STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395537	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roosevelt Rehabilitation and Healthcare Center	7800 Bustleton Avenue Philadelphia, PA 19152

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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 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. 38735 Based on a resident group interview, observations, and interviews with staff, it was determined that the facility failed to display proper contact information for the State Survey Agency, including the Hotline number on three of three nursing floors and lobby area. (Second, Third, Fouth Floor and lobby) Findings include: A Resident Council interview was held on April 24, 2025, at 1:30 p.m. with nine alert and oriented residents who regularly attend resident council meetings. When asked if they knew how to contact the Pennsylvania Department of Health (DOH) with a complaint, all residents said no. When asked again if anyone knew how to contact DOH, they all shook their head no, and Resident R103 said that he never saw this number posted, and that they should hand out pamphlets to everyone. Observations in the lobby area and on all three of the nursing floors (Second, Third and Fouth) on April 23, 2025, at 2:30 p.m. with the Administrator revealed that the State Department of Health contact information was not posted in the lobby or on any of the three nursing floors as required. Interview with the Administrator April 23, 2025, at 2:45 p.m. confirmed that the contact information was not posted as required. 28 Pa. Code 201.18(b)(1)(3) (e)(1) Management 28 Pa. Code 201.29(c.1) Resident rights

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38735 Based on clinical record review and staff interview, it was determined that the facility failed to monitor the urine output one of one resident review with a urinary indwelling catheter. (Resident R49) Findings include: Review of Resident R49's clinical record revealed that Resident R49 was admitted to the facility on [DATE], with diagnoses of but not limited to Multiple Sclerosis (slow progressive disease of the central nervous system), Spastic Hemiplegia (weakness on one side of the body), and Presence of Urogenital Implants, Review of Resident R49's physician's orders revealed the following order: Urinary Catheter # 16 Fr/30ml balloon inflation to urinary Drainage Bag. Observation conducted on April 21, 2025, at 10:25 a.m. revealed that Resident R49 had a urine bag hanging under her bed with tubing connecting the bag to the resident. Further observation revealed that the urine bag and the tubing contained 50 cc of very cloudy liquid with sediments settling at the bottom of the urine tubing and urine bag. Further the urine bag did not have a date affixed to it. Interview with Licensed nurse, Employee E20 conducted on April 21, 2025, at 10:25 a.m., confirmed that the urine in the bag was very cloudy. Further Employee E20 revealed that she sometimes changes the bag once a week. Further Employee R20 revealed that it is the facility policy that the urine bag is dated however, PRN staff (staff hired to work whenever needed) doesn't always change the bags. Employee E20 did not know when the urine bag was last replaced. Review of Resident R49's clinical record revealed no documented evidence that Resident R49's urine output was monitored. Further review of Resident R49 clinical record revealed no documented evidence that the physician was made aware of Resident R49's cloudy urine. Further, there was no documented evidence of monitoring/observation of Resident R49's status after the cloudy urine was observed. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.12(c) Nursing services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47973 Based on clinical record reviews and staff interviews, it was determined that the facility failed to implement interventions to maintain acceptable parameters of nutrition for one of 8 residents reviewed for nutrition. (Residents R38) Findings include: Review of facility policy titled, Supplementation dated January 2025, revealed that resident may benefit from a therapeutic supplement if they present with unplanned weight loss; impaired skin integrity; and reduction in the amount of food or drink is consumed by mouth. Review of Resident R38's clinical record revealed that the resident was admitted to the facility was on February 25, 2025, with diagnoses including malnutrition (lack of sufficient nutrients in the body), metabolic encephalopathy (brain dysfunction), muscle weakness, and cachexia (ill health involving weight and muscle loss). Further review revealed a BIMS score of three, indicating severe cognitive impairment. Review of Resident R38's nutrition assessment dated [DATE], revealed that the resident weighed 99 pounds, and had a BMI of 13 (extremely underweight). Further review revealed that the resident consumed 26-100% of meals. Review of Resident R38's care plan, date-initiated March 1, 2023, revealed that supplements should be provided during meals per resident's preference. Review of physician orders for Resident R38, revealed an order dated April 10, 2025, for Ensure Plus, three times a day for supplementation. Continued review Resident R38's clinical records including Medication Administration documentation failed to reveal documented evidence indicating that the Ensure Plus was provided for the resident three times a day. Observations of resident's lunch tray conducted on April 22, 2025, at 12:25 p.m. failed to reveal the Ensure Plus supplement on resident's tray. Follow-up observations of resident's conducted on April 23, 2025, at 12:14 p.m. failed to reveal the Ensure Plus supplement on resident's tray. Nurse manager, Employee E11, confirmed this finding. Interview with the Registered Dietitian, Employee E9, conducted on April 23, 2025, at 2:12 p.m. confirmed that there is no documented evidence indicating that the supplement was provided to Resident R38, per physician order. Interview with the facility Director of Nursing, conducted on April 24, 2025, at 9:35 a.m. confirmed that there was no documented evidence indicating that the resident received Ensure Plus Supplement on April 10, 2025, through April 23, 2025. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(c) Resident care policies 28 Pa. Code: 211.12(c)(d)(1)(2)(3)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39343 Based on observation, clinical record review, review of facility policy and staff interview, it was determined that the facility failed to provide appropriate respiratory care and services for one of six residents reviewed (R125). Findings include: Review of the Facility Policy and Guidelines for Implementation of Oxygen Administration indicated that the nurse should review and follow the physician's orders while administering Oxygen via nasal canula. Review of Resident R125's clinical record revealed; the resident was initially admitted to the facility on [DATE]. Resident R125 was diagnosed with Chronic Obstructive Pulmonary Disease (Chronic Obstructive Pulmonary Disease -COPD- is a progressive lung disease characterized by airflow obstruction, primarily caused by long-term exposure to irritants like cigarette smoke), and Acute Respiratory Failure (Acute respiratory failure is a life-threatening condition where the lungs cannot adequately provide oxygen to the blood or remove carbon dioxide). Review of clinical record indicated that Resident R125 was ordered on January 3, 2025, Oxygen at 2 Liters/ Minute via Nasal Cannula to keep pulse ox > 92%, every shift for Diagnosis: COPD. Observation conducated on April 22, 2025, at 9:20 a.m., revealed that Resident R125 was administered Oxygen at 5 Liters/Min, via Nasal Canula., and not 2 Liters/Min, as ordered by the physician; and the same was confirmed with a Licensed Nurse, E21, at the time of the finding. 28 Pa Code 211.12(d)(5) Nursing services

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 39343 Based on staff interviews and the review of clinical records, it was determined that the facility failed to maintain complete and accurate records related to dialysis communication for two of four dialysis residents reviewed (Residents R66, R125). Findings include: Review of Resident 66's physician order, dated March 6, 2025, revealed Resident R66 received dialysis treatment on Tuesdays, Thursdays, and Saturdays. Review of Resident R66 's Hemodialysis Communication Record revealed that it was lacking the following information as required per the communication log: On March 6, 2025, March 13, 2025, March 15, 2025, March,20, 2025, March 20, 2025, March 25, 2025, April 3, 2025, April 8, 2025, the information for new orders received and sent with patient, comment; shunt site observation; ports capped and completed yes or no, patient reports pain yes or no, lab values; pertinent /relevant observations; Signature/Title of staff, andTime. Interview with the Licensed Nurse, Employee E22, on April 24, 2025, at 10:09 a.m., confirmed lack of information in the Hemodialysis Communication Record of Resident R66. Review of Resident 125's physician order, dated January 3, 2025, revealed Resident R125 received dialysis Treatment on Tuesdays, Thursdays, and Saturdays. Review of Resident R125 's Hemodialysis Communication Record revealed that it was lacking the following information as required per the communication log: On April 3, 2025, the information for new orders received and sent with patient, comment; shunt site observation; ports capped and completed yes or no, patient reports pain yes or no, lab values; pertinent /relevant observations; signature/title of staff, and time. Interview with Licensed Nurse, Employee E22, on April 24, 2025, at 10:27 a.m., confirmed lack of information in the Hemodialysis Communication Record of Resident R125. 28 Pa Code 211.5(f) Clinical records 28 Pa Code 211.12(d)(3) Nursing services

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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** 38735 Based on clinical record review and staff interview, it was determined that the facility did not ensure the timely acquiring of medications from pharmacy for a newly admitted resident for one of one of 35 residents reviewed . (Resident R277). Findings Include: Review of the Policy, Administering Medications, Revised April 2019, states Medications are administered in a safe and timely manner, and as prescribed. Interview with Resident R277 on April 21, 2025, at 11:00 a.m. revealed that he did not get his prescribed cardiac medications on the day of his admission on April 19, 2025. Resident R277's wife confirmed this stating that she was very upset that they did not have his heart medications available. Review of the medical record revealed that Resident R277 was admitted on [DATE], with diagnosis including, but not limited to acute congestive heart failure (a sudden, life-threatening condition in which your heart is unable to do its job. Your heart is still beating, but it can't deliver enough oxygen to meet your body's needs). Further review of the clinical record for Resident R277 revealed an April 19, 2025, Carvedilol (a beta-blocker, which affect the heart and blood flow through arteries and veins, used to treat heart failure and hypertension (high blood pressure) oral tablet 3.125 mg, give one tablet by mouth every 12 hours for high blood pressure starting April 19, 2025, at 9:00 p.m. And an April 19, 2025, physician's order for Entresto oral tablet 24-26 mg (Sacubitril-Valsartan, a combination medicine that is used in adults with chronic heart failure) give one tablet by mouth every 12 hours for heart failure starting April 19, 2025, at 9:00 p.m. And an April 20, 2024 physician's order for Rivaroxaban (used to treat or prevent blood clots) oral tablet, 20 mg, give one tablet by mouth in the evening for pulmonary embolism (a blood clot in your lung that creates a blockage. This causes issues with blood flow and oxygen levels in your lungs. This is a medical emergency). And an April 20, 2025, physician's order for Spironolactone (is a potassium-sparing diuretic (water pill) that prevents your body from absorbing too much salt and keeps your potassium levels from getting too low) oral tablet, 25 mg, give 0.5 tablet by mouth one time a day in the morning for heart failure Review of the medication administration record for Resident R277 revealed that the Carvedilol that was ordered for April 19, 2025, at 9:00 p.m. was not administered on April 19, 2025, at 9:00 p.m., and that the April 20, 2025, 9:00 a.m. dose was coded 5, which is held. And that the first dose of Carvedilol was not administered until 9:00 p.m. on April 20, 2025. Further review of the medication administration record for Resident R277 revealed that the Entresto that was ordered for April 19, 2025, at 9:00 p.m. was not administered on April 19, 2025, at 9:00 p.m., and that the April 20, 2025, 9:00 a.m. dose was coded 5, which is held. And that the first dose of Entresto was not administered until 9:00 p.m. on April 20, 2025. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medication administration record for Resident R277 revealed that the Rivaroxaban and Spironolactone, important cardiac medications that the resident had been on in the hospital and recommended for use at the facility were not ordered until the day after the resident was admitted . And that the Spironolactone was ordered to be administered at 9:00 a.m. and 9:00 p.m., and that the 9:00 a.m. dose on April 20, 2025, was coded 5, or held, and his first dose was not administered until 9:00 p.m. on April 20, 2025. Interview with the Director of Nursing (DON), and Administrator, on April 24, 2025, at 10:50 a.m. confirmed that the resident was admitted at 5:00 p.m. on April 19, 2025, and that he was on these four heart medications, and that these medications were not available on April 19, 2025, and that the medications that were coded 5, for being held, should not have been coded as held, as there were no parameters in the physician orders for holding the medication. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.12(c) 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** 48347 Based on clinical record reviews, review of facility policies and documentation and interviews with staff, it was determined that the facility failed to ensure the pharmacist recommendations were reviewed by the physician in a timely manner for three of five residents reviewed related to medication regime reviews (Resident R78, Resident 93 and Resident R114). Findings include: Review of facility policy, Medication Regimen Reviews revised May 2029 revealed the consultant pharmacist reviews the medication regimen of each resident monthly with the goal is to minimize adverse consequences of potential risk of medications. An irregularity refers to the medication that is inconsistent with acceptable pharmaceutical services standard of practice, the drug may not be supported by medical evidence, or without adequate monitoring, and or excessive doses that can be a risk to persons life, health or safety. The consultant pharmacist will then contact the physician, to report the irregularity. The physician then documents that the irregularity has been reviewed and action has taken place to address it. Review of consultant pharmacist Medication Regimen Review Recommendation for Resident R78 revealed a recommendation of resident has in order for sliding scale insulin lispro. Per package insert, insulin lispro is recommended to be dosed within 10 to 15 minutes of a meal. Please update the doctor order. Further review of consultant pharmacist recommendation for Resident 78 revealed the physician agreed with recommendation and responded that the insulin time has been adjusted. This document was signed by the physician. Review of Resident R78's clinical record review revealed a physician order dated July 11, 2024, for the drug insulin Lispro Solution 100 unit/ml with instruction to inject subcutaneously three time a day related to type 2 diabetes mellitus (group of diseases that result in too much sugar in the blood). No indication that this ordered was changed to be given with meals. Review of Resident R78's medication administration record schedule for April 2025 revealed the medication insulin lispro solution 100 unit per ML with instructions to inject as per sliding scale subcutaneously three times a day for diabetes. Review of pharmacist recommendation for Resident R93 dated February 22, 2025, revealed the following labs are missing from patient chart and are required to monitor safety and efficiency of medication. Please consider adding the following to the next lab draw thank you the labs recommended recommended are CMP (Complete Metabolic Panel, lipid panel, A1C, AMIODARONE level, vitamin D level, and TSH (Thyroid Level). Further review of this document revealed the physician wrote ordered on the document, indicating the physician ordered the recommended lab work for Resident R93 and signed the document. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R93's physician orders, revealed no orders for the above recommendation of lab work . Review of Resident R93's physician order dated November 13, 2024, revealed a physician order for Flomax capsule 0.4 MG (tamsulosin) with instructions give one capsule by mouth at bedtime for benign prosthetic hyperplasia. Review of consultant pharmacist recommendations dated March 16, 2025, revealed currently receiving Tamsulosin [NAME] 0.4 MG at bedtime. Per literature, Flu Max is best absorbed and has best chance for clinical efficiency when given after dinner. Please consider switch flow Max 0.4 MG once daily after dinner Further review of this document revealed physician response stated that the physician disagreed with pharmacist's recommendation and instructed continue with HS (night) time. This document has not been signed or dated by the physician. Review of facility document entitled MRR Consultant Pharmacy Recommendations to Prescriber dated February 22, 2025, for Resident R114 revealed that Resident R114 currently receiving antihypertensive therapy without routine blood pressure and pulse monitoring. Please consider adding order for weekly BP and pulse, if appropriate. Further review of the document revealed OK written on it but signatures and date from physician indicating that the physician has reviewed the document. Review of Resident R114's clinical record revealed no other documented evidence that the physician has reviewed the document and did not have any documented evidence of actions taken by the physician to address the pharmacy recommendations. Interview with Director of Nursing, Employee E2 on April 24, 2025, at 12:50p.m. confirmed there was no evidence that these recommendations were noted and completed. 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.5 (h) Clinical records 28 Pa. Code 211.9 (f)(3) Pharmacy Services

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 39343 Based on observations, review of clinical records, and interviews with facility staff, it was determined that the facility failed to ensure that it was free of medication error rate of five percent or greater for three of seven residents observed during medication administration (Residents R17, R20, and R195). Findings include: On April 22, 2025, at 9:29 a.m., observed that Employee E21, a Licensed Nurse, administered to Resident R20, the medicine, Breo Ellipta Aerosol Powder Breath Activated 200-25 MCG/INH (Fluticasone Furoate-Vilanterol), one puff inhale orally, and it was noticed that R20 did not rinse his mouth after inhaling Breo Ellipta Aerosol Powder. Review of physician order for Resident R20, revealed an order, dated June 29, 2022, to administer Breo Ellipta Aerosol Powder Breath Activated 200-25 MCG/INH (Fluticasone Furoate-Vilanterol), one puff, inhale orally one time a day for COPD, Rinse mouth and spit after administration. The Licensed Nurse, Employee E21, did not follow the physician order as the Resident R20 inhaled Breo Ellipta Aerosol Powder Breath Activated 200-25 MCG/INH, one puff; but did not rinse his mouth after inhaling Breo Ellipta Aerosol Powder. Review of literature revealed that inhaled corticosteroids like Breo Ellipta Aerosol Powder can sometimes lead to a fungal infection in the mouth and throat, known as oral thrush or oropharyngeal candidiasis. Rinsing mouth with water after each dose helps remove any remaining medication from the mouth and throat, reducing the risk of this infection. At the time of the finding, during an interview with Licensed nurse, Employee E21, confirmed the above findings. On April 22, 2025, at 9:44 a.m., observed that Employee E22, a Licensed Nurse, was administering Resident R17, the morning scheduled medicines. Review of physician order for Resident R17 indicted an order dated February 14, 2025, to administer, Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol), 3 ml inhale orally three times a day related to Other Tracheostomy Complication. The Licensed Nurse, Employee E22, double checked the medication cart and checked with other nurses, and stated that the facility did not have Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol), 3 ml, and they are waiting for it from the pharmacy. E22 could not administer to R17, the medicine Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol), 3 ml to inhale orally. On April 23, 2025, at 9:10 a.m., observed that Employee E23, a Licensed Nurse, administered the medicine, Aspirin Tablet Enteric Coated 81 MG, to Resident R195. Review of physician order dated January 25, 2024, for R195, revealed an order to administer Aspirin Tablet Chewable 81 MG, Give 1 tablet by mouth one time a day, monitor for signs and symptoms of bleeding. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of literature revealed as follows: Regular Aspirin is absorbed in the stomach, while Enteric-Coated aspirin is absorbed in the small intestine. Do not crush or chew enteric-coated tablets. Doing so can increase stomach upset. Do not crush or chew extended-release tablets or capsules. Doing so can release all of the drug at once, increasing the risk of side effects. At the time of the observation, interview with Employee E23, confirmed the above findings. The facility incurred a medication error rate of 10.34%. Pa Code:211.12(d)(1)(2)(5) Nursing Services.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 38735 Based on review of facility documentation, observations, and resident and staff interviews, it was determined that the facility failed to provide food and drink that was palatable and served at the proper temperature for 6 of 6 residents interviewed (Residents R113 R195, R279, R103, R189 and R12). Findings include: Interview with Resident R12 conducted during the tour of the first floor unit on April 21, 2024 at 01:31 PM complained that food was cold and that she does not always get the meal items that she requested for. Interview with Resident R113, on April 21, 2025, at 11:41 a.m. revealed that the food is cold, especially the pancakes, ant that they never have cold cereal available. Interview with Resident R195, on April 21, 2025, at 11:45 a.m. revealed that the food the food sucks and is always cold. Interview with Resident R279, on April 21, 2025, at 11:49 a.m. revealed that the meals are messed up, the eggs are dry, that she doesn't like coffee, that they send a tea bag, but no hot water, and they don't send enough sugar for my hot tea and the cereal, and the food is always cold. During a group interview on April 23, 2025, at 1:30 p.m. when food was brought up and all residents agreed that there were problems with the food. Resident R103 stated that the food is always cold, and that this was an ongoing problem. Resident R189 stated that her rib sandwich today was cold. Observations during a test tray conducted with the Food Service Director, Employee E12, on April 23, 2025, at 11:35 a.m. revealed apple juice registered 46.5 degrees Fahrenheit (F); canned pineapple registered 65 degrees F; mashed potatoes 126 degrees F; pork riblet 111 degrees F; and mixed vegetables degrees F. Follow-up interview with the Food Service Director, at 11:52 a.m. revealed that that foods should be reaching 140 degrees F and confirmed that the tested food items were too cool to be palatable. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 211.6(f) Dietary services

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	395537	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roosevelt Rehabilitation and Healthcare Center	7800 Bustleton Avenue Philadelphia, PA 19152

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 38735 Based on observations, and resident and staff interviews, it was determined that the facility failed to honor resident food and drink preferences by providing food that was requested by and acceptable to the residents for six of 35 residents reviewed (Residents R279, R103, R189, R31, R53 and R27). Findings include: Interview during the initial tour of the 2 North unit with Resident R279 on April 21, 2025, at 11:35 a.m. revealed that she does not get the right food, not what I choose on my menu, that this happens several times a week. During a group interview on April 23, 2025, at 1:30 p.m. when food was brought up and all residents agreed that there were problems in the kitchen. Resident R103 stated that you don't always get what you want. Resident R189 stated that she does not always get what she wants either. Resident R31 stated that things are not always right on her meal tray, they forget things like my sugar. Interview with the Administrator on April 24, 2025, at 12:45 p.m. revealed that there had been problems in the kitchen and that they brought a management company in to run the kitchen two months ago and she feels things are getting better. Review of Resident R53 lunch meal ticket placed on his lunch tray on April 21, 2025, at 12:36 p.m. revealed a notation on the ticket that read, no pasta. Observation on April 21, 2025, at 12:36 p.m., Resident R 53's lunch tray consisted of a plate of spaghetti and meatballs. Interview with Resident R53 at time of the above observation, he stated I never get the right food, and the food does not match the ticket on the tray Interview on April 21, 2025, at 12:40 p.m. with Nursing aide, Employee E16 confirmed that the lunch ticket specified no pasta, and the resident was given pasta for lunch. Review of Resident R 27's quarterly minimum data set (MDS - a federal mandated assessment for all residents) dated February 28, 2025, revealed Resident R27 was admitted into the facility February 17, 2018, with a diagnosis of multiple sclerosis (a chronic disease immune disease that cause breakdown of the protective covering of nerves)and dependent on assistance for all activities of daily living including: transfers, personal hygiene, dressing, bathing, toileting and eating. This resident was on a mechanically altered diet and a therapeutic diet. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident R27's family member on April 22, 2025, at 12:39 p.m. on the third-floor nursing unit revealed that this resident did not receive the sandwich that is supposed to be given every day. This resident's family member revealed that she has purchased specific lunch meat, bologna, to be given to the resident for meals stating the resident will only eat this. She has also purchased apple sauce and cranberry juice because of the uncertainty of Resident R27 receiving these items from the staff. Observation of residents' lunch tray on April 22, 2025, at 12:40 p.m. revealed lunch ticket indicating that Resident R27's lunch tray should consist of fried fish, vegetables, and sweet potato fries. Further observation of this lunch tray revealed the resident received a turkey sandwich only. Interview with Licensed nurse, Employee E18 at time of the above interview revealed that Employee E18 was aware that Resident R27 was supposed to receive bologna sandwiches from the kitchen. Employee E18 confirmed that Resident R27's tray contained a turkey sandwich and was not sure why she received a turkey sandwich. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 211.6(a) Dietary services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47973 Based on observations, review of facility policy and interviews with staff, it was determined that the facility did not ensure that food was stored, prepared, distributed and served in accordance with professional standards for food service safety. Findings include: Review of facility policy titled, Food Receiving and Storage dated 2001 indicated that refrigerated foods should be labeled, dated and monitored so they are used by their use by date, frozen, or discarded. A tour of the Food Service Department was conducted on April 21, 2025, at 9:37 a.m. with Employee E12, Food Service Director (FSD), revealed the following concerns: Observations revealed a foul smell, caused by food debris, in the dishwasher area. The walls contained streaks of black dirt. Observations in the walk-in cooler revealed the following items were dated with the received date only: 10-pound turkey received 4/16; beef bologna received 4/4; and two 10-pound ground beef received 4/18. Continued observations revealed top round with a received date of 4/16; interview with he FSD revealed that it was pulled from the freezer and did not contain a date of when it was removed from the freezer to defrost. 28 Pa. Code 201.14(a) Responsibility of licensee

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39343 Based on observation, review of facility policy and procedure and interviews with staff, it was determined that the facility failed to maintain an effective infection control program related to appropriate cleaning techniques for medical equipment, on four of the seven Medication Administration Reviews (Residents R20, R176, R195, R227), and the Enhanced Barrier Precautions for four of seven residents treatments reviewed (R97, R168, R176, R195). Findings include: Review of facility policy titled Infection Prevention and Control Program revised June 2022, revealed the facility has an infection prevention and control program which monitors development and transmission of communicable disease and infections to promote safe sanitary and comfortable environment for residents' staff and visitors. Policies of this program include standard of transmission-based precautions and how and when isolation should be used for a resident including type and duration of isolation hand hygiene procedures. Review of facility policy and procedure titled Guidelines for Isolation Precaution revised March of 2023 revealed the policy is to reduce the risk of the transmission of infectious agents by utilizing in isolation guidelines established by the Center for Disease Control (CDC). Enhanced barrier precautions should be used in conjunction with standard precautions and enhanced barrier precautions are used as an infection control intervention designed to reduce the transmission of multi drug resistant organisms (MDROs) that is proportion extends the use of personal protective equipment (PPE) and refers to the use of gown and gloves during high contact resident care activities that provide opportunities for the transfer of MDROS to staff hands and clothing enhanced barrier precautions will be applied to all residents with any of the following; wounds, indwelling medical devices, regardless colonization status, staff will be properly trained on the proper use of PPE and will be implemented while resident high contact resident care activities that require gown and glove use include dressing, bathing showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care ,or use of central line, urinary catheter, feeding tube, tracheostomy, ventilator and wound care. Review of Resident R168's clinical record revealed that the resident had the diagnoses of Quadriplegia, Hemiplegia, and dysphagia (difficulty swallowing), The resident was dependent of tube feeding. Review of Resident R168's care plan revealed I require enhanced barrier precautions related to feeding tube dated June 24, 2025, with interventions including gloves and gown must be worn during high contact care activities, dressing, bathing, showering, transferring, providing hygiene care, changing linens, changing briefs assisting with toileting, and device care or use. Observation of Resident 168's room door revealed no enhanced barrier signage or any indication that the resident was on any precaution. Observation of nurse aide, Employee E13 and nurse aide, Employee E14 providing care including bathing resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R168 and changing this resident's incontinence briefs revealed that neither Employee E13 or Employee E14 were were wearing a gown as required PPE for enhanced barrier precautions. Interview with nurse aide, Employee E14 confirmed there was no signage of enhanced barrier precaution on the door. Nurse aide, Employee E14 employee was not aware that a gown was warranted. Interview with licensed nurse, Employee E18 on April 22, 2025, at 12:18 p.m. confirmed no enhanced barrier precaution signage was on Residents R168's room door and on three other doors on the third-floor nursing unit. Employee E168 stated that the signs were locked in the Assistant Director of Nursing (ADON), Employee E5 's office. Interview with ADON, Employee E5 on April 23, 2025, at 11:32 a.m. revealed that all employees are made aware of any precaution, including enhanced barrier precaution on the floor during morning meeting prior to the shift. All employees have received education of what PPE is required for enhanced barrier precaution and when all PPE must be worn. Employee E5 stated she did not know why the employees were not following the protocol and the signs alerting staff and visitors. Review of Resident R97's clinical record revealed that Resident R97 was admitted to the facility on [DATE], with current diagnoses of Infection and Inflammatory reaction due to indwelling urethral Catheter Sequela, Obstructive and Reflux Uropathy. Review of Resident R97's physician's orders revealed an order for: Urinary Catheter: Maintain SPC (suprapubic catheter) catheter with16F 10ml balloon for Obstructive Uropathy. Observation conducted on April 21, 2025, at 10:25AM revealed that Resident R97 was in bed with a urine bag. Further, Urine bag and tubing was observed with cloudy with red tinged residue. Further observation revealed that there was no signage for EBP (Enhanced Barrier Precaution) signage posted outside Resident R97's room. Follow-up observation conducted on April 22, 2025, at 10:47AM revealed that nurse aide, Employee E18 was in Resident R97's room providing care to Resident R97 without a PPE (personal protective equipment). Interview with nurse aide, Employee E18 conducted at the time of the observation confirmed that she did not use PPE and that she did not know she had to wear PPE because there was no signage outside the door. Interview with nurse aide, Employee E19 conducted on April 22, 2025, at 10:50 AM revealed that she knows that she has to use PPE because of the sign posted outside the door. Further Employee E19 revealed that without the sign will not know that she has to wear PPE. Interview with Infection Preventionist Employee E5 revealed that the unit managers are responsible for putting up EBP precaution). On April 22, 2025, 9:29 a.m., during medication administration, to Resident R20, Employee E21, a Licensed Nurse, used the sphygmomanometer (an instrument for measuring blood pressure), without disinfecting it, which was used for checking blood pressure of other residents. At the time of the finding, Employee E21 confirmed the same. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On April 23, 2025, 8:59 a.m., during medication administration, to Resident R 227, Employee E23, a Registered Nurse, used the sphygmomanometer, without disinfecting it, which was used for checking blood pressure of other residents. At the time of the finding, E23 confirmed the same. On April 23, 2025, at 9:08 a.m., review of Physician order dated June 24, 2024, for Resident R195 revealed; Enhanced Barrier Precautions, Every Shift. Observation on April 23, 2025, at 9:10 a.m., revealed that a Registered Nurse, Employee E23, was applying sphygmomanometer, to Resident R195 to check the resident's blood pressure. Employee E23 did not wear the PPE, even though Resident R195 was on Enhanced Barrier Precautions. The Registered Nurse, Employee E23 used the sphygmomanometer, without disinfecting it, which was used for checking blood pressure of other residents. At the time of the finding, confirmed the same with E23. On April 23, 2025, at 9:20 a.m. a review of physician order dated March 22, 2025, for Resident R176 revealed; Enhanced Barrier Precautions, Every Shift. Observation on April 23, 2025, at 9:23 a.m., revealed that a Registered Nurse, Employee E23, was applying sphygmomanometer, to Resident R176 to check the resident's blood pressure. Register Nurse, Employee E23 did not wear the PPE, even though Resident R176 was on Enhanced Barrier Precautions. Registered Nurse, Employee E23 used the sphygmomanometer, without disinfecting it, which was used for checking blood pressure of other residents. At the time of the finding, confirmed the same with Registered Nurse, Employee E23. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(d) Management 28 Pa Code 211.12 (d)(1)(5) Nursing services