STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395451	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inners Creek Skilled Nursing and Rehabilitation Ce	100 West Queen Street Dallastown, PA 17313

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 37116 Based on observations, facility policy review, and staff interview, it was determined that the facility failed to ensure that care and services were provided in a manner which promoted resident dignity in one of four dining areas (Station 3 Dining Room). Findings include: Review of facility policy, titled Resident Rights Under Federal Law, revised February 1, 2023, revealed, The resident has a right to be treated with respect and dignity. Observation in the Station 3 Dining Room on October 21, 2024, at 12:03 PM, revealed Employee 8 (Nurse Aide) standing while feeding Resident 115 several bites of food. Observation in the Station 3 Dining Room on October 22, 2024, at 12:16 PM, revealed Employee 10 (Nurse Aide) standing while feeding Resident 29; and observation at 12:21 PM, revealed Employee 9 (Nurse Aide) standing while feeding Resident 137. During an interview with the Director of Nursing on October 24, 2024, at 11:03 PM, she revealed the expectation that staff should be seated when assisting residents with eating. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(1) Nursing services

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 37116 Based on observations and staff interview, it was determined that the facility failed to ensure a clean, comfortable, homelike environment, as evidenced by soiled wheelchairs, for three of 35 residents reviewed (Residents 53, 72, and 96). Findings include: Observation on October 21, 2024, at 10:13 AM and on October 22, 2024, at 9:35 AM, revealed an accumulation of crumbs, pieces of food, and other dried debris on the rails of Resident 53's wheelchair. Observation on October 21, 2024, at 12:10 PM, revealed an accumulation of dried smears and crumbs on the seat, wheels, and rails of Resident 96's wheelchair. Observation on October 23, 2024, at 12:07 PM, revealed an accumulation of dried food and crumbs on the seat, handle, and rails of Resident 72's wheelchair. During an interview with the Director of Nursing on October 24, 2024, at 11:04 AM, she acknowledged that the aforementioned wheelchairs needed to be cleaned. 28 Pa. Code 207.2(a) Administrator's responsibility

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 37116 Based on policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure proper monitoring for restraint use, including consent, physician orders, initial and ongoing evaluations, and scheduled removal, for one of one residents reviewed for restraints (Resident 126). Findings include: Review of facility policy, titled Restraints: Use of, revised June 15, 2022, revealed, When the use of restraints is indicated, the Center must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints .If the device cannot be easily removed by the patient and/or restricts freedom of movement or normal access to their body, the Restraint Evaluation/Reduction will be completed prior to the application of any restraint .Patients with a restraint will be re-assessed as follows or per state regulations: Monthly for three months, then quarterly, and with any significant change in condition . There must be documentation identifying the medical symptom being treated and an order for the use of the specific type of restraint .Consent must be obtained prior to the application of the restraint. Review of Resident 126's clinical record revealed diagnoses that included dementia with behavioral disturbance (loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life) and unspecified psychosis (abnormal condition of the mind that involves a loss of contact with reality). Review of Resident 126's care plan revealed an intervention to place jump suit on resident daily as available and resident allows, initiated May 28, 2024. Review of Resident 126's nursing progress note dated May 15, 2024, revealed, Resident has been wandering through halls throughout the day. No complaints of pain voiced thus far this shift. No abnormal behaviors noted thus far. Residents new onesies arrived, sent down to laundry to be labeled. Will observe. Review of Resident 126's nursing progress note dated May 22, 2024, revealed, Resident found eating feces this morning. CNA [Certified Nurse Assistant] cleaned resident up and dressed her in her onesie to which resident looked at herself in the mirror and stated, 'oh look at you how lovely!' Further review of Resident 126's clinical record failed to reveal a physician order, initial assessment, or consent for use of the jump suit/onesie that corresponded with the initiation of its use. Review of physician orders revealed an order for application of jump suit/onesie as needed for behaviors, starting October 23, 2024. Review of Resident 126's restraint assessments revealed an evaluation was completed on July 12, 2024, which noted that use of the onesie/jumpsuit was indicated to prevent stool ingestion. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident 126's clinical record failed to reveal evidence that the restraint was re-evaluated every 30 days since initiation, or that the restraint was removed every two hours while in use. During an interview with the Director of Nursing (DON) on October 23, 2024, at 10:34 AM, she revealed that an as-needed order for the restraint was added, but that Resident 126 has not needed the one piece suit since she became bed-bound in July 2024. During a subsequent interview with the DON on October 24, 2024, at 11:00 AM, she revealed the expectation that an initial order, ongoing evaluations, and other appropriate documentation should have been present for the use of Resident 126's restraint. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.8(c.1)(1)(2)(3)(i)(d)(e)(f) Use of restraints 211.12(d)(1)(3)(5) Nursing services

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37116 Based on policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure that the resident and/or the resident's representative were provided the bed-hold notice upon transfer for two of five residents reviewed for hospitalization s (Residents 71 and 157). Findings include: Review of facility policy, titled Bed Hold Notice - Deliver Upon Transfer, last reviewed July 2024, stated, in part, Prior to a resident's transfer out of the center to a hospital or for therapeutic leave, the staff member conducting the transfer out will provide both the resident and representative, if applicable, with the bed hold policy notice and authorization form. Notice must be given regardless of payer. Review of Resident 71's clinical record revealed diagnoses that included injury of the cervical spinal cord (injury that affects the upper part of the spinal cord) and neuromuscular dysfunction of bladder (condition causing loss of bladder control). Further review of Resident 71's clinical record revealed that Resident 71 was hospitalized [DATE] - 22, 2024, and October 13 - 18, 2024. Additional review of Resident 71's clinical record failed to reveal documentation that the facility's bed-hold policy information was provided to Resident 71 or their Representative. During an interview with the Nursing Home Administrator (NHA) and the Director of Nursing (DON), it was revealed that the facility was not able to provide additional information regarding Resident 71 or their Representative receiving bed-hold information for either hospitalization . The NHA stated it was the facility's expectation that residents and/or representative be provided bed-hold information when hospitalized . Review of Resident 157's clinical record revealed diagnoses that included congestive heart failure (CHF - weakness of the heart that leads to buildup of fluid in the lungs and surrounding body tissues) and cerebral infarction (brain injury caused by a lack of oxygen to a group of brain cells). Further review of Resident 157's clinical record revealed she was transferred to the hospital on June 22, 2024, following a change in condition and was subsequently admitted . Additional review of Resident 157's record failed to reveal evidence that she or her Representative was provided with a copy of the facility's bed-hold notice upon transfer. During an interview with the DON on October 23, 2024, at 2:40 PM, she revealed that she had no additional information to provide. 28 Pa. Code 201.14(a) Administrator's responsibility (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33305 Based on clinical record review, policy review, and staff interviews, it was determined that the facility failed to ensure that physician's orders were implemented for one of 35 residents reviewed (Resident 49); and failed to ensure assessments were completed for three of 36 residents reviewed (Residents 162, 228, and 522). Findings include: Review of the facility policy, titled Skin Integrity and Wound Management, last revised October 15, 2024, stated a comprehensive initial and ongoing nursing assessment of intrinsic and extrinsic factors that influence skin health, skin/wound impairment, and the ability of a wound to heal will be performed. The plan of care for the patient will be reflective of assessment findings from the comprehensive patient assessment and wound evaluation. Staff will continually observe and monitor patients for changes and implement revisions to the plan of care as needed. Review of facility policy, titled OPS118 Hospice, last reviewed July 2024, stated, in part, 8. For Center patients being referred to hospice, the Center staff member responsible for initiating the hospice referral will: 8.1 Provide patient/representative with a list of all hospices under contract with the Center, including identification of the related investor's ownership in any of the contracted hospices; 8.2 Answer questions that patients and their representative may have regarding the available hospices . Review of Resident 49's clinical record revealed diagnoses that included chronic obstructive pulmonary disease (COPD - a group of lung diseases that cause damage to lung tissue and restricted airflow) and chronic kidney disease, stage 3 (CKD - moderate stage of kidney damage affecting the kidneys' ability to filter waste and fluid from the blood). Review of Resident 49's physician orders revealed an order for hospice eval and treat, with a start date of August 23, 2024. Further review of Resident 49's clinical record failed to reveal documentation that Resident 49 had been evaluated by hospice services. During an interview on October 24, 2024 at 12:37 PM, with the Nursing Home Administrator (NHA) and Director of Nursing (DON), it was revealed that the facility could not provide documentation that Resident 49 had been evaluated by hospice service. The NHA stated it was the expectation of the facility that physician orders be followed. Review of Resident 162's clinical record revealed diagnoses that included status post PEG (percutaneous endoscopic gastrostomy) feeding tube removal from the stomach. The tube was in place due to the Resident's inability to eat food by mouth and cerebral infarction (stroke). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview with Resident 162 on October 21, 2024, at approximately 11:50 AM, the Resident stated that on October 16, 2024, he returned from the hospital after removal of the PEG tube and that the dressing the hospital applied is still on his abdomen and that no one has looked at it. Resident also said the tape is starting to irritate his skin and shouldn't be on this long. On October 22, 2024, at 1:30 PM, surveyor requested Employee 2 (Infection Control Preventionist) to talk with Resident 162 regarding his concern. Employee 2 did speak with the Resident and looked at the bandage. The bandage was removed immediately, causing discomfort to the Resident as the tape was removed. The site and bandage had a moderate amount of dry, dark red drainage. Employee 2 informed the surveyor that staff should have called the physician for orders for the stoma (site where PEG tube was removed). Employee 2 also indicated staff should notify the wound team whenever a resident has a dressing on return from an outside facility. During an interview with the DON on October 23, 2024, at 11:30 AM, confirmed the stoma site should have been assessed by the wound team and the physician should have been notified for any additional treatment to the area. Review of the facility policy, titled Falls Management, last reviewed March 15, 2024, stated, Any patient who sustains an injury to the head from a fall and/or has a fall unwitnessed by staff will be observed for neurological abnormalities by performing neurological checks, per policy. The physician will be notified of any abnormal findings. A review of the neurological assessment form revealed it requires neurological assessments to be performed for 72 hours post fall, that includes an initial assessment, followed by every 15 minutes for 2 hours, every 30 minutes for 2 hours, every hour for 4 hours, then every 8 hours for the remainder of the 72-hour period. Review of Resident 228's clinical record revealed diagnoses that included transient cerebral ischemic attack (a brief stroke-like attack that, despite resolving within minutes to hours, still requires medical attention to rule out an actual stroke) and diabetes mellitus (condition in which the body has trouble controlling blood sugar). Review of Resident 228's Admission Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated October 18, 2024, revealed a BIMS (brief interview of mental status) score of 6, indicating cognitive status is severely impaired. On October 9, 2024, Resident 228 had an unwitnessed fall resulting in a laceration to her left eyebrow area. The facility initiated neurological checks until the Resident was sent to the hospital. On return from the hospital, the facility failed to resume the neurological checks for the remaining 32 hours. Interview with the DON on October 24, 2024, at 11:30 AM, confirmed all neurological checks are to be completed for the 72-hour period. Resident 522's clinical record revealed diagnoses included diabetes mellitus type 2 (decreased ability of the body to utilize insulin for the transport of glucose from the blood stream into the cells for nourishment) and hypertension (elevated/high blood pressure). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 522's clinical record revealed Resident 522 was admitted to the facility on [DATE]. Review of Resident 522's admission orders revealed an order for Lantus (insulin) three units via injection at bedtime and to hold for a blood sugar measurement of 150 millimoles per liter (mmol/L - metric unit of measure). The order was active between September 18, 2024, and still, upon discharge, on September 29, 2024. Resident 522's physician's orders also included orders an order to check Resident 522's blood sugar four times a day to include before meals and at bedtime. Review of Resident 522's clinical record revealed staff only documented checking Resident 522's blood sugar once on September 19, and 22, 2024; and four times on September 24, 2024. During an electronic communication on October 25, 2024, at 10:52 AM, DON revealed that the orders for blood sugar checks for Resident 522 were incorrectly added to the electronic health record and, as such, did not prompt staff to perform blood sugar checks within the Treatment Administration Record (TAR - documentation tool utilized to record when treatments are conducted). 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 37116 Based on review of facility policy, record review, observation, and staff interviews, it was determined that the facility failed ensure the resident received care, consistent with professional standards, to treat and prevent pressure ulcers for one of two residents reviewed with pressure injuries (Resident 91). Findings Include: Review of facility policy, titled Wound Dressings: Aseptic, Revised December 1, 2021, revealed in step 1. Verify order. Review of Resident 91's clinical record revealed diagnoses of pressure ulcer of left heel (localized area of damaged skin or tissue that occurs when pressure is applied to the skin for a prolonged period of time) and pressure ulcer of the left buttock (localized area of damaged skin or tissue that occurs when pressure is applied to the skin for a prolonged period of time). Review of Resident 91's current physician order on October 24, 2024, at 11:15 AM, revealed a physician's order to cleanse Resident 91's left ischium wound with Dakins (wound cleansing solution) every day and evening shift, then apply medihoney, finally apply Dakins soaked gauze and cover with a foam dressing, with an order date of August 28, 2024. Observation of Resident 91's dressing change to left ischium (lower buttock area) on October 24, 2024, at 11:36 AM, revealed Employee 16 (LPN - Licensed Practical Nurse) completed Resident 91's dressing change and failed to apply medihoney (wound medication) after cleansing the wound and prior to applying the new dressing as ordered. An interview with the Director of Nursing (DON) on October 24, 2024, at 12:45 AM, revealed that Resident 91 should have had the dressing changed as ordered by the physician. Review of Resident 91's October 2024 TAR (Treatment Administration Record - form used to document physician orders as well as when and how treatments are administered to a resident) revealed that it was not documented that the wound treatment for Resident 91's left ischium was completed the morning of October 22, 2024. During an interview with the DON on October 24, 2024, at 11:02 AM, she revealed she did not have any additional information regarding the missed treatment documentation. Review of Resident 91's physician orders revealed orders to cleanse her right heel wound with normal saline solution and apply a foam dressing daily, starting October 11, 2024. Review also revealed a second order for wound treatment to the right heel: cleanse with normal saline solution and apply skin prep (fast-drying sterile liquid that forms a waterproof, breathable barrier) every other day, starting September 29, 2024. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of wound care consult reports dated September 24, 2024; October 7, 14, and 21, 2024, revealed wound care orders to cleanse Resident 91's right heel with normal saline solution and apply skin prep daily. Review of Resident 91's October 2024 TAR revealed that nursing staff were documenting that the wound treatment to Resident 91's right heel (normal saline solution and skin prep) was being completed every other day. The October 11, 2024, order to cleanse Resident 91's right heel with normal saline solution and apply a foam dressing did not appear on Resident 91's October 2024 TAR, therefore, was not being completed/documented by nursing staff. During an interview with the DON on October 24, 2024, at 1:52 PM, she revealed that the orders and treatment record would be corrected to reflect the newest order. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. 37116 Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure proper monitoring for acceptable parameters of hydration and nutritional status for two of seven residents reviewed for nutrition or hydration (Residents 92 and 157); and failed to notify the physician of a significant weight loss for one of five residents reviewed for nutritional status (Resident 72). Findings include: Review of facility policy, titled Weights and Heights, revised February 1, 2023, revealed that significant weight changes will be reviewed by the licensed nurse for assessment. Significant weight change is defined as 5% in one month or 10% in six months. The licensed nurse will notify the physician and dietician of significant weight changes and document the notification in a progress note. The licensed nurse will notify the physician of the dietitian recommendations. Review of Resident 72's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders, personality changes, and impaired reasoning), muscle weakness, and severe protein calorie malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets). Review of Resident 72's clinical record revealed she had a 6.2% significant weight loss in one month from August 3 to September 3, 2024. Review of Resident 72's clinical record failed to reveal notation that the physician was made aware of the significant weight loss. During an interview with the Director of Nursing (DON) on October 24, 2024, at 10:58 AM, she revealed they were unable to locate documentation that the physician was notified of Resident 72's weight loss, and she would expect them to be notified. Review of facility policy, titled Fluid Restriction, effective December 1, 2006, revealed, Verify physician order . Notify Dietary Department of fluid restriction . Dietary to calculate amount of fluids to be provided during meals .Calculate remaining amount of fluids to be provided by resident. Review of Resident 92's clinical record revealed diagnoses that included congestive heart failure (CHF - weakness of the heart that leads to buildup of fluid in the lungs and surrounding body tissues) and edema (swelling caused by excess fluid accumulation in the body tissues). Review of Resident 92's orders revealed an order for 1920 cc fluid restriction daily: Nursing provides: day - 240 ml, evening - 240 ml, night - 120 ml, Dietary provides: breakfast - 540 ml; lunch - 480 ml; dinner - 300 mL, starting December 4, 2023. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 92's October 2024 MAR (Medication Administration Record - form used to document physician orders as well as when and how medications are administered to a resident) revealed that on October 1, and 3-10, 2024, nursing staff documented that they gave Resident 92 240 ml of fluids on night shift, which, when tallied with the other amounts provided for those days, put Resident 92 over her allowable daily fluid amount. Review of Resident 92's meal ticket revealed that she is provided with 4 oz of assorted fruit juice, 6 oz of coffee, and 8 oz of Lactaid milk with breakfast, 8 oz of orange juice and 8 oz of Lactaid milk with lunch, and 4 oz of apple juice and 8 oz of Lactaid milk for dinner. This would equate to 540 ml of fluids for breakfast, 480 ml of fluids for lunch, and 360 ml of fluid for dinner; therefore, exceeding the daily ordered fluid amount to be provided by the dietary department. During an interview with the DON on October 24, 2024, at 11:02 AM, she revealed that she would expect Resident 92's fluid restriction orders to be followed, and that she would follow-up with nursing and dietary. Review of Resident 157's clinical record revealed diagnoses that included dementia and type II diabetes mellitus (impairment in the way the body regulates and uses sugar [glucose] as a fuel resulting in too much sugar circulating in the bloodstream). Review of Resident 157's nutrition progress note dated August 3, 2024, revealed that it was documented that she experienced a weight loss of greater than 5% in 30 days and 10.5% since June 2024. Further review of Resident 157's clinical record failed to reveal that a practitioner was notified of this significant weight loss. Review of Resident 157's recorded weights revealed she weighed 178.7 lbs on September 6, 2024, and 164. 6 lbs on October 6, 2024, which equated to a loss of 7.89% in one month. Further review of Resident 157's clinical record revealed that as of October 24, 2024, this significant weight loss has not been addressed by nursing staff, the practitioner, or the dietician. During an interview with the DON on October 24, 2024, at 10:59 AM, she revealed that she had no additional information to provide and confirmed that she would follow-up regarding Resident 157's prior and current weight loss. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 34631 Based on document review and staff interview, it was determined that the facility failed to complete a performance review of every nurse aide at least once every 12 months for five of five nurse aide documents reviewed (Employees 11, 12, 13, 14, and 15). Findings Include: A review of Employee 11's documents revealed a hire date of December 10, 2022. A continued review of Employee 11's information revealed no recent performance evaluation. A review of Employee 12's documents revealed a hire date of December 10, 2022. A continued review of Employee 12's information revealed no recent performance evaluation. A review of Employee 13's documents revealed a hire date of September 28, 2023. A continued review of Employee 13's information revealed no recent performance evaluation. A review of Employee 14's documents revealed a hire date of August 17, 2023. A continued review of Employee 14's information revealed no recent performance evaluation. A review of Employee 15's documents revealed a hire date of August 10, 2023. A continued review of Employee 15's information revealed no recent performance evaluation. An interview with the Nursing Home Administrator on October 22, 2024, at 12:05 PM, confirmed those employees had no recent performance evaluation completed by the facility. 28 Pa. Code 201.19 (2) Personnel policies and procedures

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33305 Based on clinical records review, policy review, facility document review, and resident and staff interviews, it was determined that the facility failed to ensure that the medications ordered by the physician were available for one of 35 residents reviewed (Resident 229); and failed to provide documentation of disposition of medications for one of three closed records reviewed (Resident 170). Findings include: Review of facility policy, titled Disposal of Medication Waste, last revised October 24, 2022, read, in part, All medications will be disposed of in accordance with applicable federal, state, and local regulations for the disposal of chemical and potentially dangerous or hazardous pharmaceuticals. Medications for disposal include medications which are not taken with the patient upon discharge. Review of Resident 170's clinical record revealed diagnoses that included muscle weakness and hypertension (high blood pressure). Further review of Resident 170's clinical record revealed she was discharged from the facility on August 26, 2024. Review of Resident 170's closed record failed to include documentation of medication disposition for 11 medications. Interview with the Director of Nursing (DON) on October 24, 2024, at 11:08 AM, revealed they were unable to locate a medication disposition record for the 11 aforementioned medications, and she would expect a medication disposition form to be completed. Review of Resident 229's clinical record revealed diagnoses that includes congestive heart failure (CHF-a condition in which the heart doesn't pump blood efficiently), hypertension, and diabetes mellitus (condition in which the body has trouble controlling blood sugar). Review of Resident 229's admission Minimum Data Set (MDS-mandated assessment of a resident's abilities and care needs) dated June 17, 2024, and still in progress, indicated the Resident had a BIMS (brief interview of mental status) score of 13, indicating the Resident is cognitively intact. Review of the clinical record revealed that Resident 229 was admitted to the facility on [DATE], at 7:00 PM. During the survey screening process on October 21, 2024, the Resident informed this surveyor that her medications were not available on admission and some she didn't receive for two days. Physician orders dated October 19, 2024, revealed Resident 229 was to receive the following medication that was not available on October 19, 2024: Entresto to treat congestive heart failure, due at 8:00 PM (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hydralazine to treat hypertension, due at 8:00 PM Diltiazem to treat hypertension, due at 9:00 PM Levemir insulin to treat diabetes, due at 8:00 PM The following medication was not available for ordered administrations on October 20, 2024: Allopurinol to treat gout (treats inflamed arthritis), due at 8:00 AM Entresto to treat congestive heart failure, due at 8:00 AM and 8:00 PM Bumex to treat congestive heart failure, due at 8:00 AM Hydralazine to treat hypertension, due at 8:00 AM, 2:00 PM, and 8:00 PM Diltiazem to treat hypertension, due at 9:00 PM The following medication was not available for ordered administration times on October 21, 2024: Entresto to treat congestive heart failure, due at 8:00 AM Hydralazine to treat hypertension, due at 8:00 AM, 2:00 PM A request for a list of the facility stock meds was requested but not provided. Documentation dated October 20, 2024, at 11:40 AM, revealed the pharmacy stated medications were being worked on and should be delivered that evening or the following evening. She stated she will put in a request for STAT delivery. There is no documentation that the physician was notified about the unavailability and missed doses of the medications. The facility provided a form that stipulated how staff are to escalate the process for receiving medications timely. There was no documentation to show that staff followed through with process to notify Administration and/or the DON about the unavailability of the medications. During an interview with the DON on October 23, 2024, at 2:00 PM, the DON confirmed the pharmacy should have provided the medications timely. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 211.9 (a)(1)(k)(l)(1)(2)(3)(4) Pharmacy services 28 Pa. Code 211.10 (c) Resident care policies 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 37116 Based on policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure Medication Regimen Reviews were completed by a consultant pharmacist and responded to in a timely manner by the attending physician or prescriber for four or five residents reviewed for unnecessary medications (Residents 12, 15, 25, and 72). Findings Include: Review of facility policy, titled Section 1.3 Organization Aspects Consultant Pharmacist Services Provider Requirements, last reviewed July 2024, read, in part, Regular and reliable consultant pharmacist services are provided to residents. 4. The consultant pharmacist or designee, provides pharmaceutical care services, including but not limited to the following: .d. Medication Regimen Reviews (MRR) for each Skilled Nursing (SNF) resident at least monthly, or more frequently under certain conditions, incorporating the federally mandated standards of care in addition to other applicable professional standards. e. Communicate to the responsible prescriber, the facility's medical director and the director of nursing potential or actual problems detected, and other findings related to medication therapy orders at least monthly. Communicate recommendations for changes in medication therapy and the monitoring of medication therapy. Review of Resident 12's clinical record revealed diagnoses that included type two diabetes mellitus (the body does not make enough insulin or cannot use it as well as it should) and vascular dementia (occurs when the brain's blood supply is interrupted, damaging brain tissue and causing a decline in thinking, memory, and behavior). Review of Resident 12's progress notes revealed notes on March 8, 2024; April 4, 2024; July 2, 2024; and August 31, 2024, indicating that a monthly medication regimen review was completed by the consultant pharmacist and recommendations were made. Further review of Resident 12's clinical record failed to reveal what aforementioned recommendations were made. During an interview on October 24, 2024, at 11:55 AM, with the Director of Nursing (DON), it was revealed that was unable to locate the aforementioned pharmacy recommendation and physician responses to the recommendation. Review of Resident 15's clinical record revealed diagnoses that included Alzheimer's disease (gradually progressive brain disorder that causes problems with memory, thinking and behavior) and major depressive disorder (mental disorder characterized by at least two weeks of low mood that is present across most situations). Review of Resident 15's Pharmacist Medication Regimen Review assessments revealed that the pharmacist completed a medication regimen review and that recommendations were made on March 7, 2024, and September 11, 2024. However, further review failed to reveal what the recommendations were. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON on October 24, 2024, at 10:56 AM, revealed that she was not able to locate any additional information regarding Resident 15's March 2024 and September 2024 pharmacy recommendations. Review of Resident 25's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders, personality changes, and impaired reasoning), muscle weakness, and hypertension (high blood pressure). Review of Resident 25's clinical record revealed she had a Pharmacy MRR completed on July 5, 2024. Further review of Resident 25's clinical record failed to reveal documentation that she had a monthly MRR completed in April 2024. During an email correspondence with the Nursing Home Administrator (NHA) and DON on October 22, 2024, at 2:24 PM, the surveyor requested a copy of the aforementioned MRR's with the physician response. Interview with the DON on October 24, 2024, at 10:55 AM, revealed they were unable to locate the requested MRRs with physician response, and she would expect them to be available. Review of Resident 72's clinical record revealed diagnoses that included dementia, muscle weakness, and severe protein calorie malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets). Review of Resident 72's clinical record revealed she had a Pharmacy MRR completed on May 6, 2024; July 5, 2024; and September 9, 2024. During an email correspondence with the NHA and DON on October 22, 2024, at 2:24 PM, the surveyor requested a copy of the aforementioned MRR's with the physician response. Interview with the DON on October 24, 2024, at 10:55 AM, revealed they were unable to locate the requested MRRs with physician response, and she would expect them to be available. Follow-up interview with the NHA on October 24, 2024, at 10:56 AM, revealed the record keeping and communication between pharmacy and the physician was the responsibility of the previous DON, and he was not following-up with the process properly. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 37116 Based on policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure adequate monitoring of psychotropic medications to ensure that resident were free from unnecessary medications for one of five residents reviewed for unnecessary medications (Resident 15). Findings include: Review of facility policy, titledAntipsychotic Medication Use, dated June 2022, revealed, Antipsychotic medications may be considered for elderly patients with dementia (those with behavioral or psychological symptoms) but ONLY after medical, physical, functional, psychological, emotional, social and environmental causes have been evaluated/addressed. Antipsychotic medications must be prescribed at the lowest possible dosage, for the shortest period of time. Review of Resident 15's clinical record revealed diagnoses that included dementia with behavioral disturbance (loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life) and major depressive disorder (mental disorder characterized by at least two weeks of low mood that is present across most situations). Review of Resident 15's physician orders revealed an order for risperidone (antipsychotic medication) for dementia with psychosis, effective May 12, 2024. Review of Resident 15's clinical record failed to reveal evidence of side effect monitoring, including AIMS testing (Abnormal Involuntary Movement Scale - clinical test used to assess severity of dyskinesia [specifically, orificial movements and extremity and truncal movements] in patients taking neuroleptic medications), related to use of her antipsychotic medication. Further review failed to reveal evidence of routine behavioral monitoring to ensure the effectiveness of Resident 15's psychotropic medication. During an interview with the Clinical Resource Nurse on October 24, 2024, at 10:08 AM, she confirmed that she was not able to locate any information regarding side effect or behavioral monitoring related to Resident 15's antipsychotic use. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49123 Based on observations, facility policy review, and staff interviews, it was determined that the facility failed to place opened dates on medications in one of four medication carts (100 hall) and one of two medication storage rooms (Station 1) observed. Findings Include: Review of facility policy, titled Section 4.1 Storage of Medication, last reviewed July 2024, read, in part, Medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations, to keep their integrity and to support safe, effective drug administration. Procedures 12. Note the date on the label for insulin vials and pens when first used. Review of facility policy, titled Section 9.10 Appendix of Resources Medication with Shortened Expiration Dates, last reviewed July 2024, stated, in part, Tuberculin PPD .discard vials in use after 30 days. Observation made on October 24, 2024, at 10:07 AM, with Employee 21 present, of the medication cart in the 100-hall revealed, revealed one open insulin glargine pen with no open date, one open Humalog Kwik pen, one open Lantus insulin pen with no open date, and two open Lantus insulin vials with no open dates. During an interview on October 24, 2024, at 10:07 AM, with Employee 21, it was revealed insulin pens and vials should be labeled with an open date when first opened. Observation made October 24, 2024, at 10:20 AM, with Employee 20 present, of the Station one medication storage room, revealed two open vials of tuberculin purified protein with no open date. During an interview on October 24, 2024, at 10:20 AM, with Employee 20, it was revealed that tuberculin solution should be dated with an open date when first opened. During an interview on October 24, 2024, at 12:00 PM, with the Director of Nursing, it was revealed that it is the expectation of the facility that insulins and tuberculin solutions be labeled with an open date when first opened. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(a)(1) Pharmacy services

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 48484 Based on facility policy review, observations, clinical record review, review of facility master menu diet guide sheets, and staff and resident caregiver interviews, it was determined that the facility failed to provide an altered texture diet, as prescribed by the physician, for nine residents (Resident's 37, 41, 57, 59, 78, 112, 155, 162, and 167) observed. This failure placed 31 residents that had similar diet needs at a high risk for death, and resulted in an Immediate Jeopardy (IJ) situation for Residents 1, 3, 4, 5, 6, 7, 9, 10, 13, 15, 16, 17, 18, 19, 21, 22, 23, 24, 26, 27, 30, 31, 32, 33, 34, 36, 38, 39, 58, and 92. Findings include: Review of facility policy, titled Consistency Alterations and Therapeutic Menus, dated May 1, 2023, read, in part, Purpose: To provide diets as ordered by the physician/advanced practice provider, chopped or ground meat modifications may be used in conjunction with any diet for individuals having difficulty chewing meat. Review of physician's orders revealed that Residents 37, 41, 57, 59, 78, 112, 155, 162, and 167 were ordered the dysphagia advanced texture diet or the dysphagia mechanically altered texture diet (special diets for people who have difficulty chewing and/or swallowing- dysphagia). According to the National Dysphagia Diet, for a dysphagia advanced texture diet, food needs to be moist and pieces need to be smaller than 1 inch (bite size). For the dysphagia mechanically altered texture diet, food should be moist and soft-textured. Meats should be ground or minced and be no larger than 1/4 inch pieces. Review of the lunch menu on October 23, 2024, revealed residents were to be served meatloaf as their entree and the alternate entree item was baked fish. Review of facility master menu diet guide sheets revealed the dysphagia advanced and dysphagia mechanically altered diets should have been served ground meatloaf or fish. Observations during tray line meal service on October 23, 2024, between 11:58 AM and 12:30 PM, revealed Residents 37, 41, 57, 59, 78, 112, 155, 162, and 167 had notation on their meal tickets that they should be served ground meatloaf or fish, but they were served a regular piece of meatloaf or fish. Observations throughout the facility on October 23, 2024, between 12:10 PM and 12:46 PM, revealed Residents 37, 41, 57, 59, 78, 112, 155, 162, and 167, had been served the regular piece of meatloaf or fish. Observation of Resident 155 on October 23, 2024, at 12:32 PM, revealed he was served a whole piece of meatloaf and was receiving feeding assistance from his private caregiver. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with Resident 155's private caregiver on October 23, 2024, at 1:01 PM, revealed she provides feeding assistance to Resident 155 and whatever is served from dietary is what she believes he is allowed to have. Interview with Employee 3 (Speech Language Pathologist) on October 23, 2024, at 1:13 PM, revealed she would expect diets to be served from the kitchen staff at the appropriate textures, per the facility master menu diet guide sheets. Interview with Employee 1 (Dietary Manager) on October 23, 2024, at 1:18 PM, revealed they serve whole pieces of meatloaf to the dysphagia advanced and dysphagia mechanically altered texture diets as the meat is ground prior to being baked, and that has been the case since she has been employed at the facility and she never questioned it. Employee 1 also stated, since the fish is soft, they just serve it whole to those diets. She further revealed she had overlooked that the meatloaf and fish should have been ground for those texture diets. Review of physician's orders revealed Residents 1, 3, 4, 5, 6, 7, 9, 10, 13, 15, 16, 17, 18, 19, 21, 22, 23, 24, 26, 27, 30, 31, 32, 33, 34, 36, 38, 39, 58, and 92, were also ordered the dysphagia advanced texture diet or the dysphagia mechanically altered texture diet. Interview with the Nursing Home Administrator (NHA) on October 24, 2024, at 9:34 AM, revealed his expectation that the facility master menu diet guide sheets for mechanically altered diets should be followed. The NHA was notified of the IJ situation on October 23, 2024, at 2:28 PM, and was provided the IJ template. An Immediate Action Plan was requested. The Immediate Action Plan was provided by the NHA on October 23, 2024, at 4:24 PM, and approved at 4:35 PM. The approved plan included: 1. The facility cannot retroactively go back and fix the diet textures for the residents that were served. 2. Food Service Director will immediately re-educate the dietary and nursing team members that are currently working on following the master menu diet guide sheet in regards to altered texture diets. Remaining team members will be educated prior to the start of their next shift. Speech Language Pathologist will re-evaluate current residents on an altered texture diet to determine appropriateness. 3. Meal service will be audited for 7 days to assure the appropriate diet textures are being followed. 4. Results will be reported to QAPI (Quality Assurance and Performance Improvement) to further follow-up and recommendations. 5. Date of compliance: October 24, 2024. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On October 24, 2024, between 7:56 AM and 9:12 AM, breakfast tray line meal service was observed to ensure all residents received the appropriate texture diet per their physician order. The audit of dinner service on October 23, 2024, as well as the audit of breakfast service on October 24, 2024, were reviewed without concern. Staff interviews revealed the facility had re-educated staff on mechanically altered diets and the master menu diet guide sheet. Interviews were conducted with three registered nurses, six licensed practical nurses, eight nursing assistants, three dietary employees, and the dietary manager; all were able to verbalize their role in providing appropriate diet textures. Interview with Employee 3 on October 24, 2024, at 9:18 AM, revealed she had evaluated Resident 59, 112, and 167, a call went out to Resident 155's hospice provider to get an order for an evaluation; and she plans to see Resident 41, 57, and 78 that day, as well as evaluate all other residents as per the action plan. On October 24, 2024, at 10:59 AM, the Immediate Jeopardy was lifted when the action plan implementation was verified. Observations on October 23, 2024, revealed that the facility failed to provide food in a form ordered by the physician to meet the individual needs of nine residents (Resident's 37, 41, 57, 59, 78, 112, 155, 162, 167). This failure placed 31 additional residents that had similar diet needs at a high risk for death and resulted in an Immediate Jeopardy situation for Residents 1, 3, 4, 5, 6, 7, 9, 10, 13, 15, 16, 17, 18, 19, 21, 22, 23, 24, 26, 27, 30, 31, 32, 33, 34, 36, 38, 39, 58, and 92. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.12(c)(d)(1)(2)(3)(5) Nursing services

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48484 Based on facility policy review, observations, and staff interviews, it was determined that the facility failed to store food and utilize equipment in accordance with professional standards for food service safety in the main kitchen and four of four pantry areas. Findings include: Review of facility policy, titled Refrigerated/Frozen Storage, dated [DATE], read, in part, Food stored under refrigeration/freezer storage is maintained in a safe and sanitary matter. All foods are labeled with the name of the product and the date received and 'use by' dates are used until opened. Prepared foods are labeled and dated with the name of the product, date opened, and 'use by' date. Food and Nutrition Services employees observe and record equipment temperatures daily according to the Refrigeration/Freezer Temperature Standards. Foods are kept in their original containers. If removed from the original container, foods are completely covered and labeled with the name of the product and 'use by' date. Observation of the dry storage area on [DATE], at 9:54 AM, revealed one open bag of pasta without an open date. Observation of the milk refrigerator on [DATE], at 9:57 AM, revealed a crate of individual fat free milk cartons with expiration dates of [DATE]. Observation of the walk-in refrigerator on [DATE], at 9:58 AM, revealed one can of energy drink, and one open container of chocolate topping not labeled with an open date. Further observation of the walk-in refrigerator on [DATE], at 9:59 AM, revealed a box of green peppers and the peppers looked shriveled like they had gone bad. Interview with Employee 1 (Dietary Manager) on [DATE], at 9:59 AM, revealed the energy drink belonged to a staff member and should not be stored in the facility walk-in refrigerator, and that the peppers were received on [DATE]. Observation of the walk-in freezer on [DATE], at 10:01 AM, revealed two bags of spinach removed from their original container and not dated. Observation of the three-compartment sink on [DATE], at 10:03 AM, revealed a large pot in the sanitizer water. The surveyor requested Employee 1 to test the concentration of the sanitizer water with the test strips and the test strips did not change color, indicating it was not at the appropriate concentration to sanitize. Interview with Employee 1 on [DATE], at 10:03 AM, revealed there is no log to record the concentration of the sanitizer of the three-compartment sink when it is used to sanitize food preparation equipment. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation in the main kitchen on [DATE], at 10:05 AM, revealed a bin of breadcrumbs not dated and a scoop was stored inside. Interview with Employee 1 on [DATE], at 10:07 AM, revealed the scoop should not be stored directly in the breadcrumbs and the bin should be dated. Observation of reach-in refrigerator 1 on [DATE], at 10:09 AM, revealed one container of prepared pork labeled use by [DATE]; one bag of shredded carrots not dated; and one bag of shredded purple cabbage not dated. Observation of reach-in refrigerator 2 on [DATE], at 10:11 AM, revealed two individual side salads not dated. Observation of the [DATE] dish machine temperature log on [DATE], at 10:13 AM, revealed wash and rinse temperatures failed to be logged on [DATE], 12, and 30th, 2024, at dinner time. During an interview with Employee 1 on [DATE], at 10:13 AM, revealed she is unable to locate any temperature logs for the dish machine prior to [DATE]. Observation of the [DATE] dish machine temperature log on [DATE], at 10:13 AM, revealed wash and rinse temperatures failed to be logged on [DATE]-8, ,d+[DATE], and ,d+[DATE], 2024, at breakfast, lunch, and dinner. Observation of the reach in freezer in the main dining room on [DATE], at 10:17 AM, revealed a slushie with a plastic spoon inside. Interview with Employee 1 on [DATE], at 10:18 AM, revealed the slushie likely belonged to a staff member and should not be stored in the reach-in freezer. Observation of the [DATE] Station 2 Refrigerator and Freezer Temperature Log on [DATE], at 10:19 AM, revealed temperatures failed to be logged on [DATE], ,d+[DATE], and 16, 2024. Observation of the [DATE] Station 3 Refrigerator and Freezer Temperature Log on [DATE], at 10:27 AM, revealed temperatures failed to be logged on [DATE] and 14, 2024. Further observation of the Station 3 Refrigerator and Freezer Temperature Logs from April through [DATE] revealed temperatures failed to be logged on 31 days. Observation in the Station 3 Refrigerator on [DATE], at 10:28 AM, revealed one container of thickened lemon water not labeled with an open date. Observation of the [DATE] Station 1 Refrigerator and Freezer Temperature Log on [DATE], at 10:32 AM, revealed temperatures failed to be logged on [DATE]. Observation in the Station 1 Refrigerator on [DATE], at 10:33 AM, revealed one container of thickened lemon water with an open date of [DATE], and one container of thickened milk with an open date of [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Employee 1 on [DATE], at 10:34 AM, revealed the aforementioned open containers should be discarded after seven days of being open. Observation of the [DATE] Station 4 Refrigerator and Freezer Temperature Log on [DATE], at 10:45 AM, revealed temperatures failed to be logged on [DATE]. Further observation of the Station 4 Refrigerator and Freezer Temperature Logs from February 2024 through [DATE] revealed temperatures failed to be logged on 21 days. Observation in the Station 4 Refrigerator on [DATE], at 10:46 AM, revealed one container of thickened lemon water not labeled with an open date, and one container of thickened orange juice not labeled with an open date. Interview with Employee 1 on [DATE], at 10:51 AM, revealed her expectation that food items are labeled and dated per policy and discarded once expired; and food items and kitchen equipment are stored and utilized in accordance with professional standards. Interview with the Nursing Home Administrator (NHA) on [DATE], at 1:06 PM, revealed it was the facility's expectation that food items and kitchen equipment are stored and utilized in accordance with professional standards. Follow-up interview with the NHA on [DATE], at 11:10 AM, revealed they were unable to locate the refrigerator/freezer temperature logs for Station 1 and 2 from February through [DATE]; or the kitchen dish machine temperature logs from February through [DATE]. 28 Pa. Code 211.6(f) Dietary services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 37116 Based on observations, facility policy review, and staff interviews, it was determined that the facility failed to ensure implementation of Enhanced Barrier Precautions to prevent the spread of infection by wearing required PPE (personal protective equipment) and hanging correct signage for six of 37 residents observed (Residents 2, 47, 58, 71, 91, and 159). Findings Include: Review of facility policy, titled Enhanced Barrier Precautions, revised January 8, 2024, revealed that enhanced barrier precautions are to be used to reduce the risk of epidemiologically important microorganisms by direct or indirect contact. Additionally, Enhanced Barrier Precautions is based on the Centers for Disease Control & Prevention (CDC) guidance. Further review of the policy failed to reveal any expectation that residents with indwelling medical devices should be placed on Enhanced Barrier Precautions. Review of CDC guidance, Review of Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated April 2, 2024, at cdc.gov revealed, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status; Infection or colonization with an MDRO. Review of Resident 2's clinical record revealed diagnoses that included pressure ulcer of the sacral region, stage four (full thickness skin loss that extends into deeper tissues) and type two diabetes mellitus (when the body doesn't produce enough insulin or use it properly, resulting in high blood sugar). Observations of Resident 2's room door on October 21, 2024, at 10:15 AM, and October 24, 2024, at 11:11 AM, failed to reveal any signage or any other notification that Resident 2 was on enhanced barrier precautions. Review of Resident 2's physician orders failed to reveal any orders for Resident 2 to be on enhanced barrier precautions. Observation made on October 24, 2024, at 11:11 AM, revealed Employee 19 and Employee 22 failed to don gowns prior to performing Resident 2's wound care and dressing change. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on October 24, 2024, at 11:52 AM, it was revealed that Resident 2 should have been on enhanced barrier precautions, and that employees are expected to wear appropriate PPE. Review of Resident 47's clinical record revealed diagnoses that included benign prostatic hyperplasia (prostate enlargement) and obstructive uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow). Observation of Resident 47's room door on October 21, 2024, at 12:23 PM, failed to reveal any signage or any other notification that Resident 47 was on enhanced barrier precautions. Further observation of Resident 47 at that time revealed the Resident lying in his bed. It also revealed that Resident 47 had an indwelling catheter. Review of Resident 47's physician orders failed to reveal any orders for Resident 47 to be on enhanced barrier precautions. An interview with the DON on October 24, 2024, at 11:00 AM, revealed that Resident 47 should have been on enhanced barrier precautions because of his medical conditions. Review of Resident 58's clinical record revealed diagnoses that included vascular dementia (condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain that causes problems with reasoning, planning, judgment, and memory) and obstructive uropathy. Observation of Resident 58 on October 21, 2024, at 10:08 AM, revealed she had a catheter (a hollow, partially flexible tube that collects urine from the bladder and leads to a drainage bag). No enhanced barrier precautions signage was present in or around Resident 58's room. Additional observations on October 22, 2024, at 9:35 AM, and on October 23, 2024, at 9:31 AM, also failed to reveal any enhanced barrier precautions signage. Review of Resident 58's care plan and physician orders failed to reveal any notation of enhanced barrier precautions. During an interview with the DON on October 23, 2024, at 2:44 PM, she revealed the expectation that Resident 58 should have been placed on enhanced barrier precautions due to her indwelling catheter. Review of Resident 71's clinical record revealed diagnoses that included urinary tract infection (UTI - bacterial infection in the urinary tract) and neuromuscular dysfunction of the bladder (condition causing loss of bladder control). Observations of Resident 71's room door on October 21, 2024, at 12:23 PM, and October 22, at 10:25 AM, failed to reveal any signage or any other notification that Resident 71 was on enhanced barrier precautions. Observation of Resident 71 on October 21, 2024, at 12:23 PM, revealed an indwelling catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 71's physician orders revealed orders for maintaining Resident 71's suprapubic catheter. Further review of Resident 71's physician orders failed to reveal any orders for Resident 71 to be on enhanced barrier precautions. During an interview with the DON on October 24, 2024, at 11:48 AM, it was revealed that Resident 71 should have been on enhanced barrier precautions. Review of Resident 91's clinical record revealed diagnoses that included stage 4 pressure ulcer of left buttock (wound caused by pressure that extends below the subcutaneous fat into deep tissue) and type 2 diabetes mellitus (impairment in the way the body regulates and uses sugar [glucose] as a fuel, resulting in too much sugar circulating in the bloodstream). Review of Resident 91's wound consult note dated October 21, 2024, revealed that she had an unhealed stage 4 pressure injury at that time. Observations on October 22, 2024, at 9:35 AM, and on October 23, 2024, at 9:31 AM, failed to reveal any enhanced barrier precautions signage on or near Resident 91's room. Review of Resident 91's care plan and physician orders failed to reveal any notation of enhanced barrier precautions. During an interview with the DON on October 23, 2024, at 2:44 PM, she revealed the expectation that Resident 91 should have been on enhanced barrier precautions due to her open wound. Review of Resident 159's clinical record revealed diagnoses that include benign prostatic hyperplasia (prostate enlargement) and obstructive uropathy. Observation of Resident 159's room door on October 23, 2024, at 12:23 PM, failed to reveal any signage or any other notification that Resident 159 was on enhanced barrier precautions. Further observation of Resident 159 at that time revealed the Resident lying in his bed. It also revealed that resident 159 had an indwelling catheter. Review of Resident 159's physician orders failed to reveal any orders for Resident 159 to be on enhanced barrier precautions. Interview with the DON on October 24, 2024, at 11:00 AM, revealed that Resident 159 should have been on enhanced barrier precautions because of his medical conditions. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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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. 34631 Based on employee file review and staff interview, it was determined that the facility failed to ensure the required nurse aide in-service training be no less than 12 hours per year and include dementia management training and resident abuse prevention training for three of five nurse aide documents reviewed (Employees 12, 13, and 15). Findings Include: A review of Resident 12's training information revealed a total of 6:13 hours documented and did not include the required dementia management or resident abuse prevention training. A review of Resident 13's training information revealed a total of 9:00 hours documented and did not include the required resident abuse prevention training. A review of Resident 15's training information revealed a total of 3:08 hours documented and did not include the required dementia management training. An interview with the Nursing Home Administrator on October 22, 2024, at 12:05 PM, revealed an acknowledgment of those nurse aides not having completed the required trainings and meeting the required 12 hours of training. 28 Pa. Code 201.19 (7) Personnel policies and procedures