene and grooming, transfers, and meal assistance for residents dependent on staff for assistance with these activities of daily living (ADL) for two of 33 residents reviewed (Residents 33 and 241). Findings include: Review of Resident 33's clinical record documented diagnoses that included polyneuropathy (multiple peripheral nerve become damaged; symptoms include problems with sensation and coordination), congestive heart failure (CHF - the heart doesn't pump blood as it should), cognitive loss, and chronic obstructive pulmonary disease (COPD - lung diseases that block airflow and make it difficult to breathe). Review of Resident 33's care plan included a focus area for activities of daily living self-care deficit, as evidenced by ambulatory dysfunction related to COPD and shortness of breath, initiation date November 9, 2021. Interventions included one-person physical assist with bathing and grooming, initiation date November 9, 2021. Observation on March 25, 2024, at 10:22 AM, revealed Resident 33's finger nails were long and contained a brown substance underneath. Observation on March 26, 2024, at 11:59 AM, revealed Resident 33's finger nails were long. Observation on March 26, 2024, at 1:50 PM, with the Director of Nursing (DON), revealed Resident 33's fingernails were long and his right thumb and pointer finger nail contained a brown substance underneath. During an interview with the DON on March 26, 2024, at 1:50 PM, it was revealed that Resident 33's finger nails need to be trimmed. At that time, the DON asked Resident 33 if staff could trim his finger nails, and the Resident nodded his head yes in agreement of having his finger nails trimmed. Review of Resident 241's clinical record revealed they were admitted to the facility on [DATE], and were discharged on [DATE]. Their diagnoses included chronic diastolic congestive heart failure (heart failure that occurs when the heart does not relax properly between beats causing the heart to be unable to pump an adequate amount of blood to the body), chronic kidney disease stage 4 severe (longstanding disease of the kidneys leading to renal failure), and diabetes mellitus (disease that occurs when your blood glucose, also called blood sugar, is too high). Review of Resident 241's care plan revealed a focus area for ADL self-care deficit, as evidenced by need for assistance related to physical limitations, with an initiation date of February 13, 2024. Interventions included two-person physical assist, with an initiation date of February 15, 2024; and to assist with daily hygiene, grooming, dressing, oral care, and eating as needed, with an initiation date of February 13, 2024. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 241's care plan revealed a focus area for requires assistance with transferring from one position to another, as evidenced by need for assistance related to physical limitations, with an initiation date of February 13, 2024. Interventions included two-person assist for transfers with gait belt and rolling walker, with an initiation date of February 15, 2024. Review of Resident 241's February ADL and transfer documentation revealed the following: 1) Bed mobility documentation was blank on the 17th and 22nd for evening shift and on the 23rd for night shift; 2) Dressing was blank on the 20th and 21st for day shift and 17th and 22nd for evening shift; and documented as N/A (Non-Applicable) on the 22nd and 23rd for day shift and on the 23rd for evening shift; 3) Personal hygiene was blank on the 17th, 20th, 21st, and 23rd for day shift, on the 17th and 22nd for evening shift, and on the 23rd for night shift; and was documented as N/A on the 15th and 26th for day shift, on the 23rd for evening shift and on the 18th, 19th, 21st, and 22nd for night shift; 4) Toileting was blank for the 20th and 21st on day shift and the 17th and 22nd for evening shift, and the 23rd for night shift; 5)Meal/Eating was blank for all meals on the 17th and 23rd, on the 25th for breakfast, and on the 22nd for supper; and 6)Transfers was blank on the 13th and 20th for day shift and on the 17th and 22nd for evening shift; and coded as N/A on the 15th, 21st, 23rd, and 24th for day shift and on the 13th, 21st, 23rd, and 24th evening shift. During an interview with the Nursing Home Administrator (NHA) and DON on March 28, 2024, at 10:46 AM, ADL documentation concerns with staff documenting N/A or leaving blank was shared. It was indicated that they have had a lot of issues with documentation because they were switching to a new documentation system, and that only the aides had access to this documentation. She further indicated she would review for follow-up. During an interview with Employee 12 (Registered Nurse Unit Manager) on March 28, 2024, at 12:00 PM, she indicated that she had no additional documentation or information to provide regarding Resident 241's ADL care being provided. During a final interview with the NHA and DON on March 28, 2024, at 12:50 PM, the DON confirmed that they had no additional information to provide regarding Resident 241's ADL care provision and that she would expect care to be provided and documented accordingly. 28 PA Code 211.10(d) Resident Care Policies 28 PA code 211.12(d)(1)(5) Nursing Services

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 40010 Based on staff and resident interviews, facility policy review, and review of facility documents, it was determined that the facility failed to provide an ongoing program of activities designed to meet the needs, interests, and functional abilities for seven of seven months reviewed (September 2023-March 2024) and for five of five residents interviewed (Residents 39, 54, 77, 109, and 132). Findings include: Review of facility policy, Recreation Services Policies and Procedures, Rec202 Program Design, revised August 7, 2023, revealed in step 6, Opportunities for evening entertainment and leisure opportunities are provided. Structured programs are offered a minimum of two times weekly during waking hours, following the dinner meal unless specified as more frequent due to designation as a special care unit. Interviews with five residents (Residents 39, 54, 77, 109, and 132) present at the resident council meeting on March 26, 2024, at 10:20 AM, revealed that the facility didn't provide any activities for the residents in the evening hours, and they were wondering if it was a possibility. Review of facility-provided activity calendars for the months of September 2023-March 2024 failed to reveal any structured programs offered during waking hours following the dinner meal. An interview with Employee 8 on March 27, 2024, at 10:00 AM, revealed that none of the activities department staff work the evening shift and that there used to be an activities department staff member who worked in the evenings, but that employee left the department in 2022 to pursue other employment. An interview with the Nursing Home Administrator on March 28, 2024, at 11:15 AM, revealed that she would expect evening activities to be offered for the residents. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 211.10(d) Resident care policies.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46253 Based on facility policy review, observations, clinical record review, and staff interviews, it was determined that the facility failed to ensure care and services are provided in accordance with professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for two of 33 residents reviewed (Residents 11 and 241). Findings include: Review of facility policy, titled NSG236 Skin Integrity and Wound Management, with a last revision date of February 1, 2023, and a last review date of December 29, 2023, revealed, in part: 4. Identify patient's skin integrity status and need for prevention or treatment interventions through review of all appropriate assessment information. 5. The nursing assistant will observe skin daily and report any changes or concerns to the nurse. 6. The licensed nurse will: 6.1 Evaluate any reported or suspected skin changes or wounds;6.2 Document newly identified skin/wound impairments as a change in condition; 6.3 Document skin/wound findings on the 24-hour Report; 6.4 Perform and document skin inspection on all newly admitted /readmitted patients weekly thereafter and with any significant change of condition. 6.5 Complete wound evaluation upon admission/readmission, new in-house acquired, weekly, and with unanticipated decline in wounds. 6.6 Perform daily monitoring of wounds or dressings for presence of complications or declines. 6.6.1 Document daily monitoring of ulcer/wound site with or without dressing. Monitor: 6.6.1.1 Status of the dressing (e.g., intact and clean); 6.6.1.2 Status of the tissue surrounding the dressing (e.g., free of new redness or swelling); 6.6.1.3 Adequate control of wound associated pain; 6.6.1.4 Signs of decline in wound status. 6.6.1. 4.1 If unanticipated decline in wound, surrounding tissue, or new or increased wound associated pain, complete a wound re-evaluation, change in condition. Review of Resident 11's clinical record revealed diagnoses that included cerebral infarction (a stroke-damage to the brain from interruption of its blood supply), dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), and localized infection of the skin and subcutaneous tissue (tissue just under the skin). Observation of Resident 11 on March 25, 2024, at 10:42 AM, revealed a dark colored area to left great toe. Observation of Resident 11 on March 27, 2024, at 11:10 AM, revealed the dark colored area to their left great toe, as well as a pinpoint dark colored area to the outer aspect of left second toe. Review of Resident 11's clinical record progress notes revealed a note dated February 1, 2024, at 1:49 PM, by the Certified Registered Nurse Practitioner (CRNP - a registered nurse who has advanced education and clinical training in a health care specialty area) that indicated they had seen Resident 11 for evaluation of their great toe for a possible infection, which was described as great toe red, warm to touch, and very tender. there is an open area with some bleeding and purulent drainage. unable to express anymore drainage at this time. toenails are thick. no other open areas noted at this time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 11's clinical record progress notes revealed a nurses note dated February 1, 2024, at 2:39 PM, that stated the CRNP assessed Resident 11's left great toe and gave treatment orders that the bacitracin was to be discontinued when the area was resolved, and for Resident 11 to be seen by the podiatrist. Review of Resident 11's physician order history revealed orders for Keflex (antibiotic) oral capsule 500 mg (milligrams) give one capsule twice daily by mouth for infected left great toe for seven days, and bacitracin external ointment 500 units/gram apply to left great toe topically daily until infection resolved and as needed for infection until healed, both dated February 1, 2024. Review of Resident 11's Medication Administration Record for February 2024, revealed that the Resident completed their ordered Keflex on February 8, 2024. Review of Resident 11's Treatment Administration Record (TAR) for February 2024, revealed that they had received the ordered bacitracin ointment from February 2, 2024, through February 20, 2024. Review of the podiatry visit note dated February 15, 2024, revealed that there was a scabbed lesion to the tip of the left great toe with subungual (situated or occurring under a fingernail or toenail) hematoma (blood clot), that the Resident had been on Keflex, and that the podiatrist questioned if the area was from an injury and that the scab was left intact. No new orders were given by podiatrist. Further review of Resident 11's clinical record progress notes and assessments failed to reveal any further documentation of an assessment or evaluation of the Resident's left great toe after February 1, 2024. During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on March 27, 2024, at 11:42 AM, observations of Resident 11's toes and the lack of documentation of an assessment of Resident 11's ongoing issues with the left great toe were shared. The DON indicated that she would look into the concern. During an interview with Employee 7 (Registered Nurse Unit Manager) on March 27, 2024, at 2:21 PM, she indicated that she reassessed the areas on Resident 11's toes and obtained a new treatment order today. During a final interview with the NHA and DON on March 28, 2024, at 12:49 PM, the DON again confirmed that she would expect ongoing evaluations/assessments to have been completed and documented for Resident 11's ongoing identified toe issue. Review of Resident 241's clinical record revealed they were admitted to the facility on [DATE], and were discharged on [DATE]. Their diagnoses included chronic diastolic congestive heart failure (heart failure that occurs when the heart does not relax properly between beats causing the heart to be unable to pump an adequate amount of blood to the body), chronic kidney disease stage 4 severe (longstanding disease of the kidneys leading to renal failure), and diabetes mellitus (disease that occurs when your blood glucose, also called blood sugar, is too high). (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 Resident 241's progress notes revealed a note dated February 20, 2024, at 10:08 AM, that indicated that the Resident was lethargic (sluggish) but responded to verbal stimuli, their color was pale gray, that their skin turgor (the elasticity of the skin-method used to determine hydration status) was poor, their mouth was dry, that the Resident was seen by the CRNP with orders given for lab work. Review of the CRNP visit note dated February 20, 2024, at 10:13 AM, indicated that the CRNP saw Resident 241 for reports of lethargy and not acting like themselves, had not eaten breakfast, and their blood sugar was on the low side for them, but that the Resident was able to answer questions appropriately. The note further indicated that Resident 241 was on fluid restrictions and taking diuretics. The note indicated that orders were given for labs, to discontinue the fluid restrictions, and to hold the evening dose of the diuretic. Review of Resident 241's physician order history revealed a verbal order for Hypodermoclysis Subcutaneous (method of administering fluids under the skin): 0.45% Normal saline at 75 milliliters an hour for a 1000 milliliters every shift for hydration for 2 Days, dated February 21, 2024, and completed on February 23, 2024. Review of facility policy, titled 6.3 Hypodermoclysis, with a last revision date of June 1, 2021, and a last review date of December 29, 2023, revealed the following, in part: 1. Hypodermoclysis is the subcutaneous administration of fluid for short term fluid deficits. It is indicated for mild to moderate dehydration. (For subcutaneous medication administration, refer to procedure 6.1 Initiating a Subcutaneous Infusion) 8. Subcutaneous infusion sites with a continuous infusion will be observed at least every 2 hours for redness, prominent swelling, leaking, or discomfort. 24. Documentation in the medical record includes, but is not limited to: Date and time, Solution, Rate and method of infusion, Site location/assessment, Complications and interventions and Patient response to procedure and/or solution. Review of Resident 241's clinical record failed to reveal any documentation of the rationale for the hypodermoclysis order, order details, administering, tolerance, or the completion of the hypodermoclysis. This review revealed one eMAR (electronic medication administration record) note dated February 21, 2024, at 5:17 PM, that indicated Clysis continue to run no s/s [signs/symptoms] of complications. Review of Resident 241's February 2024 Medication Administration Record (MAR) failed to reveal any entries regarding the administration of the ordered hypodermoclysis. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the NHA and DON on March 28, 2024, at 10:46 AM, the DON indicated that the hypodermoclysis order was entered into Resident 241's physician orders under the category other and, therefore, it did not populate onto their MAR for proper documentation. She said she would expect the order to have been put in properly so it would show on the MAR for proper administration documentation. She confirmed that she had no additional information to offer regarding the hypodermoclysis administration for Resident 241 (when started; where placed; tolerance; monitoring of the administration site; amount of fluid infused; discontinuation of the site; or any additional follow-up). She further indicated that she would be educating nurses on proper order entry. 28 Pa. Code 201.18(b)(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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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. 46253 Based on facility policy review, clinical record review, facility incident report review, and staff interviews, it was determined that the facility failed to ensure that a thorough investigation was conducted following resident falls, and failed to ensure that residents received adequate assistance to prevent accidents for one of four residents reviewed for falls (Resident 3). Findings include: Review of facility policy, titled OPS100 Accidents/Incidents, with a last review date of December 29, 2023, revealed, in part, in section titled Policy, that Center staff will report, review, and investigate all accidents/incidents which occurred. The policy further indicated in section titled Follow-up/Investigation, the following: 4.2 that the Administrator, DON [Director of Nursing], or designee will review all accidents/incidents to determine if: [in part] 4.2.2. Required documentation has been completed; 4.2.3 Accident/Incident has been investigated; 4.4 When conducting an investigation, the Administrator, DON, or designee will 4.4.1 Make every effort to ascertain the cause of the accident/incident; 4.4.4 Conduct witness interviews from all staff and visitors who may have knowledge of the accident/incident; 4.4.5 Document the root cause and initiate actions to prevent or reduce recurrence of further accident/incident; and 4.4.7 Complete the investigation within 5 working days. Review of Resident 3's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), vertebral disc degeneration (wearing down of spinal discs-normal part of aging process), and abnormalities of gait (manner of walking) and mobility (ability to move). Review of Resident 3's clinical record revealed that they had experienced falls on October 15, 2023, and December 10, 2023. Review of Resident 3's care plan revealed that they had a focus for at risk for falls due to weakness, pain, and difficulty walking, with a last revision date of December 29, 2022. Interventions included, but were not limited to, provide assist to transfer and ambulate as needed, dated December 15, 2022; offer toileting before supper, dated September 16, 2023; and offer toileting before lunch, dated December 11, 2023. Review of Resident 3's facility incident report dated October 15, 2023, at 12:45 PM, revealed that the Resident was found on the floor at the foot end of their bed, that the Resident had been incontinent of bowel, had no injuries, and that the new intervention would be to offer toileting before lunch. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The incident report packet contained one investigation witness statement, which was completed by a Nurse Aide. This witness statement indicated at the question Were you assigned to the patient at the time of the event? that they didn't divide assignments as there was only 2 aides working on the floor. The questions When did you last provide care for the patient and what care did you provide were both blank. Further review of the facility incident report failed to reveal any investigation into the witness statement, indicating that Resident 3 was not assigned to anyone specifically or that no care was documented as being provided prior to Resident 3's fall at 12:45 PM. Review of Resident 3's facility incident report dated December 10, 2023, at 11:45 AM, revealed that the Resident was attempting to toilet themselves in their bathroom because the Resident had to go to the bathroom and could not wait; the Resident had no visible injuries, but were experiencing back pain. The incident report packet contained one investigation witness statement, which was completed by a Nurse Aide, which indicated that the Nurse Aide was assigned to Resident 3. Review of this witness statement revealed that the Employee had last provided wash-up for Resident 3 at 8:05 AM, last observed Resident 3 in the dining room (no time given), and that they heard Resident 3 screaming for help and the Employee responded. Further review of the facility incident report failed to reveal any investigation into the witness statement, indicating that Resident 3 was last provided care at 8:05 AM, approximately 4 hours and 40 minutes prior to their fall. During an interview with the Nursing Home Administrator (NHA) and DON on March 27, 2024, at 11:50 AM, the aforementioned concerns were shared for further follow-up. During a follow-up interview with the NHA and DON on March 28, 2024, at 10:40 AM, the DON indicated that she had no additional information to offer. She confirmed that a thorough investigation should have been completed at the time of Resident 3's aforementioned falls. During an interview with Employee 7 (Registered Nurse Unit Manager) on March 28, 2024, at 12:10 PM, she confirmed that she could find no additional information regarding Resident 3's toileting and care for the aforementioned dates. During a final interview with the NHA and DON on March 28, 2024, at 12:56 PM, the DON confirmed that there was no additional information regarding Resident 3's toileting and care for the aforementioned dates. 28 Pa Code 201.18(b)(1) Management 28 Pa Code 211.10(d) Resident Care Policies 28 Pa Code 211.12(d)(1)(2)(3)(4)(5) Nursing Services

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 49123 Based on clinical record review, policy review, and staff interview, it was determined that the facility failed to ensure physician orders were followed for catheter care for one of four residents reviewed for catheters (Resident 127). Findings include: Review of facility policy, titled Catheter: Indwelling urinary - care of, with a review date of December 29, 2023, revealed 1. Perform catheter care twice a day and PRN (as needed). Section 10. Provide routine hygiene for meatal care, 22. Document, and 22.1 catheter care provided. Review of Resident 127's clinical record on March 27, 2024, at 11:26 AM, revealed diagnoses that included end stage renal disease (condition in which kidneys cease functioning) and obstructive and reflux uropathy (blockage of the urinary tract that causes urine to back up into one or both kidneys). Review of Resident 127's comprehensive plan of care revealed a focus area for use of indwelling urinary catheter needed due to obstructive uropathy/benign prostatic hyperplasia (noncancerous enlargement of the prostate gland), with an intervention for catheter care every shift. Review of Resident 127's physician orders revealed an order for, maintain: 18F 10cc indwelling foley catheter every shift for obstructive uropathy. Review of Resident 127's TAR (Treatment Administration Record - documentation for treatment administered or monitored) failed to reveal documentation to indicate Resident 127's aforementioned catheter order was completed on day shift January 3, 8, 9, 11, 18, 23, and 29, 2024; February 1, 6 ,12, 21, 23, and 29, 2024; and March 6, 10, 11, 12, 20, and 22, 2024; failed to reveal documentation the catheter order was completed on evening shift January 14, 2024; and failed to reveal documentation the catheter order was completed on night shift January 27, 2024; February 3, 13, and 22, 2024; and March 19, 2024. During an interview on March 28, 2024 at 10:57 AM, with the Nursing Home Administrator and Director of Nursing (DON), the DON revealed it was the facility's expectation that physician orders be followed and documented as completed. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. 34631 Based on clinical record review and staff interview it was determined that the facility failed to ensure residents requiring urostomy services receive care consistent with professional standards of practice and based on the comprehensive person-centered plan of care for one of one resident reviewed needing nephrostomy care (Resident 53). Findings Include: A urostomy is defined as an opening in the belly (abdominal wall) that's made during surgery. It re-directs urine away from a bladder that's diseased, has been injured, or isn't working as it should. Review of Resident 53's clinical record revealed diagnoses that included obstructive and reflux uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow) and a history of urinary tract infection (UTI-An illness in any part of the urinary tract, the system of organs that makes urine and often start when bacteria get into the tube through which urine leaves the body, the urethra). Review of Resident 53's March 2024 physician orders revealed documentation that read Nephrostomy Right-maintain monitor for s/s [signs and symptoms] of complications, empty Q [every] shift. A Nephrostomy tube is defined as a tube that lets urine drain from the kidney through an opening in the skin on the back. A thin, flexible tube goes through the opening and into the kidney. The tube is often used if something is blocking the normal flow of urine from the kidney to the bladder. Review of Resident 53's February 2024 Treatment Administration Record (TAR) revealed the nephrostomy care to included documentation of the color of the urine, the amount of urine present and emptied and the time of day the care was provided to the nephrostomy (day, evening and night shifts). Continued reivew of the February TAR revealed staff did not document the color of the urine nor the amount of urine during the evening shift on February 3rd , during the night shift on February 6th , February 8th and February 15th, during the day and night shifts on February 22 nd, during the day shift on February 23rd, and during the day and night shifts on February 26th. Review of Resident 53's March 2024 TAR revealed staff did not document the color of the urine nor the amount of the urine during the night shift on March 1st, during the evening shift on March 11th, during the day shift on March 17th, during the night shift on March 20th and during the day shift on March 26th. An interview with the Director of Nursing, on March 28, 2024, at 10:55 AM confirmed her awareness of the staff not documenting providing the care to Resident 53's nephrostomy during those shifts. 28 Pa. Code 211.12 (d) (1) (5) Nursing services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33879 Based on clinical record review, facility policy review, and staff interview, it was determined that the facility failed to monitor the resident's clinical condition after a significant weight loss was identified for two of five residents reviewed for nutrition (Residents 93 and 129). Findings include: Review of facility policy, titled NSG244 Weights and Heights, last revised June 15, 2022, revealed it stated, Patients are weighed upon admission and/or re-admission, then weekly for four weeks and monthly thereafter. Additional weights may be obtained at the discretion of the interdisciplinary care team . During an interview with Resident 93 on March 25, 2024, at 10:54 AM it was revealed that she has had weight loss. Clinical record review of Resident 93 documented diagnoses that included: diabetes mellitus (the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine), edema (swelling in extremities), and pressure ulcer (an open area of the skin caused by pressure). Review of Resident 93's weight history revealed an 11 pound weight loss between August 2023, and March 2024, greater than 10%, in six months. Weights were obtained: August 1st, September 2nd, October 5th, November 1st, and 15th; December 6th, January 4th, February10th, and March 3rd. Review of Resident 93's nutrition progress notes documented on November 2, 2023 a significant weight loss of 5% from the previous month, and recommended to re-weigh to verify accuracy of the weight. Nutrition note dated November 15, 2023, revealed re-weight obtained and weight loss was confirmed, requested weekly weight monitoring. December 6, 2024, documented significant weight loss in three and six months, noting weight stable over the past month and monitoring weekly weights. Nutrition note dated January 5, 2024 documented significant weight loss of 9% in three months, weight stable over the past month, and monitoring weekly weights. February 12, 2024, nutrition note documented a significant weight loss of 11% in six months, weight stable over the past three months. Review of Resident 93's Medical Practitioner Notes dated: November 1, 2023 for a wound evaluation, December 27, 2023 for routine follow up, February 20, 2024 for routine follow up, and March 7, 2024 an acute visit for sacral wound; all aforementioned notes filed to document acknowledgement of significant weight loss. During a staff interview on March 28, 2024, at approximately 11:30 AM, Director of Nursing revealed it was the facility's expectation that Resident 93's weight would have been monitored per policy. Review of Resident 129's clinical record on March 26, 2024, at approximately 9:15 AM, revealed diagnoses that included stage 4 pressure injury of the sacral region (wound of the skin caused by pressure over a bony prominence that extends through the layers of skin to the underlying connective tissue and/or bone) and paraplegia (paralysis of both lower limbs). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 129's clinical record revealed upon admission to the facility on [DATE], Resident 129 was documented as weighing 220.0 pounds (lbs). Review of Resident 129's clinical record revealed weekly weights were not performed upon admission. Review of Resident 129's clinical record revealed that the next documented weight following admission was 24 days later on February 3, 2024. On February 3, 2024, Resident 129's documented weight was 218.0 lbs. Review of Resident 129's clinical record revealed that on February 22, 2024, a weight of 186.6 lbs was documented at 10:31 PM, and again approximately two hours later at 12:32 AM on February 23, 2024, a weight was documented as 186.6 lbs. Resident 129 demonstrated a significant weight loss of 14.4% between February 3, 2024, and February 23, 2024. Review of Resident 129's interdisciplinary progress notes revealed that on February 28, 2024, at 2:50 PM, Employee 14 (Registered Dietician) entered a progress note which included, [Current body weight] captured on 186.6 lbs. This [weight] triggers for significant [weight] loss of 15.2% x 1 month. Though unsure of [usual body weight] and no other [weight history] available. Will cont[inue] to monitor weekly [weights] to better assess [weight] trends. Review of Resident 129's clinical record revealed that on March 7, 2024, Employee 12 (Registered Nurse Unit Manager) entered a Nurse Aide task for Resident 129 to be weighed weekly. Review of Resident 129's clinical record on March 27, 2024, at approximately 10:00 AM, revealed no documented weights for Resident 129 after February 23, 2024. During a staff interview on March 28, 2024, at approximately 11:30 AM, Director of Nursing revealed it was the facility's expectation that Resident 129's weight would have been monitored per policy. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 37817 Based on review of facility policy, observations, record review, and staff interviews, it was determined that the facility failed to provide respiratory care/oxygen services consistent with professional standards of practice of one of 33 residents reviewed (Resident 73). Findings include: Review of facility policy, Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (CPAP- a method of respiratory therapy in which air is pumped into the lungs through the nose or nose and mouth during spontaneous breathing), revised April 1, 2022, read, in part, orders for C-PAP must include pressure and hours of use. Review of Resident 73's clinical record revealed diagnoses that included diabetes mellitus (the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine), sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts), and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow imprecise movement). Observation on March 25, 2024, at 11:59 AM, revealed Resident 73 was sleeping in bed, the CPAP nasal mask was on the night stand on top of the machine, and it was not covered. Observation on March 26, 2024, at 12:03 PM, revealed the CPAP nasal mask was on the night stand on top of the machine and was not covered. Observation on March 26, 2024, at 1:50 PM, with the Director Of Nursing (DON), revealed Resident 73's CPAP nasal mask was stored on the night stand on top of the machine, not covered. During an interview with the DON on March 26, 2024, at 1:50 PM, it was revealed that the nasal mask should be stored in the plastic bag that was behind the machine. It was also revealed that the resident was unable to remove and store the nasal mask independently. Review of Resident 73's physician orders on March 26, 2023, revealed CPAP: Nasal Mask; Humidifier: Yes Pressure Settings: (left blank) every evening and night shift for Sleep Apnea and as needed, order date February 14, 2024. This order did not include any pressure settings for Resident 73's CPAP machine nor did it specify hours of use. Further review of Resident 73's physician orders on March 27, 2024, documented a new order CPAP: Nasal Mask; humidifier: yes, pressure settings: RAMP time 0.20, RAMP 4.0, CMh20 4, flex 2 with humidify as needed for sleep and every evening and night shift for sleep apnea, order date March 27, 2024. During an interview with Employee 9 (Registered Nurse Supervisor) on March 27, 2024, at 1:30 PM, Employee 9 revealed that Resident 73's physician orders should contain information pertaining to pressure and time, and the care plan should contain an intervention for the CPAP. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on March 28, 2024, at 10:50 PM, it was revealed that Resident 73's initial Physician order should have contained pressure settings and hours of use. 28 Pa. Code 211.12(d)(1)(2) Nursing services.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 49123 Based on review of facility policy, clinical record review, and interviews with staff, it was determined that the facility failed to ensure that residents who require dialysis receive such services consistent with professional standards of practice for one of one residents reviewed for dialysis (Resident 127). Findings include: Review of facility policy, titled Dialysis: Hemodialysis (HD) - External Catheter Evaluation and Maintenance, with a review date of December 29, 2023, revealed section 11. Document, 11.1 Catheter/Site observation q shift. Review of facility policy, titled NSG253 Dialysis: Hemodialysis (HD) - Communication and Documentation, with a review date of December 29, 2023, revealed center staff will communicate with the certified dialysis facility regarding the ongoing assessment of the patient's condition by monitoring for complications before and after hemodialysis (HD) treatments received at a certified dialysis facility. Section titled Practice Standards revealed 1. Prior to a patient leaving the Center for HD, a licensed nurse will complete the top portions of the Hemodialysis Communication Record or the state required form and send with the patient to his/her HD facility visit. 3. Upon return of the patient to the Center, a licensed nurse will: 3.3 Complete the post-hemodialysis treatment section on the Hemodialysis Communication Record or state required form. Review of Resident 127's clinical record on March 27, 2024, at 9:59 AM, revealed diagnoses that included end stage renal disease (condition in which kidneys cease functioning leading to the need for long-term dialysis) and dependence on renal dialysis (remove waste products and excess fluid from the blood when the kidneys stop working properly). Review of Resident 127's physician orders revealed an order for dialysis Monday, Wednesday, and Friday. Further review of Resident 127's physician orders failed to reveal an active order for dialysis site monitoring. Review of Resident 127's discontinued physician orders revealed an order for Quinton Dialysis cathlon RCW: Monitor Hemodialysis site for signs/symptoms of complications (e.g. bleeding, swelling, pain, drainage, odor, hardness or redness at site). Notify the physician and dialysis center immediately with any urgent problems, with a discontinued date of December 14, 2023. Review of Resident 127's TAR (treatment administration record) and MAR (medication administration record) for January 2024, February 2024, and March 2024 failed to reveal documentation of dialysis site monitoring. Review of Resident 127's hard chart revealed dialysis communication forms with only pre-dialysis vital signs documented. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with staff on March 27, 2024, at 11:09 AM, Employee 21 revealed it was the responsibility of night shift nursing staff to complete the pre-dialysis section of the form, but it was not being done. Employee 21 also revealed the post-dialysis section of the form is not being completed because the dialysis center sends their summary post-dialysis. During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on March 27, 2024, at 12:02 PM, the surveyor requested additional information regarding the dialysis catheter monitoring and incomplete dialysis communication forms. During an additional interview on March 28, 2024 at 11:00 AM, with the NHA and DON, the DON revealed that physician orders had been entered to monitor Resident 127's dialysis catheter site and confirmed nursing staff had not been completing the dialysis communication forms. The DON also revealed that is was the expectation of the facility that dialysis site monitoring was completed and documented, and dialysis communication forms were completed pre- and post- dialysis. 28 Pa Code 211.5(f) Clinical records 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33879 Based on clinical record review and resident and staff interviews, it was determined that the facility failed to ensure that the physician addressed a significant weight loss in a timely manner for two of four residents reviewed for nutritional concerns related to weight loss (Residents 93 and 129). Findings include: Review of Resident 93's clinical record revealed diagnoses that included diabetes mellitus (the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine), edema (swelling in extremities), and pressure ulcer (an open area of the skin caused by pressure). During an interview with Resident 93 on March 25, 2024, at 10:54 AM, it was revealed that she had weight loss. Review of Resident 93's weight history revealed an 11 pound (lb) weight loss between August 2023 and March 2024, equating to greater than 10% in six months. Review of nutrition progress notes dated November 2, 2023, revealed a significant weight loss of 5% from the previous month, and a recommendation to re-weigh the resident to verify accuracy of the weight. Review of nutrition note dated November 15, 2023, revealed that a re-weight was obtained, and weight loss was confirmed. Weekly weight monitoring was requested. Notes dated December 6, 2024, documented significant weight loss in three and six months. A nutrition note dated January 5, 2024, documented significant weight loss of 9% in three months. On February 12, 2024, a nutrition note documented a significant weight loss of 11% in six months. During an interview with the Director Of Nursing (DON) on March 27, 2024, at 12:30 PM, it was revealed that the Registered Dietitian works remotely. During an interview with the DON on March 28, 2024, at 10:50 AM, it was revealed there was no documentation that the Physician was notified of Resident 93's significant weight loss. Review of Resident 129's clinical record on March 26, 2024, at approximately 9:15 AM, revealed diagnoses that included stage 4 pressure injury of the sacral region (wound of the skin caused by pressure over a bony prominence that extends through the layers of skin to the underlying connective tissue and/or bone) and paraplegia (paralysis of both lower limbs). Review of Resident 129's clinical record revealed upon admission to the facility on [DATE], Resident 129 was documented as weighing 220.0 lbs. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 129's clinical record revealed weekly weights were not performed upon admission. Review of Resident 129's clinical record revealed that the next documented weight following admission was 24 days later on February 3, 2024. On February 3, 2024, Resident 129's documented weight was 218.0 lbs. Review of Resident 129's clinical record revealed that on February 22, 2024, a weight of 186.6 lbs was documented at 10:31 PM, and again approximately two hours later at 12:32 AM on February 23, 2024 a weight was documented as 186.6 lbs. Resident 129 demonstrated a significant weight loss of 14.4% between February 3, 2024, and February 23, 2024. Review of Resident 129's interdisciplinary progress notes revealed that on February 28, 2024, at 2:50 PM, Employee 14 (Registered Dietician) entered a progress note which included, [Current body weight] captured on 186.6 lbs. This [weight] triggers for significant [weight] loss of 15.2% x 1 month. Though unsure of [usual body weight] and no other [weight history] available. Will cont[inue] to monitor weekly [weights] to better assess [weight] trends. Review of the progress note revealed there was no documentation that the attending physician was notified of the significant weight loss. Review of Resident 129's clinical record revealed that on March 20, 2024, at 1:15 PM, Certified Registered Nurse Practitioner (CRNP) 1 entered a Medical Practitioner Note, which was identified as a routine medical follow-up visit. Review of CRNP 1's progress note revealed it did not address Resident 129's significant weight loss. As of March 28, 2024, at 2:00 PM, the facility was unable to provide documentation that the attending physician was notified of Resident 129's significant weight loss. 28 Pa. Code 211.12(d)(3)(5) Nursing services.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 37817 Based on observation, staff and resident interviews, and record review, it was determined that the facility failed to provide routine and/or emergency dental services for one of 33 residents reviewed (Resident 67). Findings: Review of Resident 67's clinical record revealed diagnoses that included anxiety (a feeling of worry, nervousness, or unease), chronic obstructive pulmonary disease (COPD - a group of lung disease that block airflow and make it difficult to breathe), and epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures). During an interview with Resident 67 on March 25, 2024, at 11:04 AM, it was revealed that she saw the dentist several months ago, and it was recommended that her full upper denture be replaced and that she be fitted for a partial lower denture; however, the dentist never came back and the Resident hasn't heard anything. It was also revealed that her upper denture is loose, but that it didn't hinder her ability to eat. Observation on March 25, 2024, at 11:04 AM, revealed Resident 67's upper denture was noted to be loose. Further review of Resident 67's clinical record documented Medicaid as the Resident's payor source. Review of Resident 67's dental consult dated January 18, 2024, read, in part, full-upper dentures were loose fitting. Recommended full mouth x-ray to evaluate dentition for possible fabrication of a new upper complete denture and partial lower denture, along with a six month dental cleaning. Follow-up with Resident following dental x-ray. Review of the dental hygienist schedule for March 25, 2024, revealed Resident 67 was added to be seen on that date for a full mouth x-ray to evaluate dentition and possible pre-authorization. The request to be seen was submitted on January 19, 2024. During an interview with Resident 67 on March 26, 2025, at 1:45 PM, it was revealed that she wasn't seen by the dental hygienist on March 25, 2024. During an interview with Employee 6 (Director of Social Work), he revealed that Resident 67 should have been seen by the hygienist on March 25, 2024. Employee 6 stated he spoke with the contracted dental group and wasn't given an explanation as to why Resident 67 wasn't seen on March 25th, 2024, but that she was scheduled to be seen in April 2024. Per Employee 6, he wasn't given a date when the dental group would be at the facility in April 2024. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing on March 28, 2024, at 11:00 AM, it was confirmed that Resident 67 was scheduled to receive an x-ray for denture fitting, which is the first step, and was rescheduled for April 2024. The Resident uses poly-grip for the loose fitting denture. It was also revealed that the interdisciplinary team felt that completion of the x-ray in April 2024 for new dentures would be fine since Resident 67 has had no ill effects. 28 Pa Code 211.15 Dental services

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 37817 Based on observation, review of facility policy, and resident and staff interviews, it was determined that the facility failed to provide food and beverage that were at a safe and appetizing temperature for one of one meals observed on the Heritage Nursing Unit. Findings include: Review of the Food And Nutrition Services Test Tray Evaluation form, not dated, read, in part, hot entree, starch, and vegetable should be greater than 140 degrees Fahrenheit; and the cold food and beverage should be less than 55 degrees Fahrenheit (F) Interviews with several residents (Residents 3, 36, and 65) during the initial pool process on March 25, 2024, revealed concerns with the temperature and the quality of the food. A test tray was completed on March 26, 2024, on the Heritage Nursing Unit. Test tray temperatures were taken by Employee 2 (Food Service Director 1) on March 26, 2024, at 1:07 PM, and revealed the following: Roast Pork 127 degrees F, not palatable temperature; Green Peas 136 degrees F, not palatable temperature and texture; Mashed Potatoes 146 degrees F, palatable; Vanilla Ice Cream 27, degrees F, palatable; Apple Juice 59 degrees F, not palatable; Milk 49 degrees F, palatable; Coffee 152 degrees F, palatable. During an interview with Employee 2 on March 26, 2024, at 1:10 PM, it was revealed that she would have expected the hot food to be warmer and the cold food to be cooler. During an interview with the Nursing Home Administrator on March 27, 2024, at 2:00 PM, the surveyor informed the NHA of the temperature and texture concerns regarding the test tray completed on March 26, 2024. No further information was provided. 28 Pa Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) Management.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395442	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
York North Skilled Nursing and Rehabilitation Ctr	1770 Barley Road York, PA 17408

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37817 Based on observations, review of facility policy, and staff interviews, it was determined that the facility failed to store and serve food/beverages in accordance with professional standards for food safety in the kitchen area. Findings include: Review of facility policy, Food And Nutrition Services Use By Dating Guidelines, dated May 1, 2023, read, in part, use manufacture's expiration date, when available, is the use by for unopened items. Ready-to-eat foods, including thickened liquids, are to be used by seven days after opening; frozen foods stored in the freezer use by date within 45 days. Observation in the reach-in refrigerator in the receiving area revealed there were two 46 ounce containers of nectar thickened apple juice, dated received on March 9th; one 46 ounce container of nectar thickened cranberry juice, dated received on March 9th; and one 32 ounce container of nectar thick milk, dated received on March 9th. All aforementioned items were open with contents partially removed and were not date marked with an open or use by date. During an interview with Employee 2 (Food Service Director), it was revealed that each of the aforementioned containers were marked with a manufacturers' use by date. Employee 2 wasn't aware that items should be dated once opened, and wasn't sure how soon the aforementioned thickened beverages should be used by once opened. Observation in the walk-in freezer with Employee 2 on March 25, 2024, at 9:34 AM, revealed there were three 1 gallon plastic bags of sloppy joes that were not labeled or date marked; and one plastic container containing 14 quarts of chili was not labeled or date marked. During an interview with Employee 2 on March 26, 2024, at 9:34 AM, it was revealed that the gallon bags contained sloppy joes, and the plastic container contained chili. It was also revealed that when leftovers are stored, they should be labeled and date marked. Observation in the preparation area of the kitchen on March 25, 2024, at 9:41 AM, revealed the following spices were opened with contents partially removed and weren't date marked with an open or use by date: curry, thyme, Italian seasoning, ground cumin, and two containers of chili powder. During an interview with Employee 2 on March 25, 2024, at 9:41 AM, it was revealed that the spices should be date marked once opened. During an interview with the Nursing Home Administrator on March 27, 2024, at 2:00 PM, the surveyor shared concerns regarding the aforementioned items in the kitchen not being labeled and/or date marked. No further information was provided. 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
	395442	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
York North Skilled Nursing and Rehabilitation Ctr	1770 Barley Road York, PA 17408

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.18(b)(1)(3) Management.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395442	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 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. 34631 Based on document review and staff interview, it was determined that the facility failed to ensure nurse-aides are sufficient with in-service training, continuing education competencies to include dementia and resident abuse prevention training, and the training be no less than 12 hours per year for five of five nurse aide training documents reviewed (Employees 16-20). Findings Include: Review of Employee 16's employment documentation revealed a hire date of December 10, 2022. Continued review of the documentation revealed Employee 16 to have no annual dementia or abuse prevention training and annual training hours to total 4.5 hours. Review of Employee 17's employment documentation revealed a hire date of December 10, 2022. Continued review of the documentation revealed Employee 16's annual training hours to total 10:44. Review of Employee 18's employment documentation revealed a hire date of December 10, 2022. Continued review of the documentation revealed Employee 16 to have no annual dementia or abuse prevention training and annual training hours to total 1:26 hours. Review of Employee 19's employment documentation revealed a hire date of December 10, 2022. Continued review of the documentation revealed Employee 19 to have no annual dementia or abuse preventions training and 0 annual training hours. Review of Employee 20's employment documentation revelaed a hire date of January 9, 2023. Continued review of the documentation revealed Employee 20 to have no annual dementia or abuse prevention training and annual training hours to total 4:58. An interview with the Director of Nursing on March 28, 2024, at 10:59 AM, revealed the facility could not access the Nurse Aide training documentation, and a new Registered Nurse Educator will be addressing the lack of nurse-aide training requirements going forward. 28 Pa. Code 201.14 (a) Responsibility of licensee