STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395456	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Wyoming Valley	50 N. Pennsylvania Ave. Wilkes Barre, PA 18701

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 41460 Based on observations and staff interview, it was determined that the facility failed to maintain a clean and orderly environment on two of two resident care units. (Second and Third Floor) Findings include: Observations on April 24, 2024, at approximately 10:37 AM of the Unit 2 second floor revealed the following: An accummulation of dust and debris in a discolored ceiling vent in the Spa room. The tile directly under the sink on the left-hand side of the wall was chipped exposing plaster on the wall. The toilet to the left upon entrance to the room, was observed as you walk into this room was noted to have a brown substance with an odor of feces covering the seat and in the bowl. In the shower room bathroom, there was a large gap observed between the wall and sink, which extended the length of the sink. The sink appeared to be pulling away from the wall. The bases of the mechanical lifts that were stored in the shower room were heavily soiled with dirt and debris. One of the lifts had a white cream like substance on the handle. A soiled fall mat was observed inside the Jacuzzi tub and outside the tub was a chair/bed pressure pad sensor/alarm laying on the floor, and the floor was soiled with dirt, debris, and small dead bugs. Cob webs, dead bugs, and debris were observed in the corners and along the sill of the window. The private shower room ceiling vent was heavily coated with a thick layer of lint. The toilet was soiled with a brown fecal appearing substance. The vents in the ceiling and outside the nurse's station were heavily covered with lint, and ceiling tiles were stained dark brown from what appeared to be water-stained. Observations on April 24, 2024, at approximately 12:54 AM of the Unit 3 third floor revealed the following: (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395456	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cobwebs, small dead bugs, and debris were observed on the window sill in the large shower room. A soiled adult brief was observed in the walk-in tub. A reclining chair was stored in shower room, and the chair was soiled with dirt, debris, and a white cream-like substance. A loose bolt was observed on the seat of the chair. The ceiling vent by the window was coated with lint. Observation in the Private Bath revealed an accummulation of dust and debris in a ceiling vent with scattered brown colored stains on the ceiling surrounding the vent. Interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on April 26, 2024, at approximately 1:45 PM confirmed the facility is to be maintained daily to provide a clean and sanitary environment for the residents. 28 Pa. Code 201.18 (e)(2.1) Management

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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** 41460 Based on review of select facility policy and clinical records, and interviews with staff, it was determined the facility failed to provide nursing services consistent with professional standards of practice to ensure that licensed nurses properly evaluated and provided nursing care for a change in condition for one resident out of 20 sampled (Resident 52) and failed to follow physician orders for bowel protocol for two residents out of 20 sampled (Resident 40 and 15). Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain and restore the well-being of individuals. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the LPN (licensed practical nurse) (a) The LPN is prepared to function as a member of the health-care team by exercising sound judgement based on preparation, knowledge, skills, understandings, and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. A review of facility policy entitled Change in a Resident's Condition or Status last reviewed January 18, 2024, indicated that the facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical/mental condition or status. The nurse will notify the resident's attending physician or physician on call when there has been a discovery of injuries of an unknown source. The nurse will record the resident's medical record information relative to changes in the resident's medical/mental condition or status. If a significant change of the resident's physical or mental condition occurs a comprehensive assessment of the resident's condition will be conducted. A review of clinical record revealed that Resident 52 was admitted to the facility on [DATE], with diagnoses to include dementia (a major neurocognitive disorder that affects memory, thinking and interferes with daily life) without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety and reduced mobility. A quarterly Minimum Data Set assessment ([MDS]) is part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes) dated February 16, 2024, revealed that the resident was cognitively impaired with a BIMS score (A brief interview mental survey test is used to detect cognitive impairment) of 10. The resident required extensive staff assistance with activities of daily living (ADL). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of progress notes dated March 28, 2024, revealed that the certified registered nurse practitioner (CRNP) assessed Resident 52 for a chief complaint of following up on a urinary tract infection (UTI) and left hand swollen. The resident had some tenderness, but was able to move her hand, no bruising noted but the area was warm and red with good capillary refill. The resident denied any injury and was afebrile (without fever). Plan of care: give a dose of uric acid one time question gout (a type of arthritis that causes inflammation of joints due to excess uric acid), x-ray of the hand wrist, check labs, may need a Dexa (imaging that measures how dense a person's bones are) the resident has a history of vitamin D deficiency. A physician order dated March 28, 2024, at 2:42 PM, revealed STAT (immediately) x-ray (imaging that takes pictures of bones and soft tissue using a safe amount of radiation) of the left wrist and hand for swelling and pain. However, there was no evidence that imaging was performed as ordered. A review of progress notes dated March 29, 2024, revealed that the CRNP followed up with Resident 52 regarding hand pain. The resident had labs uric acid (a waste product in the body that can build up in the joints and tissues, leading to gout and other health conditions) level was 3.1 after one dose of colchicine (a medication used to treat gout), left wrist red slightly improved, still swollen but less than yesterday with positive capillary refill, only pain with palpation (touch) of the area. X-ray scheduled. Plan of care: await x-ray, resident denies injury, could be gout related since symptoms slightly improved after colchicine, use ice as needed, will consider a Dexa due to risk factors for osteoporosis (a disease that weakens the bones), pain is intermittent continue Tylenol as needed. There was no further nursing documentation regarding the physical condition, status and appearance of resident's left hand, including any potential injuries, prior to, and subsequent to, the documentation noted by the CRNP, regarding the resident's chief complaint of the presence of swelling and pain in the left hand. A review of imaging results titled Radiology Left Wrist, 2 Views/Left Hand, 2 Views dated March 30, 2024, at 11:16 AM revealed an anteriorly (front) displaced (disturbance of normal relation of bones at a joint) and angulated fractures (bone break) of the distal (away from the center of the body) radius and ulna (wrist). Joint spaces are aligned and maintained. There are no bony lesions. Mineralization is decreased, soft tissue swelling is noted. Acute distal radial and ulna (wrist) fractures. This imaging report was conducted two days after the STAT physician order. A review of nursing progress notes dated March 30, 2024, at 10:54 PM revealed the resident's left wrist was splinted/casted by emergency department CRNP. During an interview April 26, 2024, at 1:30 PM, the Nursing Home Administrator (NHA), Director of Nursing (DON) and Nurse Consultant confirmed that the facility was unable to demonstrate a complete initial and ongoing nursing assessment of Resident 52's change in condition and that diagnostic studies were not performed timely. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the American Academy of Family Physicians (The American Academy of Family Physicians is one of the largest medical organizations in the US founded to promote the science and art of family medicine) the primary goal of constipation management should be symptom improvement, and the secondary goal should be the passage of soft, formed stool without straining at least three times per week. A review of facility policy entitled Bowel Protocol last reviewed January 18, 2024, indicated that the following protocol will be used for assessing all residents for constipation. Milk of Magnesia (MOM) 30 milliliters (ml) by mouth every three days on 7:00 AM to 3:00 PM shift first thing in the AM if no bowel movement (BM). Dulcolax Suppository one 10 milligram (mg) rectally every third day on 3:00 PM to 11:00 PM shift if MOM is ineffective or no BM by 9:00 PM - 10:00 PM that evening. Fleet enema rectally every fourth day if Dulcolax is ineffective or no BM on 11:00 PM to 7:00 AM shift by 6:00 AM that morning. Notify the physician if bowel regimen is ineffective for BM. A review of clinical record revealed that Resident 40 was admitted to the facility on [DATE], with diagnoses that include constipation (infrequent, irregular, or difficult evacuation of the bowels). A quarterly MDS dated [DATE], revealed that the resident was cognitively intact with a BIMS score of 15. The resident required extensive staff assistance with ADLs. A review of physician's ordered protocol dated January 9, 2024, at 9:44 PM indicated that the resident was to Magnesium Hydroxide Suspension (MOM) 400 mg/5 ml with instructions to give 30 ml by mouth as needed for constipation once daily for no BM, every third day if on 7:00 AM to 3:00 PM shift if no BM by 10:00 AM. Dulcolax suppository 10 mg, insert one suppository rectally as needed for constipation after MOM is administered every third day on 3:00 PM to 11:00 PM shift if no BM by 10:00 PM. Fleet Enema 7-19 grams (gm)/118 ml, insert one application rectally as needed for constipation, after MOM and suppository have been administered without results, every fourth day on 11:00 PM to 7:00 AM shift if no BM by 6:00 AM. An interview with Resident 40 on April 23, 2024, at 10:20 AM revealed that the resident stated that he has been constipated and having painful BMs. He states he is currently taking a medication (for his problem of constipation) but he could not remember the name, but it is a liquid that tastes horrible and is not working well. The resident states that staff is aware of the medication he takes to treat constipation A review of Documentation Survey Report v2 titled bowel movements for April 2024, revealed that the resident did not have a bowel movement on April 2, 3, 4, 5, 2024. A review of Medication Administration Record (MAR) for April 2024 revealed that the resident did not refuse or receive any prn medication prescribed for lack of bowel movements on the above dates failing to follow physician's orders and facility policy. Review of Resident 15's clinical record revealed admission to the facility on [DATE], with diagnoses which included congestive heart failure, diabetes, and chronic obstructive pulmonary disease (COPD). (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 15's current physician orders revealed orders dated June 28, 2023, for Magnesium Hydroxide Suspension (MOM) 400 mg/5 mL give 30 mL as needed for constipation on 7-3 shift by 10 AM if no bowel movement in 3 days, Dulcolax suppository 10mg rectally as needed for constipation on 3-11 shift by 10 PM for no BM in 3 days and MOM ineffective, and Fleet enema rectally as needed for constipation as needed on 11-7 shift for no BM in 4 days and MOM and suppository ineffective, and notify physician if bowel protocol is ineffective for BM. Review of Documentation Survey Report dated March 2024 revealed that there was no documented evidence that Resident 15 had a bowel movement on March 18, 2024, through March 21, 2024, a total of 4 days. Review of Medication Administration Record dated March 2024 revealed that nursing staff administered MOM on March 21, 2024, at 9:36 AM, and indicated that the medication was effective. There was no documented evidence that Resident 15 had a BM on March 21, 2024. According to the Documentation Survey Report, Resident 15 did not have a BM until March 22, 2024, on day shift. A review of the resident's March 2024 MAR revealed that staff administered a Dulcolax suppository on March 22, 2024, at 3:04 PM despite Resident 15 already having a BM. The Documentation Survey Report dated March 2024 revealed that there was no documented evidence that Resident 15 had a bowel movement March 27, 2024, through March 31, 2024, a total of five days. Review of Resident 15's MAR revealed that there was no evidence that MOM or a Dulcolax suppository were administered to treat the resident's constipation. According to physician order, MOM should have been administered on March 30, 2024, during the 7-3 shift. According to the MAR, a Fleet enema was administered on March 31, 2024, at 6:21 AM and was effective in treatment of constipation. There was no documented evidence that Resident 15 had a bowel movement on March 31, 2024. According to the Documentation Survey Report dated April 2024, Resident 15 did not have a BM until April 1, 2024, on the 7-3 shift. There was no evidence that nursing staff performed an assessment of Resident 15 to evaluate for potential complications due to prolonged constipation. During an interview April 26, 2024, at 12:30 PM, the Nursing Home Administrator (NHA), Director of Nursing (DON) and Nurse Consultant confirmed the facility failed to provide documented evidence in the clinical record that the physician ordered bowel protocol was followed. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services 28 Pa. Code 211.10(a)(c)(d) Resident care policies (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.5 (f) Medical records

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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. 41460 Based on observation and staff interview, it was determined that the facility failed to maintain an environment free of potential accident hazards on one of two resident care units. (Second Floor) Findings include: An observation conducted on April 24, 2024, at approximately 10:42 AM, revealed a crash cart was in the resident area, the Sunshine Terrace on the second floor. The cart was unattended and not locked, and contained emergency equipment that included 24-gauge needles. Employee 1, Certified Nurse Aide (CNA) confirmed the above observation at this time and removed the cart from the resident area. During an interview on April 26, 2024, at 1:46 PM with the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed the cart should have been locked to prevent resident access to potentially hazardous items. 28 Pa Code 211.12 (c)(d)(5) Nursing services 28 Pa. Code 201.18 (e) (2.1) Management

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460 Based on review of select facility policies/reports and clinical records, and staff, and resident interviews it was determined that the facility failed to provide necessary behavioral health care to promote the highest practicable physical and psychosocial well-being of one resident out of 20 sampled (Resident 52). Findings include: A review of facility policy entitled Behavioral Assessment, Intervention and Monitoring last reviewed January 18, 2024, indicated that behavioral symptoms will be identified using facility-approved behavioral screening tolls and the comprehensive assessment. The nursing staff will identify, document and inform the physician about specific details regarding changes in an individual's mental status, behavior, and cognition including the onset, duration, intensity, and frequency of behavioral symptoms, any precipitating factors or relevant factors, appearance and alertness of the resident and related observations. New onset of changes in behavior will be documented regardless of the degree of risk to the resident or others. Care plan management includes the interdisciplinary team to determine the degree of severity, distress and potential safety risk to the resident and develop a plan of care accordingly. The care plan will incorporate findings from the comprehensive assessment and be consistent with current standards of practice. Review of clinical record revealed that Resident 52 was admitted to the facility on [DATE], with diagnoses to include dementia (a major neurocognitive disorder that affects memory, thinking and interferes with daily life) without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety and schizoaffective (a mental disorder when a person experiences a combination of symptoms of schizophrenia and mood disorder) disorder, bipolar type (a serious mental illness characterized by extreme mood swings). Review of resident's care plan, initially dated May 25, 2021, last revised on April 26, 2022, indicated that the resident has negative behaviors as evidence by non-compliance with safety precautions and false accusations towards staff, with a goal to be free from injury due to noncompliance with safety precautions for 90 days with an intervention noted to consult behavioral services. The care plan noted that the resident may become suspicious of new people encourage time out of room to socialize and familiarize self with new surroundings, engage in conversation to help calm and aid in adjustment to her placement, explain each action prior to not startle, if found to be calling out assess and meet all needs at that time and educate the use of the call bell, if observed ambulating unassisted assist and meet needs, introduce to peers of similar cognitive function to encourage conversation. A quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process) dated February 16, 2024, revealed that the resident was moderately cognitively impaired. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of behavior tracking for the month of March 2024, related to the resident's psychoactive drug use, revealed that the facility was monitoring the resident for behaviors crying, tearful, negative statements, withdrawal, refusals of meals or care, hallucinations, delusional thinking, paranoia. Interventions staff were to employ in response to these behaviors were 1:1, activity, adjust room temperature, backrub, change position, fluids/food, redirect, change environment, toileting and other. Two instances of behaviors were noted to occur during March 2024, on March 19th and 20th, and the interventions used were to redirect the resident. The effectiveness of the intervention was noted as N/A. Review of nursing progress notes dated March 19, 2024, at 11:28 AM revealed that the resident was yelling this place is full of immigrants, and they are keeping her and her boyfriend here against their will. The resident was encouraged that she was safe, and resident stated her neighbor said she belongs in a nuthouse. The certified registered nurse practitioner (CRNP) was made aware, with new orders to obtain a urine analysis with culture and sensitivity. Nursing progress notes dated March 20, 2024, at 4:00 AM revealed that the resident was yelling out and cursing until 2:00 AM. Review of nursing progress notes dated March 27, 2024, at 5:12 AM revealed that the resident displayed intermittent periods of yelling out. When asked what is wrong the resident replies nothing denies pain or discomfort, snack and beverage were offered and refused. Nursing noted that the resident was awake most of the shift call light within reach, will continue to monitor. An Incident/Accident Review dated March 30, 2024, revealed that the resident had sustained a fracture. The root cause of the injury was noted as decreased mineralization and the resident stated that she hits her table when she is angry. The facility padded the table. The resident denied anyone causing the injury or falling, states she gets mad banged it. The resident stated, I don't remember when it happened, but I may have hit my arm off the table a couple times when I was mad. The resident was transferred and treated at the emergency department, returned to the facility with a left wrist cast. Employee witness statements obtained surrounding the resident's injury on March 30, 2024, revealed that employees reported the resident's agitation and behavioral symptoms. Employee 3, a Certified Nurse Aide (CNA), stated when giving care to Resident 52 for the last week she has been more agitated yelling and cursing at staff and sometimes refusing care. Employee 4, Licensed Practical Nurse (LPN), stated on March 24, 2024, when assigned to the resident and the resident was verbally abusive to the staff throwing her personal belongings to the floor. Redirection was ineffective. Employee 4 was able to administer Resident 52's medications after several attempts in the AM hours of March 25, 2024, and no injury was observed. Employee 5, CNA, provided care for this resident and reported that the resident was combative and throwing things from the nightstand. Employee 6, CNA, stated that the resident was observed grabbing at her privacy curtain trying to see her roommate, swinging arms and legs, and yelling at her roommate. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employee 7, CNA, stated that the resident is always very combative whenever she is receiving care. Employee 8, CNA, stated that the resident has been in a bad mood, having bad behaviors cursing at staff and trying to hit and kick staff. The resident's bed was moved away from the curtain because she was snatching the curtain back and roommate thought she was trying to get her. Employee 2 LPN stated that the resident sometimes has behaviors where she gets mad and throws items to the floor. Employee 9 LPN stated that the resident has been having behavioral issues this week cursing at staff, spitting out meds, pushing bedside table across the room. Review of a Psych Note dated April 11, 2024, indicated that Resident 52 was seen in her room she was alert, awake and oriented times one with general confusion. She was pleasant and states her mood has been doing ok she denies depression or anxiety. Some confusion with behaviors of delirium were noted two weeks ago, on an antibiotic medication for urinary tract infection. Has a cast with swelling of her hand. Discussed current behaviors and mood with interdisciplinary team and Seroquel (antipsychotic medication) was titrated back up on January 19, 2024, and staff reports no mood or behavioral changes. Assessment and plan include continue medication as ordered, allow resident to vent thoughts and feelings, listen with empathy, continue to encourage the resident to participate in positive activities and increase engagement, continue to monitor, and document mood changes and behaviors of concern. Despite the resident's ongoing behavioral symptoms there was no change in the resident's behavioral health plan to manage or modify the resident's behaviors or the development of individualized interdisciplinary interventions for staff to employ in response to the resident's behaviors to promote the resident's psychosocial and physical well-being. A review of the resident's behavior tracking for April 2024 revealed that the resident displayed no behaviors, that were being tracked in relationship to the resident's psychoactive drug use. Interview with Resident 52 on April 24, 2024, at 10:06 AM the resident stated she had an appointment yesterday for her wrist and pointed at the splint applied to her left wrist. When asked what happened she replied, I don't know what the heck I did to it. Observation on April 24, 2024, at 10:06 AM revealed that there was no padding on the resident's bedside table as indicated in the investigation report as an immediate intervention in place to prevent future injury. There was no documented evidence that the facility had developed and implemented an interdisciplinary approach to the resident's care, with qualified staff that demonstrate the competencies and skills necessary to provide appropriate services to the resident, individualized approaches to care, including direct care and activities provided to support the resident's physical, mental, and psychosocial environment. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Nursing Home Administrator (NHA), Director of Nursing (DON) and Nurse Consultant on April 26, 2024, at approximately 1:00 PM, revealed that the facility was unable to provide evidence that the facility had provided the necessary care and services to meet and manage the resident's behavioral health care needs. 28 Pa Code 211.12 (d)(1)(3)(5) Nursing Services 28 Pa. Code 201.18 (b)(1)(e)(1)(3) Management

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Wyoming Valley	50 N. Pennsylvania Ave. Wilkes Barre, PA 18701

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F 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41460

Based on review of manufacturer's directions for use, observation, and staff interview, it was determined that the facility failed to ensure adherence to pharmacy supplies expiration/use by dates on one of three resident units (Second Floor).

Findings include:

Observations on [DATE], at 9:00 AM of the facility's second floor medication room revealed the following:

There were 62 needleless sterile (germ free) connectors that expired on the following dates: [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE].

One sterile normal saline flush found on the floor under a table with an expiration date of [DATE].

10 multifunction red sterile caps that expired on [DATE].

Two 27 Gauge x ,d+[DATE] inch precision BD glide needle that expired on [DATE].

Two sterile 16 French [NAME] Male Catheter that expired on [DATE].

46 Assure TB Syringe 28 Gauge x ,d+[DATE] inch needles that expired on [DATE].

One sterile irrigation tray with piston syringe that expired on [DATE].

A ureteral self-catheterization kit that expired on [DATE].

Two RX Destroyer bottles that leaked a thick sticky black substance with a foul odor all over the sink countertop, causing them to be stuck the countertop.

Two empty cardboard boxes on the floor.

Two loose pills (medication) in an orange-colored tray on the second shelf above the sink, one pink oval shaped pill with the inscription of the numbers 894 (s) on it and one beige oval shaped pill with the inscription of the numbers 525 on it.

One small peach colored pill stuck to the floor under a table.

One opened sterile dressing change tray with manufacturer instructions that note sterile single use do not reuse found in the second drawer of the cabinet next to the Pyxis system (automated dispensing system for medication management).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employee 2 Licensed Practical Nurse (LPN) confirmed the observed findings above. During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on [DATE], at approximately 12:30 PM confirmed expired pharmacy products should have been removed from the storage room and discarded and the medications should have been wasted. 28 Pa. Code 211.9 (a)(1)(k) Pharmacy Services 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460 Based on clinical record review and interviews with staff, it was determined that the facility failed to timely obtain radiology/diagnostic services to meet the needs of one resident of 20 sampled (Resident 52). Findings include: Review of clinical record revealed that Resident 52 was admitted to the facility on [DATE], with diagnoses to include dementia (a major neurocognitive disorder that affects memory, thinking and interferes with daily life) without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety and reduced mobility. A review of progress notes dated March 28, 2024, revealed that the certified registered nurse practitioner (CRNP) assessed the resident with a chief complaint of following up on a urinary tract infection (UTI) and left hand swollen. The resident had some tenderness but was able to move her hand, no bruising noted but the area was warm and red with good capillary refill. The resident denies any injury and was afebrile (without fever). Plan of care: give a dose of uric acid one time question gout (a type of arthritis that causes inflammation of joints due to excess uric acid), x-ray (imaging that takes pictures of bones and soft tissue using a safe amount of radiation) of the hand wrist, check labs, may need a Dexa (imaging that measures how dense a person's bones are) the resident has a history of vitamin D deficiency. A physician order dated March 28, 2024, at 2:42 PM, was noted for a STAT (immediately) x-ray of the left wrist and hand for swelling and pain. There was no evidence that the STAT x-ray of the resident's left wrist was obtained as ordered on March 28, 2024. Two days later, imaging results titled Radiology Left Wrist, 2 Views/Left Hand, 2 Views dated March 30, 2024, at 11:16 AM revealed there were anteriorly (front) displaced (disturbance of normal relation of bones at a joint) and angulated fractures (bone break) of the distal (away from the center of the body) radius and ulna (wrist). Joint spaces are aligned and maintained. There are no bony lesions. Mineralization is decreased, soft tissue swelling is noted. Acute distal radial and ulna (wrist) fractures. This imaging study was conducted two days after the STAT physician order delaying treatment and care to the resident. A review of nursing progress notes dated March 30, 2024, at 10:54 PM revealed the resident's left wrist was splinted/casted by emergency department CRNP. During an interview on April 26, 2024, at approximately 12:30 PM, the Nursing Home Administrator (NHA), Director of Nursing (DON) and Nurse Consultant confirmed the Stat X-rays were not completed as ordered on March 28, 2024. (continued on next page)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12 (d)(3)(5) Nursing services

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 43944 Based on review of facility planned menus and select facility policy, observations, and resident and staff interviews, it was determined that the facility failed to ensure residents were provided meals that accommodated food preferences for four of 20 residents reviewed (Residents 59, 66, 32, and 40). Findings Include: A review of a facility policy entitled Alternative Menu Program that was last reviewed by the facility on January 18, 2024, indicated that always available items must be posted by the menu on all floors for the residents to see and all items must be available for the meal. There are three menu items on the alternate menu that includes grilled cheese, hamburger on a bun, and a deli sandwich. Based on resident decisions from the facility's monthly Food Committee meeting, two selections per the resident's selection will be added to the permanent always available menu items. The two selections will be rotated monthly. A review of the facility's April 2024 events/activities handout that was provided to each resident listed that the monthly Always Available Menu for lunch/dinner meals would include ham sandwich, chicken salad sandwich, hamburger on a bun, grilled cheese sandwich, cheese steak, and cottage cheese and fruit. During an interview with Resident 32 on April 23, 2024, at 10:10 a.m., the residents stated that food items on the Always Available menu, such as cheese steak hoagies, chicken salad, hamburgers, and grilled cheese were not consistently available to residents when requested. During an interview with Resident 40 on April 23, 2024, at 10:20 a.m., the resident stated when he dislikes a meal served, he requests an entree from the Always Available menu, but those items are often not available, such as cheese steaks that were planned to be available throughout this month of April. During an interview with Resident 59 on April 23, 2024, at 12:31 p.m., the resident stated that he frequently made meal selections from the facility's Always Available Menu but the items listed on the monthly always available menu weren't always available when requested. Resident 59 stated that the always available menu for April 2024 was supposed to include chicken salad sandwiches but when he requested one, staff told him that it wasn't an available choice. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Resident 66 on April 23, 2024, at 12:33 p.m., revealed that the resident stated that items on the facility's Always Available Menu aren't always available. The resident explained, that for example, for April 2024 the residents voted, and cheese steak hoagies were added to the Always Available Menu, but were not available when ordered. Resident 66 presented his tray ticket dated April 14, 2024, that indicated he requested a cheese steak and staff noted on the tray ticket sorry, no cheese steaks. The resident was given an egg salad sandwich with three bean salad instead. He stated he was served items that he disliked. regular meal of egg salad sandwich. Resident 66 reported that items from the Always Available Menu were more frequently unavailable, and as a result he food he disliked instead. A review of the facility's placed food orders dated April 1 through April 14, 2024, revealed that the meat used for the always available selection of steak and cheese was not consistently ordered to fulfill the residents always available requests. During an interview with the facility's dietary manager on April 25, 2024, at 12:15 p.m., the employee stated that she orders one case of the beef used for the steak and cheese and that no par levels were established to maintain an in-house supply readily available to ensure that resident requests could be accommodated. The dietary manager confirmed that items listed on the Always Available menu were not consistently available. 28 Pa. Code 211.6 (a) Dietary services 28 Pa. Code 201.18 (a) Resident rights

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43944 Based on observation and staff interview, it was determined that the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness, in the dietary department and the second- floor resident food storage area. Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). The initial tour of the dietary department was conducted with the facility's food services manager on April 23, 2024, at 9:27 a.m., revealed the following unsanitary practices with the potential to introduce contaminants into food and increase the potential for food-borne illness, was identified: Observations of the inside of the tray line reach-in cooler revealed trays of 4-ounce shakes were not labeled with a discard/thaw date. The dietary manager reported that the shakes are dated when staff pull them from the freezer and confirmed that the actual pull was unknown therefore acceptable use by dates were not known. Inside the cooking storage room there was a stained ceiling tile that was bowed, and pots were stored directly underneath. Several other stained ceiling tiles were observed and a small missing tile near plumbing. There were dead bugs inside of the light cover of the ceiling light. Inside the dry storage area there were several stacked cases of food directly on the floor. The dietary manager confirmed the observation and the food should be stored at least six inches above the floor. Also in the dry storage area there were two bulk storage bins (one with flour and one with chicken base) that had ill-fitting lids that failed to secure the contents of the bins. Observations of the dish machine area revealed that several ceiling tiles appeared water stained and black-mold like spots on the surface of the tiles. During an observation of the second-floor supply storage area on April 23, 2024, at 11:25 a.m., there was a gray 8-ounce thermal bowl containing a white powdery substance that wasn't labeled or dated. Observations of the second-floor activity/lounge area revealed that inside the reach-in refrigerator there were two six packs of yogurt that with a manufacturer's expiration date of April 12, 2024. The temperature inside of the refrigerator felt warm and the thermometer inside read 45 degrees Fahrenheit (refrigerator temperatures should be at or below 41 degrees Fahrenheit). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Further observation of the second-flood activity/lounge resident refrigerator on April 24, 2024, at 12:12 p.m., revealed that the inside of the refrigerator continued to feel warm and the thermometer inside of the unit read 46 degrees Fahrenheit. Dried food splattered was observed inside the microwave. During an interview with the Nursing Home Administrator (NHA) on April 24, 2024, at 1:45 p.m., confirmed that the facility failed to ensure that the dietary department and resident pantry/kitchenette food storage were maintained in a sanitary manner and foods properly labeled and dated. 28 Pa. Code 201.18 (e) (2.1) Management 28 Pa. Code 211.6 (f) Dietary Services