STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395464	A. Building B. Wing	07/12/2024

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Forest Hills Rehabilitation & Healthcare Center	1000 Evergreen Avenue Weatherly, PA 18255

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on review of clinical records, and staff interview it was determined that the facility failed to develop and implement a resident's person-centered comprehensive care plan designed to meet a resident's safety needs related to suicidal ideations and expressions of distress voiced by one out of 35 sampled (Resident 178). Findings included: Review of the clinical record revealed that Resident 178 was admitted to the facility on [DATE], with diagnoses to include anoxic brain damage, hypertension, and disorientation. A review of the admission Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated June 3, 2024, revealed that the resident was moderately cognitively impaired, with a BIMS score (Brief Interview for Mental Status - a tool to assess cognitive function) of 8, and had no functional limitations in range of motion of her upper and lower extremities. A nurses note dated June 6, 2024, at 1:34 AM indicated that a nurse aide notified the nurse that Resident 178 stated that she was going to kill herself. The nurse spoke with resident who stated that she does not have a plan but does wish to die. The conversation with resident was brief as resident was not making complete statements and changed from one subject to another. The nurse noted that the resident is not physically capable of harming self or others at this time. The physician and the resident's responsible party were made aware of statements made. A new order was noted for every 15 minute checks for 24 hours for safety. A nurse's note dated June 6, 2024, at 7:46 AM indicated that a new order was noted to to send the resident to the emergency department for evaluation and treatment. A review of facility form entitled einteract transfer for V5.1 dated June 6, 2024, at 7:35 AM indicated that the resident was being transferred to the hospital because she pulled out her g-tube (gastrostomy tube - a surgically placed, rubber tube, placed to give direct access to your stomach for feeding). A nurses note dated June 6, 2024, at 2:13 PM indicated that the resident returned to facility. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Social Services note dated June 6, 2024, at 3:16 PM noted that a support visit was held with the resident secondary to suicidal ideations. The entry indicated that the resident was alert, oriented to person, resting in bed, without appearing in any distress, speaking calmly. The resident did confirm not wishing to hurt herself and denies any suicidal ideations at this time. Resident appeared to feel safe within her surroundings and did not voice any concerns. Referral made for psych services. Resident 178 does not receive any psychotropic medications. Social Services will continue to update as needed/requested. A review of a psychiatry note dated June 10, 2024, at 12:00 AM indicated that the resident was seen for an initial psychiatric evaluation. She admits to anxiety, depression, and racing thoughts. Tearful throughout visit and per staff, her mood is very anxious. Sleep waivers, appetite limited. Denies suicidal/homicidal ideation The psychiatry note did not include reference to the practitioner's aware of the resident's statements that she was going to kill herself, and wished to die. A review of the resident's care plan in effect during the time of the review on July 10, 2024, revealed that the resident's comprehensive care plan did not include the resident's statement of wanting to kill herself, and wishing to die. Interview with Employee 1 (Social Services) on July 10, 2024, at approximately 2:00 PM confirmed that the resident's care plan did not identify the resident's statement of wanting to kill herself, and wishing to die. Interview with the Director of Nursing (DON) on July 11, 2024, at approximately 9:25 AM, confirmed that the facility failed to fully develop and implement person-centered comprehensive care plan in a manner that assures staff are aware of the resident's specific and individualized safety needs, relating to her statement of going to kill herself, and wishes to die.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on review of clinical records, and staff interview, it was determined that the facility failed to review and revise a resident's care plan related to the resident's unsafe smoking behaviors and non-compliance with the facility smoking policy for one out of two residents sampled (Resident 43). Findings include: A review of the clinical record revealed that Resident 43 was admitted to the facility on [DATE], with diagnoses to include morbid (severe) obesity due to excess calories, diabetes, pressure ulcers (bed sores), opioid abuse, and acquired absence of his left leg below the knee, and right foot. A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated February 12, 2024, revealed that the resident was cognitively intact, with a BIMS score (Brief Interview for Mental Status - a tool to assess cognitive function) of 15. A review of Resident 43's care plan, date-initiated May 20, 2021, and revised on August 15, 2023, revealed that the resident a potential to exhibit behaviors that are a result of past traumas, which may impact moods or behaviors as evidence by attempting to manipulate staff to complying with his requests by threatening them with calling state agencies and report them. He will also attempt to manipulate other residents and family members into giving him items and money to purchase items within the facility i.e.: snacks, sodas. The resident's care plan, dated August 3, 2023, and revised on April 5, 2024, also revealed that the resident had behaviors related to major depressive disorder/anxiety, resistive/noncompliant with treatment/care (Refusing a Shower, repositioning/ rest periods in bed to provide pressure relief, wound treatments, medications, refuses fingernail trimming, refuses facial hair removal, non-adherence to recommended dietary restrictions/diet, returning to bed to receive incontinence care; unplugging wound vac/removing wound vac, removes TED stockings) related to beliefs that treatment isn't needed/working. Nursing documentation dated April 10, 2024, at 6:04 AM indicated that a nurse aide and an LPN (licensed practical nurse) twice during the shift reports alerted the registered nurse (RN) of reports of smoke in the resident's room. When resident asked if he knew why there was smoke in his room, the resident denied smoking. Staff asked the resident if he has any smoking devices in room which he denied. Staff reminded the resident of facility smoking policy and he verbalized understanding. A review of a nurses note dated April 18, 2024, at 4:45 PM indicated that while giving the resident his medication he stated did you hear I set the smoke alarms off in the middle of the night? vaping sets them off I didn't know that. In response, the nurse told him he should not be vaping in the building, or in his room its against the policy. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurses note dated May 5, 2024, at 1:07 PM noted that the nurse aides in area 1 alerted the nurse that they could smell Resident 43 vaping in his room. Resident 43 adamantly denied it. Staff educated him, and reminded him, of the consequences of doing so. Resident 43 later apologized and gave his vape to the nurse to put in the cigarette box saying he didn't want to lose privileges. A review of a nurse's note dated May 5, 2024, at 10:14 PM noted that the resident was vaping in his room, setting off smoke alarm. Fire company came to reset alarm. Officers spoke with the resident and obtained the vape. A nurses note dated June 10, 2024, at 10:28 PM indicated that the resident was found smoking - vaping in room. Vape was confiscated and brought to the supervisor's office. A review of a Social Services note dated June 11, 2024, at 11:56 AM indicated that Social Services department and Nursing Home Administrator (NHA) met with alert and oriented Resident 43 on this date. The NHA and SS Dept reviewed a smoking contract with the resident who expressed understanding. No concerns noted at this time. Social services noted Will continue to update as needed/requested. When reviewed at the time of the survey ending July 12, 2024, there was no documented evidence that Resident 43's care plan had been reviewed and revised related to the resident's smoking contract, vaping and or his non-compliance with smoking/vaping policy for safety. Interview with Employee 1 (Social Worker) on July 10, 2024, at approximately 2:00 PM confirmed there was no documented evidence that the resident's care plan was updated to address the resident's vaping, or that it was reviewed and revised related to his non-compliance with facility smoking/vaping policy to assure safety. Interview with the Director of Nursing (DON) on July 11, 2024, at approximately 9:25 AM, confirmed that the resident's care plan had not been reviewed and revised in response to resident's vaping, smoking contract, and non-compliance with the facility smoking policy

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on a review of select facility policy and clinical records and staff interview it was determined that the facility failed to provide nursing services consistent with professional standards of quality by failing to ensure that licensed nurses timely administered a resident's medications as scheduled for one of 35 reviewed (Resident 129). Findings included: According to 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 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 Licensed Practical Nurse (LPN) (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. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) Document and maintain accurate records. According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of patient care including Medication Records. A review of the facility policy titled Administering Medications last reviewed by the facility on June 3, 2024, indicated that medications are administered within one hour of their prescribed time. A review of the clinical record of Resident 129 revealed admission to the facility on [DATE], with diagnoses which included Type 2 diabetes (failure of the body to produce insulin), and dementia with agitation dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain). A physician's order dated December 22, 2023, was noted for Lantus Subcutaneous Solution 100 unit/ml (medication used to treat diabetes), inject 12 units subcutaneously (administered under the skin) once daily for diabetes. A review of Resident 129's Medication Administration Record (MAR) for April 2024, revealed that the resident was prescribed Lantus injection and scheduled to receive the Lantus at 9:30 AM. Further review of the resident's MAR for April 2024, indicated that on the following dates, the Lantus injection for diabetes was administered more than one hour beyond the physician prescribed 9:30 AM administration time: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	April 3, 2024 11:02 AM April 6, 2024 11:15 AM April 7, 2024 1:21 PM April 12, 2024 1:53 PM April 21, 2024 11:18 AM April 25, 2024 11:22 AM A review of Resident 129's MAR for May 2024, revealed that the resident was prescribed Lantus injection and scheduled to receive the Lantus at 9:30 AM. Further review of the resident's MAR for May 2024, indicated that on the following dates, the Lantus injection for diabetes was administered more than one hour beyond the physician prescribed 9:30 AM administration time: May 9, 2024 11:18 AM May 10, 2024 11:24 AM May 13, 2024 11:24 AM May 16, 2024 11:56 AM May 18, 2024 12:49 PM May 23, 2024 11:54 AM A review of Resident 129's MAR for June 2024, revealed that the resident was prescribed Lantus injection and scheduled to receive the Lantus at 9:30 AM. Further review of the resident's MAR for June 2024, indicated that on the following dates, the Lantus injection for diabetes was administered more than one hour beyond the physician prescribed 9:30 AM administration time: June 2, 2024 10:48 AM June 7, 2024 1:58 PM June 10, 2024 11:06 AM June 20, 2024 10:46 AM June 22, 2024 10:47 AM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	June 24, 2024 11:08 AM Interview with the Director of Nursing on July 11, 2024, at approximately 1:00 PM confirmed that the late administration of Resident 129's Lantus medication is not consistent with the professional standards for diabetes management. 28 Pa. Code 211.10 (a)(c)(d) Resident care policies 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing Services

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records and staff interview it was determined that the facility failed to administer pain medication in accordance with physician orders for one of the 35 residents sampled (Resident 113). Findings include: Clinical record review revealed Resident 113 was admitted to the facility on [DATE], with diagnoses that include chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and myeloid leukemia (a cancer in the blood and bone marrow). Resident 113's care plan, dated April 11, 2024, indicated that the resident has potential for pain related to cancer, rib fracture, and pneumonia with planned interventions to administer medications per physician orders. A physician's order was noted on June 3, 2024, for Oxycodone HCL Oral Tablet 5 mg (an opioid medication), one tablet by mouth every six hours, as needed, for moderate to severe pain, rated from 4 through 10 (on a pain scale of 1-10 with 1 being the least pain and 10 the most severe) Resident 113's medication administration record (MAR) dated from May 1, 2024, through July 11, 2024 revealed facility staff administered Oxycodone HCL Oral Tablet 5 mg outside of the physician's prescribed parameters for the resident's pain level. Resident 113 received Oxycodone HCL Oral Tablet 5 mg on: June 28, 2024, at 6:30 PM for a pain level of 0 June 30, 2024, at 5:01 PM for a pain level of 0 July 1, 2024, at 4:26 PM for a pain level of 3 July 2, 2024, at 5:05 PM for a pain level of 3 July 8, 2024, at 8:52 PM for a pain level of 3 During an interview on July 12, 2024, at approximately 11:00 AM, the Director of Nursing (DON) confirmed the facility staff administered Resident 113 Oxycodone HCL Oral Tablet 5 mg, an opioid pain medication, outside of the parameters of the physician's orders. The DON confirmed it is the facility's responsibility to ensure Resident 113's pain medication is administered within the parameters of the physician's orders. 28 Pa. Code 211.5 (f)(xi) Medical records. 28 Pa. Code 211.10 (c) Resident care policies. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12 (d)(1)(5) Nursing services.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on review of clinical records and staff interviews, it was determined that the facility failed to develop and implement an individualized person-centered plan to provide trauma-informed care to a resident with a diagnosis of Post Traumatic Stress Disorder (PTSD) for one resident out of one sampled with a diagnosis of PTSD (Resident 19). Findings include: A review of the clinical record revealed that Resident 19 was admitted to the facility on [DATE], with diagnoses to include major depression, intellectual disability, dementia, and Post Traumatic Stress Disorder (PTSD). An annual Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated June 4, 2024, indicated that the resident has an active diagnosis of post-traumatic stress disorder (PTSD). A review of Resident 19's current care plan, initially dated January 8, 2024, indicated that the resident has a history of PTSD (post-traumatic stress disorder) related to surviving a traumatic event but unable to recall triggers secondary to cognitive deficits, and a diagnosis of Mental Retardation (MR). Planned intervention/tasks noted that the resident will be able to identify the triggers that cause anxiety, trauma, and flashbacks and learn coping mechanisms to mitigate their impact the resident's well-being, and the facility will consult psychiatry/psychology as needed. Resident 19's current care plan, in effect at the time of review on July 10, 2024, revealed no documented evidence that since the resident's admission to the facility had attempted to identify,the resident's triggers which may re-traumatize this resident with a history of trauma. {A trigger is a psychological stimulus that prompts recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening. For many trauma survivors, the transition to living in an institutional setting (and the associated loss of independence) can trigger profound re-traumatization. Most triggers are highly individualized} The resident's care plan did not include trigger-specific interventions and ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident. Interview with Employee 1 (Social Worker) on July 10, 2024, at approximately 2:00 PM confirmed that the resident's care plan did not identify the resident's specific past experience, trauma, leading to the diagnosis of PTSD. Employee 1 confirmed that there was no evidence that the facility had since identified or attempted to obtain the information from the resident's family/representative or past social and medical history, the resident's triggers to develop specific interventions to meet the resident's needs for minimizing triggers and/or re-traumatization. The facility failed to develop and implement an individualized person-centered care plan to address, this resident's diagnosis of PTSD according to standards of practice to promote the resident's emotional well-being and safety. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) on July 11, 2024, at approximately 9:25 AM, confirmed the facility was unable to demonstrate that the facility provided trauma-informed care in accordance with professional standards of practice and accounting for resident's specific experiences to eliminate or mitigate triggers that may cause re-traumatization of the resident. 28 Pa Code 211.12 (d)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records and a staff interview, it was determined that the facility failed to ensure the pharmacist identifies irregularities in drug regimens of one of 35 residents sampled (Resident 101). Findings include: A review of the clinical record revealed that Resident 101 was admitted to the facility on [DATE], with diagnoses that included dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). The resident began receiving Hospice care at the facility on April 6, 2024, for a diagnosis of Parkinson's disease. A physician order was noted for ABH (Ativan 0.5 mg/Benadryl 12.5 mg/Haldol 0.5 mg) Gel apply topically to the back every 6 hours as needed for anxiety or agitation for 30 days; Apply 2 syringes = 1 mg/50 mg/1 mg on April 14, 2024. The order was discontinued on May 13, 2024. (The ABH gel concentrate contains Ativan {an anti-anxiety medication}, Benadryl {an anti-histamine medication}, and Haldol {an anti-psychotic medication}). The physician order to administer two syringes of the above ABH (Ativan 0.5 mg/Benadryl 12.5 mg/Haldol 0. 5 mg) concentrate gel would not equal 50 mg of Benadryl as indicated in the order, but 25 mg. The physician order did not include the supporting diagnosis for the use of the ABH gel. The physician ordered the ABH (Ativan 0.5 mg/Benadryl 12.5 mg/Haldol 0.5 mg) gel, apply topically to the back every 6 hours as needed for anxiety or agitation for 30 days; Apply 2 syringes =1 mg/50 mg/1 mg initiated on June 13, 2024, and discontinued on July 12, 2024. The order to administer two syringes of the above ABH (Ativan 0.5 mg/Benadryl 12.5 mg/Haldol 0.5 mg) concentrate gel would provide a total of of 25 mg Benadryl, not 50 mg. There was no documented evidence that the physician evaluated the resident's continued need for the resident's use of the prn antipsychotic medication every 14 days. A review of the Monthly Medication Reviews dated August 2023 through June 2024 revealed no documented evidence that the pharmacist identified irregularities with the physician's order for ABH (Ativan 0.5 mg/Benadryl 12.5 mg/Haldol 0.5 mg) concentrate gel. A review of Resident 101's MAR (Medication Administration Record) dated May 1, 2024 through July 11, 2024, revealed that staff administered two syringes of ABH (Ativan 0.5 mg/Benadryl 12.5 mg/Haldol 0.5 mg) concentrate gel PRN (as needed) 25 times in May 2024, 15 times in June 2024, and 6 times in July 2024. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The pharmacist failed to identify the irregularity in the order for the dosage of the ABH, the lack of supporting diagnosis with the physician order, the increased use of the prn medication, and 30 day prn order. During an interview on July 11, 2024, at approximately 1:00 PM, the Director of Nursing (DON) was unable to provide documented evidence that the facility pharmacist reported or identified any irregularities during Resident 101's monthly medication regimen reviews. Refer F758 28 Pa. Code 211.2 (d)(3)(9) Medical director. 28 Pa. Code 211.9 (k) Pharmacy services. 28 Pa. Code 211.12 (d)(3) Nursing services.

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Forest Hills Rehabilitation & Healthcare Center	1000 Evergreen Avenue Weatherly, PA 18255

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records and a staff interview, it was determined that the facility failed to ensure that a physician evaluated the appropriateness of an as-needed anti-psychotic medication at least every 14 days for one of the five residents sampled. Findings include: Clinical record review revealed that Resident 101 was admitted to the facility on [DATE], with diagnoses that included dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A physician's order was noted on April 14, 2024, for ABH (Ativan 0.5 mg/Benadryl 12.5 mg/Haldol 0.5 mg) Gel, apply topically to the back every 6 hours as needed for anxiety or agitation for 30 days; the order noted Apply 2 syringes = 1mg/50mg/1mg and was discontinued on May 13, 2024. (The ABH gel concentrate contains Ativan {an anti-anxiety medication}, Benadryl {an anti-histamine medication}, and Haldol {an anti-psychotic medication}. The physician order was noted on June 13, 2024, for ABH (Ativan 0.5 mg/Benadryl 12.5 mg/Haldol 0.5 mg) Gel, apply topically to the back every 6 hours as needed for anxiety or agitation for 30 days; Apply 2 syringes =1mg/50mg/1mg and the order was discontinued on July 12, 2024. The physician's orders for ABH gel, dated April 14, 2024, and June 13, 2024, were for a 30-day duration, without physician documentation of the clinical necessity of extending the prn order beyond 14-days. The physician also failed to document in the resident's clinical record, that the resident's use and need of the prn antipsychotic had been evaluated for continued appropriateness. A review of Resident 101's medication administration record (MAR) dated May 1, 2024, through July 11, 2024, revealed staff administered two syringes of ABH (Ativan 0.5 mg/Benadryl 12.5 mg/Haldol 0.5 mg) concentrate gel PRN (as needed) 25 times in May 2024, 15 times in June 2024, and 6 times in July 2024. During an interview on July 11, 2024, at approximately 1:00 PM, the Director of Nursing (DON) was unable to provide documented evidence that the physician had documented the clinical rationale, in the resident's medical record, for the necessity of the extending the prn antipsychotic order beyond 14 days, and without documented evidence that the resident's use and need of the prn antipsychotic had been evaluated for continued appropriateness. Refer F756 28 Pa. Code 211.2 (d)(3)(9) Medical director. 28 Pa. Code 211.9 (k) Pharmacy services.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on review of clinical records and staff interview, it was determined that the facility failed to maintain accurate and complete clinical records, according to professional standards of practice for three residents out of 35 sampled (Resident 127, 149, and 178). Findings include: According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient record to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care: Assessments, Clinical problems, Communications with other health care professionals regarding the patient, Communication with and education of the patient, family, and the patient's designated support person and other third parties. According to the Title 49, Professional and Vocational Standards, Department of State, Chapter 21 State Board of Nursing Subsection 21.11 (a) The register nurse assesses human responses and plans, implements and evaluates nursing care for individuals or families for whom the nurse is responsible. In carrying out this responsibility, the nurse performs all of following functions: (4) Carries out nursing care actions which promote, maintain, and restore the well-being of individuals (6)(b) The registered nurse is fully responsible for all actions as a licensed nurse and is accountable to clients for the quality of care delivered and Subsection 21.18. (a)(5) document and maintain accurate records. According to the Title 49, Professional and Vocational Standards, Department of State, Chapter 21 State Board of Nursing Subsection 21.145. (a) The licensed practical nurse (LPN) is prepared to function as a member of a health-care team by exercising sound nursing judgement based on preparation, knowledge, skills, understanding 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 Resident 127's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included cerebral infarction (occurs when the blood supply to part of the brain is blocked or reduced and prevents brain tissue from getting oxygen and nutrients), muscle weakness, and lack of coordination. A review of Resident 149's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD - is a common, preventable and treatable disease that is characterized by persistent respiratory symptoms like progressive breathlessness and cough), emphysema (is a lung condition that causes shortness of breath due to damage to the air sacs in the lungs (alveoli) and over time, the surface area of the lungs is reduced and the amount of oxygen reaching the bloodstream is decreased). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of information dated April 16, 2024, at 1:00 p.m., submitted by the facility revealed that bed bugs were found in Residents 127 and 149's room and that both residents were relocated to two separate rooms. A review of Resident 127's clinical record, conducted during the survey ending July 12, 2024, revealed no documented evidence of the bed bugs in the resident's room and evidence that the resident was assessed for any physical effects, such as bites, rash, swelling or skin irritation. There was also no documented evidence that Resident 127's representative was informed of the temporary room change and the reason. A review of Resident 149's clinical record, conducted during the survey ending July 12, 2024, revealed no documented evidence of the bed bugs in the resident's room and evidence that the resident was assessed for any physical effects, such as bites, rash, swelling or skin irritation. There was also no documented evidence that Resident 149's representative was informed of the temporary room change and the reason. During an interview with the Director of Nursing (DON) on July 11, 2024, at 11:20 a.m., revealed that when the bed bugs were found the nursing performed skin assessments, but did not document the assessment in the resident's clinical record. The DON confirmed that Resident 127 and 149's clinical records did not include documented evidence of the bed bugs, physical assessment of the residents, and any measures taken with the residents related to the bed bugs. Review of the clinical record revealed that Resident 178 was admitted to the facility on [DATE], with diagnoses to include anoxic brain damage, hypertension, and disorientation. Nursing noted on June 6, 2024, at 1:34 AM that a nurse aide informed the nurse that Resident 178 stated that she wanted to kill herself. The nurse spoke with resident, who stated that she does not have a plan, but does wish to die. A Social Services note dated June 6, 2024, at 3:16 PM indicated that a support visit held with resident secondary to suicidal ideations. Resident is alert, oriented to person, resting in bed, without appearing in any distress, speaking calmly. The resident did confirm not wishing to hurt herself and denies any suicidal ideations at this time. Resident appeared to feel safe within her surroundings and did not voice any concerns. Referral made for psych services. Resident 178 does not receive any psychotropic medications, according to the entry. A review of a psychiatry note dated June 10, 2024, at 12:00 AM indicated that the resident was seen for an initial psychiatric evaluation. She admits to anxiety, depression, and racing thoughts. Tearful throughout visit and per staff, her mood is very anxious. Sleep waivers, appetite limited. Denies suicidal/homicidal ideation). Resident has been compliant with psychotropic medications with no adverse effects noted. No problems reported per staff or nurses, notes. No concerns noted during visit today. The continued use of psychotropics is in accordance with relevant current standards of practice and any attempted dose reduction would be likely to impair the resident's function or exacerbate their underlying psychiatric disorder. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the resident's medication administration record (MAR) for the month of June 2024, revealed however, that the resident was not prescribed, nor received any psychotropic medications at the time of the psychiatry note dated June 10, 2024. The psychiatry note dated June 10, 2024, at 12:00 AM did not reference awareness of the resident's statement that she was going to kill herself, and wished to die. The psych note also inaccurately documented that the resident was receiving psychotropic medications, when no physician orders, for psychotropic medications, were in effect and the resident had not been prescribed psych meds at that time Interview with the Director of Nursing (DON) on July 11, 2024, at approximately 9:25 AM, confirmed that there was no documented evidence in the resident's psychiatry note dated June 10, 2024, at 00:00 hours (12:00 AM), of the resident's statement of suicidal ideations, and that the note inaccurately documented that the resident was receiving psychotropic medications. 28 Pa. Code 211.5 (f)(iii) Medical records. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on observation, clinical record review, and staff interview, it was determined that the facility failed to ensure the coordination of hospice services with facility services to meet the resident's needs on a daily basis for two out of 35 residents sampled (Residents 98 and 101). Findings include: Clinical record review revealed Resident 101 was admitted to the facility on [DATE], with diagnoses that included dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities) and atherosclerotic heart disease (a condition characterized by the thickening or hardening of arteries caused by a buildup of plaque in the inner lining of an artery). Resident 101's care plan, revised April 5, 2024, indicated that the resident has a terminal prognosis with hospice care related to end-of-life diagnoses of cerebral atherosclerosis with a planned intervention indicating that nursing staff will collaborate with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs are met. The resident's care plan also indicated that hospice nurse aides are scheduled to visit Resident 101 every Tuesday and Friday at 12:00 PM, and a hospice registered nurse will visit every Tuesday at 12:00 PM. Resident 101's care plan indicated that integrated care will be provided by facility nursing staff and external hospice staff, ensuring the resident's physical and psychosocial needs are met. A physician's order was noted April 6, 2024, for Resident 101 to receive hospice care for a diagnosis. However, a review of the resident's clinical record revealed no documented evidence of that Resident 101 was diagnosed with Parkinson's disease. A review of the clinical record revealed that Resident 98 was admitted to the facility on [DATE], with diagnoses that included Parkinson's disease (a disease that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination) and quadriplegia (severe or complete loss of motor function in all four limbs). Resident 98's care plan, dated April 5, 2024, revealed that the resident had a terminal prognosis and was under the care of a hospice provider related to Parkinson's disease. Resident 98's care plan indicated that integrated care will be provided by facility nursing staff and hospice staff, ensuring the resident's physical and psychosocial needs are met. An intervention was planned for nursing staff to collaborate with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs are met. The care plan indicated that hospice nurse aides are scheduled to visit Resident 98 Monday through Friday at 10 AM, and a hospice registered nurse will visit every Tuesday, Thursday, and Friday at 11:30 AM. A physician's order was noted on April 6, 2024, for Resident 98 to receive hospice care related to a diagnoses of Parkinson's disease. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When reviewed at the time of the survey ending July 12, 2024, there was no documented evidence in Resident 98's and 101's clinical records of the communication between hospice nurse aides and hospice registered nurses and facility nursing staff. An observation on July 11, 2024, at approximately 10:00 AM revealed Resident 98 and Resident 101's hospice communication binder in the 2nd floor nursing station. When reviewed binder contained no documented evidence of the care provided by the hospice registered nurses or hospice nurse aides. During an interview on July 11, 2024, at approximately 1:00 PM, the Director of Nursing (DON) was unable to provide documented evidence that hospice staff was communicating the care and services provided during their scheduled visits with Residents 98 or 101. The DON stated that communication information should be kept in each resident's hospice communication binder to coordinate care and ensure the resident's physical and psychosocial needs are met. 28 Pa. Code 211.5 (f)(ii)(iii) Medical records. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (d)(3)(5) Nursing services.