STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Anne Home	685 Angela Drive Greensburg, PA 15601

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 48809 Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to determine if residents were safe to self-administer medications for one of 48 residents reviewed (Resident 58). Findings include: The facility's self-administration of medications policy, dated October 13, 2023, indicated that if a resident desired to self-administer medications, they would require a physician's order. The facility's medication administration policy, dated October 13, 2023, indicated that the nurse must stay with the resident until the medication is taken. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 58, dated June 14, 2024, indicated that the resident was cognitively intact and required extensive assistance from staff with care. Current physician's orders included an order for the resident to receive a 100 mg tablet of Colace (a medication to treat constipation) twice a day; 5 mg of Eliquis (a blood thinning medication), 1 tablet in the a.m.; 800 mg of Renvela (a medication to control phosphorus levels), 3 tablets once a day; 25 mg of Benadryl (a medication to treat allergies), 1 tablet twice a day; and 81 mg of aspirin in the a.m. The resident's record contained no documented evidence that an evaluation was completed to determine if the resident was capable of self-administering medications and no evidence of a physician's order for self-administering medications. Observations during medication administration on July 25, 2024, at 8:25 a.m. revealed that Resident 58 was lying in bed with a medication cup containing the morning doses of the medications listed above and Licensed Practical Nurse 1 was not in the room. Interview with Licensed Practical Nurse 1 on July 25, 2024, at 8:29 a.m. confirmed that she left the room after administering medication to Resident 58 and did not observe the resident taking his medication. Interview with the Director of Nursing on July 25, 2024, at 1:23 p.m. confirmed that there was no assessment completed to determine if Resident 58 was safe to self-administer medications and no physician's order for self-administration. She also confirmed that Licensed Practical Nurse 1 should not have left the morning medications with Resident 58. (continued on next page)

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F 0554 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 48941 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the resident and/or resident representative had an opportunity to develop an advance directive or assist in formulating an advance directive for three of 48 residents reviewed (Residents 3, 7, 55). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated July 3, 2024, revealed that the resident was cognitively impaired, was understood and able to understand others, required assistance with care needs, and had a diagnosis of dementia. A review of the resident's clinical record revealed no evidence that the resident or their representative was informed of their rights to develop advance directives and no documented evidence that they were provided an opportunity and assistance to formulate one if they chose to do so. A significant change MDS assessment for Resident 7, dated May 26, 2024, revealed that the resident was cognitively impaired, was usually understood and usually understood others, required assistance with care needs, and had diagnoses that included hemiplegia (paralysis or weakness to one side of the body due to brain injury) and stroke. A review of the resident's clinical record revealed no evidence that the resident or their representative was informed of their rights to develop advance directives and no documented evidence that they were provided an opportunity and assistance to formulate one if they chose to do so. A quarterly MDS assessment for Resident 55, dated April 25, 2024, revealed that the resident was cognitively impaired, was understood and understood others, required assistance with care needs, and had a diagnosis of dementia. A review of the resident's clinical record revealed no evidence that the resident or their representative was informed of their rights to develop advance directives and no documented evidence that they were provided an opportunity and assistance to formulate one if they chose to do so. An interview with the Social Service Director on July 25, 2024, at 9:36 a.m. confirmed that the above residents did not have an advance directive. She stated that there was no official admission's person, and there was no official process in place to address advance directives with residents and/or their representatives on admission or periodically during their stay. She revealed that if the residents did not have an advance directive, they were not offered or assisted with formulating one. 28 Pa. Code 201.29(a)(d) Resident Rights.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 42079 Based on clinical record reviews and staff interviews, it was determined that the facility failed to provide the required notice to the resident or the resident's representative following the end of their Medicare coverage or a 48-hour advanced notice for one of three residents reviewed (Resident 122). Findings include: A Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form, completed by the facility and dated July 23, 2024, revealed that Medicare coverage for Resident 122 started on April 21, 2024, and that her last covered day was May 8, 2024. The form indicated that the facility initiated discontinuation from Medicare Part A coverage and that the resident's benefit days were not exhausted. The form was signed by the resident on May 6, 2024. The facility had no documented evidence that the resident was issued a SNF Beneficiary Protection Notification form or an Advanced Beneficiary Notice (ABN) notice as required. Interview with Social Worker on July 24, 2024, at 2:28 p.m. confirmed that Resident 122 did not have an ABN completed timely. She forgot to issue any ABN notices for any residents. 28 Pa. Code 201.18(e)(1) Management.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 48809 Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to provide confidentiality of residents' personal health information during medication administration for one of 48 residents reviewed (Resident 137). Findings include: The facility policy regarding privacy of health information, dated October 13, 2023, indicated that the resident's health information needs to remain private. Observations during medication administration on July 25, 2024, at 8:27 a.m. revealed that Licensed Practical Nurse 1 walked away from the medication cart to assist Resident 137 with something. Resident 137's personal health information was visible on the computer screen, which was facing the hallway. Interview with Licensed Practical Nurse 1 on July 25, 2024, at 8:33 a.m. confirmed that she should have covered the residents' personal information when leaving the medication cart by securing the computer screen. Interview with the Director of Nursing on July 25, 2024, at 11:51 a.m. confirmed that the computer screen with Resident 137's personal health information should have been covered when the nurse was not attending the medication cart. 28 Pa. Code 211.5(b) Clinical Records.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48941 Based on review of facility policies and grievance records, as well as resident and staff interviews, it was determined that the facility failed to make ongoing efforts to resolve a grievance regarding dietary complaints for one of 48 residents reviewed (Resident 5). Findings include: The facility's policy regarding grievances, dated October 13, 2023, indicated that it is the policy of the facility to acknowledge any resident grievance and actively work toward a resolution. The grievance official and/or designee will meet with the party filling the grievance to discuss findings and necessary corrective action. A review of the facility's grievance logs for six months revealed no grievances related to food; however, minutes from the resident council meeting on April 29, 2024, revealed that Resident 5 had concerns with hot food. She documented that it would be nice to have the hot meal cart at all meals. The meals are hotter and taste better. A memo from the Director of Resident and Community Engagement, dated May 2, 2024, revealed that she had spoken with the Dietary Director regarding food concerns including temperatures of food. The Dietary Director stated she would have dietary check to make sure the temperatures are taken properly and food is served at correct temperature. A memo with attached education and a signature page, dated May 4, 2024, revealed that the Dietary Director spoke with dietary staff to make sure temperatures were taken for each meal. Observations of the lunch meal tray line and distribution on July 24, 2024, at 12:14 p.m. revealed that trays were delivered to [NAME] court on a metal, open cart on warmed plates covered by a warmed-plate cover. The cart was not enclosed or insulated. A total of three trays were passed to that unit. The first tray was passed at 12:20 p.m. and the last tray passed was at 12:25 p.m. A test tray for temperature was sampled at 12:25 p.m. The temperature of the foods were as follows: French fries were 108 degrees Fahrenheit (F), the hamburger was 116 degrees (F), and the soup was 153 degrees (F). The French fries and hamburger were cool to taste. Dietary Aide 2, who was temping the foods at the time of the test tray, stated that the food could always be heated up in the microwave if needed. Interview with the Dietary Director on July 25, 2024, at 8:48 a.m. revealed that they have one insulated cart to keep food warm during transport. She stated that the units that have steam tables do not need them and stated she may suggest that they get a couple more. Interview with the Dietary Director on July 25, 2024, at 3:16 p.m. confirmed that dietary staff had been educated on taking food temperatures in the kitchen and that she would have to re-educate them. 28 Pa. Code 201.29(i) Resident Rights.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48941 Based on review of facility policies, clinical records, and investigation documents, as well as staff and resident interviews, it was determined that the facility failed to ensure that residents were free from abuse and neglect for one of 48 residents reviewed (Resident 63). Findings include: The facility's abuse policy, dated October 13, 2023, indicated that residents have the right to be free from any verbal, sexual, physical, and mental abuse; corporal punishment; involuntary seclusion; exploitation; and misappropriation of resident property. Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff or other agencies serving the individual, family members or legal guardians, friends or other individuals. The intent of the policy is to develop and maintain a proactive process of detection and prevention of resident mistreatment, neglect, abuse, and misappropriation of property. Any staff member found guilty of abusing, neglecting or mistreating residents will be discharged immediately. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 63, dated, May 29, 2024, revealed that the resident was cognitively impaired, was sometimes understood and sometimes understood others, required assistance with care needs, and had diagnoses that included dementia, Alzheimer's disease, and anxiety. A cognitive care plan for Resident 63, dated March 10, 2023, revealed that the family reported Resident 63 was triggered by showers and gets agitated around 10:00 to 10:30 a.m. and in the evening. A current care plan for Resident 63 regarding her activities of daily living revealed that she was afraid of showers and bathtubs. A facility investigation document, dated January 29, 2024, at 10:30 a.m., revealed that on the morning of January 29, 2024, Nurse Aide 3 and Licensed Practical Nurse 4 were trying to give Resident 63 a shower, which she was refusing. The daughter-in-law, who is also an employee, was bringing other residents back from church and witnessed the interaction with the staff. The daughter-in-law was trying to talk Resident 63 into the shower when Nurse Aide 3 came up and gave Resident 63 a hug while picking her up at the waist and carried her on her hip down the hallway. Resident 63 called out ouch repeatedly until Nurse Aide 3 put her down. Resident 63 stated that hurt while rubbing her right hip. Licensed Practical Nurse 4 reported it to Registered Nurse Supervisor 5. A written statement from Nurse Aide 3, dated January 29, 2024, revealed that on January 29, 2024, she was trying to get Resident 63 to go get a shower, and the resident was very difficult and needed to redirect. Licensed Practical Nurse 4 was present. Nurse Aide 3 stated she did give the resident a hug and lifted her and walked a few steps. She stated that is how she gets her to get a shower by joking with her and relaxing her nerves. She stated that it relaxes her nerves and calms her down a little every shower day. She stated that the resident was very combative and it takes more than one person to help shower her and she did not feel she was being abusive at all. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A written statement from Licensed Practical Nurse 4, dated January 29, 2024, revealed that she was walking Resident 63 to the shower room with Nurse Aide 3 when the resident started to give them a hard time and refused to get a bath. She stated that as this was happening, they saw the daughter-in-law, who is also an employee, and she also tried to calm the resident down explaining that she needed to get washed. As the daughter-in-law was explaining this, Nurse Aide 3 went over and gave the resident a hug and picked her up off the floor, holding her around her waist, and carried the resident on her hip all the way from room [ROOM NUMBER] to past the medication room. As she was doing this the resident was yelling ouch repeatedly, approximately three to four times until Nurse Aide 3 put her down. Resident 63 stated that hurt as she was rubbing her right hip. Nurse Aide 3 then proceeded to tell the daughter-in-law that sometimes you just have to be stern with them and not give them an option. Licensed Practical Nurse 4 stated she did tell Nurse Aide 3 that they needed to be gentle and make sure they were not hurting the resident or causing harm. Licensed Practical Nurse 4 stated she discussed the situation with the daughter-in-law afterwards and they both felt the behavior was very inappropriate and reported the situation to Registered Nurse Supervisor 5. A written statement from the daughter-in-law, dated January 29, 2024, revealed that around 10:30 a.m. on January 29, 2024, she was returning residents from mass and Licensed Practical Nurse 4 and Nurse Aide 3 were attempting to encourage Resident 63 to take a bath. Resident 63 was refusing and slightly agitated. She stopped to see if she could assist or talk to the resident about taking a bath. She stated that she, Licensed Practical Nurse 4, and Nurse Aide 3 were standing in the hallway on [NAME] right past the nurse's station talking with the resident, and Nurse Aide 3 bent down and picked the resident up below the waist, around her thigh area, and carried her around the corner to take her to get a bath. After they turned the corner, Resident 63 yelled, Ouch, you are hurting me, you are hurting me, put me down, and Nurse Aide 3 then put her down. Resident 63 stated that Nurse Aide 3 hurt her as she rubbed her right upper hip area. The resident's daughter-in-law stated she was concerned about the resident and walked with her around the corner to the front of the unit where she sat down and was shaken. She sat with her to calm her down and talked with her about taking a bath and she still refused. She stated that Nurse Aide 3 attempted one more time and when she opened the door to the shower room, the resident said no and returned to her room and laid down on her bed. The daughter-in-law also explained that perhaps evening would be a better time for a bath since the resident is usually appears to be in a better mood. A nursing note for Resident 63, dated January 31, 2024, at 2:03 p.m. as a late entry for January 29, 2024, by Registered Nurse 6, revealed that the resident was observed sitting in a chair in the back dining room. The resident was agitated and resistant prior to her bath. The daughter-in-law attempted to calm the resident by talking with the resident. Nurse Aide 3 inappropriately attempted to assist the resident into the tub room. The actions were witnessed by Licensed Practical Nurse 4 and the daughter-in-law. The resident was assessed by Registered Nurse 6 after Licensed Practical Nurse 4 reported the incident. No redness, bruising, bumps or complaints of pain were voiced at time of the assessment. Vital signs were done, and the Medical Director was to see the resident in the morning. Nursing notes for Resident 63, dated January 31, 2024, revealed that the resident was seen by the Medical Director. No injuries or complaints of pain were noted. Description of follow up-action, as documented on the event report for Resident 63, dated January 30, 2024, revealed that Nurse Aide 3 was immediately removed from the unit and sent home until the investigation was completed. Nurse Aide 3 was last trained on resident rights and abuse on July 20, 2023. Added to the description of follow up-action following investigation revealed that, as of February 1, 2024, Nurse Aide 3 was terminated. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Registered Nurse 6 on July 25, 2024, at 6:33 p.m. revealed that she was working the day of the incident with Resident 63 but did not witness the incident. She stated she was asked by Registered Nurse Supervisor 5 to assess the resident after the incident. She confirmed that Nurse Aide 3 was immediately removed from the facility. An interview with the Director of Nursing on July 25, 2024, at 7:00 p.m. revealed that the investigation was completed by Assistant Director of Nursing 7 as she was on vacation at the time of the incident involving Resident 63. Assistant Director of Nursing 7 is no longer employed at the facility and could not be interviewed. The Director of Nursing confirmed that Nurse Aide 3 was sent home and not permitted to work pending the investigation, that all required agencies were notified, and that was she was terminated. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(e)(1) Management. 28 Pa. Code 201.29(a)(j) Resident Rights. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 43856 Based on review of facility policies, clinical records, and facility investigation documents, as well as staff interviews, it was determined that the facility failed to prevent the misappropriation of medication for one of 48 residents reviewed (Resident 111). Findings include: The facility's policy regarding abuse, dated October 13, 2023, indicated that misappropriation included the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 111, dated May 28, 2024, revealed that the resident was cognitively intact, required extensive assistance for daily care needs, and had a diagnosis of chronic pain. Physician's orders for Resident 111, dated May 29, 2024, included an order for the resident to receive one 350 milligrams (mg) tablet of Carisoprodol (a muscle relaxant) four times a day. A facility investigation document, dated June 1, 2024, at 6:30 a.m. revealed that on June 1, 2024, at 6:30 a.m. Licensed Practical Nurse 8 attempted to perform the narcotic count; however, she could not locate the night shift nurse. Licensed Practical Nurse 8 noticed that Resident 111's controlled narcotic count for Carisoprodol 350 mg was incorrect reflecting a count of 56 pills instead of 55. Licensed Practical Nurse 8 notified the Registered Nurse Supervisor that a controlled medication cassette for Resident 111 appeared to be tampered with. It was observed that slots 52 thru 56 of the blister foil pack had been broken and was covered with surgical tape. The pills that were in the opened areas on the blister pack did not appear to match the remaining pills. Resident 111 was seen by the physician and was at his baseline with no change in mental or physical status. The alleged perpetrator was Licensed Practical Nurse 9, an agency nurse who left the facility before performing the controlled medication count at the end of the shift and had no further contact with residents. The staffing agency that employed Licensed Practical Nurse 9 was notified of the event and was made aware that Licensed Practical Nurse 9 would be questioned during the investigation. The Director of Nursing spoke to Licensed Practical Nurse 9 and scheduled a meeting for June 4, 2024, at 10:00 a.m. to obtain her statement concerning the medication in question. Licensed Practical Nurse 9 did not come to the facility to give her statement and after several unsuccessful attempts to contact her, the Greensburg Police Department was called and came to the facility to identify the pills that were placed in the opened blister pack. The investigation was completed on June 6, 2024, at 4:30 p.m. and the PA State Board of Nursing was notified of the event on June 7, 2024. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Assistant Administrator on July 25, 2024, at 11:00 a.m. confirmed that the investigation initiated on June 1, 2024, at 6:30 a.m. was completed on June 6, 2024, at 4:30 p.m. and concluded that misappropriation of Resident 111's medication did occur. 28 Pa. Code 201.14(a) Responsibility of License. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 42079 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to notify the ombudsman in writing regarding the reason for transfers/discharge to hospital for five of 48 residents reviewed (Residents 11, 47, 67, 73, 108). Findings include: The facility's policy regarding Emergent Facility Initiated Discharge/Transfer reporting to the Ombudsman, dated October 13, 2023, indicated that the facility is to report emergent facility discharges/transfers to the State Long Term Care Ombudsman on a monthly basis. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 11, dated August 18, 2024, revealed that the resident was cognitively impaired, was clearly understood and able to understand others, required assistance with care needs, was receiving antipsychotic medications, and had diagnoses that included hyponatremia (low sodium in the blood). Nursing notes for Resident 11, dated September 3, 2024, at 10:27 a.m., revealed that the resident was agitated and was unable to be redirected. The resident then stood up and urinated on the floor. A friend of the resident reported that in the past when Resident 11 acted like this she was septic, and the resident was transported to the emergency room for evaluation. There was no documented evidence that a written notice of Resident 11's transfer to the hospital was provided to the Ombudsman regarding the reason for transfer. Interview with the Director of Nursing on July 25, 2024, at 2:21 p.m. confirmed that the facility did not notify the Ombudsman in writing regarding the reason for Resident 11's transfer/discharge to the hospital. A quarterly MDS assessment for Resident 47, dated May 10, 2024, indicated that the resident was cognitively impaired, required assistance from staff for her daily care needs, and had diagnoses that included Parkinson's disease (a degenerative brain condition that affects muscle control and movement). Nursing notes for Resident 47, dated February 1, 2024, at 4:28 p.m., revealed that the resident had a fall and complained of pain in the back of her head and left hip. Her left leg was externally rotated. She was sent to the hospital and was admitted with a hip fracture. There was no documented evidence that a written notice of Resident 47's transfer to the hospital was provided to the Ombudsman regarding the reason for transfer. Interview with the Director of Nursing on July 24, 2024, at 3:08 p.m. confirmed that the facility did not notify the Ombudsman in writing regarding the reason for Resident 47's transfer/discharge to the hospital. (continued on next page)

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Saint Anne Home	685 Angela Drive Greensburg, PA 15601

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An admission MDS assessment for Resident 67, dated April 6, 2024, indicated that the resident was cognitively intact, required assistance from staff for her daily care needs, and had diagnoses that included heart failure. Nursing notes for Resident 67, dated July 2, 2024, at 10:28 a.m. revealed that the resident was sent to Independence Latrobe Hospital for evaluation. There was no documented evidence that a written notice of Resident 67's transfer to the hospital was provided to the Ombudsman regarding the reason for transfer. Interview with the Director of Nursing on July 25, 2024, at 10:10 a.m. confirmed that the facility did not notify the Ombudsman in writing regarding the reason for Resident 67's transfer/discharge to the hospital. A quarterly MDS assessment for Resident 73, dated May 8, 2024, indicated that the resident was cognitively impaired, required assistance from staff for her daily care needs, and had a Stage 4 pressure ulcer (pressure wound with full thickness tissue loss with exposed bone, tendon or muscle). Nursing notes for Resident 73, dated February 1, 2024, at 1:59 p.m., indicated that the resident was sent to the hospital for evaluation of an unstageable pressure injury (full-thickness pressure injuries in which the base is obscured by slough and/or eschar) to the sacrococcygeal region (lower part of the spine) for surgical debridement and was admitted . There was no documented evidence that a written notice of Resident 73's transfer to the hospital was provided to the Ombudsman regarding the reason for transfer. Interview with the Director of Nursing on July 24, 2024, at 3:08 p.m. confirmed that the facility did not notify the Ombudsman in writing regarding the reason for Resident 73's transfer/discharge to the hospital. An admission MDS assessment for Resident 108, dated April 30, 2024, indicated that the resident was cognitively intact, required assistance from staff for her daily care needs, and had diagnoses that included stroke. Nursing notes for Resident 108, dated July 18, 2024, at 5:35 p.m., revealed that the resident had a fall and was sent to the hospital for evaluation. There was no documented evidence that a written notice of Resident 108's transfer to the hospital was provided to the Ombudsman regarding the reason for transfer. Interview with the Director of Nursing on July 25, 2024, at 10:10 a.m. confirmed that the facility did not notify the Ombudsman in writing regarding the reason for Resident 108's transfer/discharge to the hospital. 28 Pa. Code 201.25 Discharge Policy. 28 Pa. Code 201.29(f)(g) Resident Rights.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 42079 Based on a review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for three of 48 residents reviewed (Residents 45, 73, 77). Findings include: The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, revealed section O0100K1B (hospice) was to be coded yes if a resident was identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The care plan for Resident 45, dated February 15, 2022, included that the resident was receiving hospice services with Vitas hospice and hospice staff were to coordinate the care to facilitate the resident's and or the family's wishes for comfort and symptom management with respect and dignity and the resident's and family's requested comfort care/ hospice care. A quarterly MDS assessment for Resident 45, dated July 8, 2024, revealed that Section O0100K1B was checked no, indicating that the resident did not receive hospice services as a resident. The RAI User's Manual, dated October 2023, revealed that Section N0415A (Antipsychotic Medications - medications used to mental disorders) was to be coded if the resident took the medication during the seven-day look-back period. Physician's orders for Resident 73, dated February 10, 2024, included an order for the resident to receive five milligrams of Aripiprazole (an antipsychotic medication) daily for depression. Resident 73's Medication Administration Record for May 2024 revealed that the resident was administered Aripiprazole during the seven-day look-back assessment period. A quarterly MDS assessment for Resident 73, dated May 8, 2024, revealed that N0415A was not coded, indicating that she did not receive an antipsychotic medication during the seven-day look-back assessment period. The RAI User's Manual, dated October 2023, revealed that Sections H0100 through H0300 were to gather information on the use of bowel and bladder appliances and urinary and bowel continence. Section H0100 was to be coded for each appliance that was used at any time in the past seven days. Select none of the above if none of the appliances A-D were used in the past seven days. Section H0300 was to be coded nine (9), not rated if during the seven-day look-back period the resident had an indwelling bladder catheter (a tube held in the bladder to drain urine) or other types of catheters or no urine output for the entire seven days. A quarterly MDS assessment for Resident 73, dated May 8, 2024, revealed that Section H0100A was checked, indicating that the resident had an indwelling urinary catheter, and Section H0300 was coded with a zero (0), indicating that the resident was always continent of urine. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Physician's orders for Resident 73, dated February 10, 2024, included an order for the resident to have an indwelling foley catheter connected to the bedside drainage bag every shift. Resident 73's Treatment Administration Record for May 2024 revealed that she received catheter checks for connection to the drainage bag every shift during the review period. The RAI User's Manual, which gives instructions for completing MDS assessments, dated October 2023, revealed that section O0100C1B (oxygen therapy) was to be coded yes if a resident was provided continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item. Physician's orders for Resident 77, dated February 10, 2024, included an order for the resident to be provided oxygen at a flow rate of 2 to 5 liters per minute (lpm) as need to maintain an oxygen saturation level of 91 percent or greater via nasal cannula (flexible tubes inserted into the nares to deliver oxygen). A quarterly MDS assessment for Resident 77, dated June 4, 2024, revealed that Section O0100C1B was checked no, indicating that the resident did not receive oxygen therapy as a resident. Interview with the Corporate Compliance Officer on July 25, 2024, at 5:13 p.m. confirmed that the MDS assessments listed above for Residents 45, 73 and 77 were not completed accurately. 28 Pa. Code 211.5(f) Clinical Records.

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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. 42079 Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was created to reflect the resident's specific care needs for one of 48 residents reviewed (Resident 84). A facility policy dated, October 13, 2023, revealed that the purpose of the interim care plan on admission and comprehensive care plans were driven by the CAA process to address resident concerns and resident unique characteristics, strengths, weakness, preferences, and needs which require interdisciplinary intervention. It will include diagnosis, activity level, diet, medication, treatments, limitations, and specific requests for therapeutic interventions and will provide directions to nursing services with the goal of maintaining health status and addressing acute and chronic illness or discharge plan while providing a safe and therapeutic environment thereby eliminating the need for hospitalization A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 84, dated June 8, 2024, revealed that the resident was cognitively impaired, was clearly understood and able to understand others, required assistance with care needs, was receiving antipsychotic medications, and had diagnoses that included depression and dementia. Physician's order for Resident 84, dated April 2, 2024, indicated that the resident was ordered 25 mg of Quetiapine (an antipsychotic medication) twice a day times day for depression/behaviors. Clinical record review for Resident 84 revealed that there was no documented evidence that the care plan was created to reflect the resident's need for antipsychotic medications with a diagnosis of dementia. Interview with the Director of Nursing on July 25, 2024, at 4:10 p.m. confirmed that Resident 84 did not have a care plan developed to reflect the need for antipsychotic medications with a diagnosis of dementia, and it should have been. 28 Pa. Code 201.24(e)(4) Admission Policy. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 42079 Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for seven of 48 residents reviewed (Residents 3, 7, 26, 30, 64, 66, 73). Findings include: The facility policy for care plans, dated October 13, 2024, indicated that care plans are to reviewed/rewritten/revised quarterly and/or on an ongoing basis to reflect the changes in the resident and the care that the resident is receiving. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated July 3, 2024, revealed that the resident was cognitively impaired, was clearly understood and able to understand others, required assistance with care needs, was receiving antianxiety and antipsychotic medications, and had diagnoses that included depression, anxiety, and dementia. Physician's order for Resident 3, dated April 2, 2024, indicated that the resident was ordered five milligrams (mg) of Olanzapine (an antipsychotic medication) daily for Sundowning Dementia with Behaviors. Physician's order for Resident 3, dated April 22, 2024, indicated that the resident was ordered 0.5 mg of Lorazepam (an antianxiety medication) three times daily for restlessness/anxiety. Clinical record review for Resident 3 revealed that she had a care plan, dated June 22, 2022, for psychotropic medications that addressed antidepressant medications. There was no documented evidence that the care plan was revised to reflect the resident's need for antianxiety and antipsychotic medications. Interview with the Director of Nursing on July 25, 2024, at 1:16 p.m. confirmed that Resident 3's care plan was not revised to reflect the need for antianxiety and antipsychotic medications and it should have been. A significant change MDS assessment for Resident 7, dated May 26, 2024, revealed that the resident was cognitively impaired, was clearly understood and able to understand others, and required assistance with care needs. Clinical record review for Resident 7 revealed that she had a care plan, dated September 10, 2019, for history of falls with a fracture and risk for falls related to her inability to ambulate related to left hemiparesis, muscle weakness, and poor balance. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An event report for Resident 7 related to a fall on July 7, 2024, revealed that failure to use her reacher was a contributing fall factor and indicated that both therapy and nursing would re-educate the resident on the importance of using the reacher. There was no documented evidence that the care plan was revised to reflect the resident's need for a reacher to aide in fall prevention. There was no documented evidence in the resident's care plan to address her failure to use to reacher and her need for re-education on the use of the reacher. Interview with the Director of Nursing on July 25, 2024, at 5:01 p.m. confirmed that Resident 7's care plan was not revised to reflect the resident's need for a reacher to aide in fall prevention and was not revised to address her failure to use to reacher and her need for re-education on the use of the reacher. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 26, dated July 2, 2024, revealed that the resident was cognitively impaired, required substantial assistance with care needs, and required a mechanically altered diet. Observations of Resident 26 at lunch on July 23, 2024, at 12:13 revealed the resident had plastic utensils. Review of Resident 26's nutrition care plan did not indicate that the resident was to use plastic utensils. A nurse's note, dated April 27, 2024, revealed that Resident 26 was on a feeding program and required plastic utensils for her safety. Interview with the Director of Nursing on July 25, 2024, at 11:2 a.m. revealed that Resident 26 has been using plastic utensils for a long period of time, and the care plan should have been updated to reflect the use of plastic utensils. A quarterly MDS assessment for Resident 30, dated April 25, 2024, revealed that the resident was cognitively impaired, was usually understood and usually understood others, required assistance with care needs, and had a feeding tube (a mechanical device surgically implanted into the stomach to provide nutrition, fluids and medications to a person who is unable to eat or drink by mouth). Physician's orders for Resident 30, dated June 29, 2024, indicated that the resident's feeding tube was to be flushed with 250 milliliters (ml) of water every four hours. Clinical record review for Resident 30 revealed that she had a nutrition care plan, dated June 26, 2019, that indicated the resident's feeding tube was to be flushed with 175 ml of water every four hours effective October 3, 2023. There was no documented evidence that the care plan was revised to reflect the current order for feeding tube flushes as of June 29, 2024. Interview with the Director of Nursing on July 25, 2024, at 12:38 p.m. confirmed that Resident 30's care plan was not revised to reflect the current order for feeding tube flushes. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An annual MDS assessment for Resident 64, dated June 29, 2024, revealed that the resident was cognitively impaired, required extensive assistance from staff for daily care needs, and had diagnoses that included urinary retention (a condition that occurs when a person is unable to empty their bladder). Physician's orders for Resident 64, dated August 1, 2023, included an order for the resident have a urinary catheter (a tube that is inserted into the bladder to drain urine) and an order to discontinue the urinary catheter on August 8, 2023. A review of care plans for Resident 64, dated July 27, 2023, included a care plan for an indwelling catheter related to a history of urinary retention. There was no documented evidence that the care plan was revised to reflect the discontinuation of the urinary catheter on August 8, 2023. Interview with the Director of Nursing on July 25, 2024, at 3:32 p.m. confirmed that Resident 64's care plan, dated July 27, 2023, should have been revised to reflect the discontinuation of the urinary catheter and it was not. A quarterly Minimum Data Set (MDS) assessment for Resident 66, dated June 3, 2024, revealed that the resident was cognitively impaired, required assistance with care needs, and was receiving anticoagulant (a blood thinning medication) medication. Physician's order for Resident 66, dated January 2, 2024, indicated that the resident was ordered 5 mg of Eliquis (anticoagulant medication) twice a day times day for atrial fibrillation (abnormal heartbeat). A care plan for Resident 66, dated January 2, 2024, revealed that the resident was being monitored for side effects of anticoagulant medication, with an intervention for staff to be aware that Xarelto (an anticoagulant medication) drug information, including the mechanism of the medication to indirectly inhibit platelet aggregation induced by thrombin. Interview with the Director of Nursing on July 25, 2024, at 2:45 p.m. confirmed that Resident 66's care plan was not revised to reflect the current ordered anticoagulant medication, and should have been. A quarterly MDS assessment for Resident 73, dated May 8, 2024, indicated that the resident was cognitively impaired, required assistance from staff for her daily care needs, and had a Stage 4 pressure ulcer (pressure wound with full thickness tissue loss with exposed bone, tendon or muscle). Physician's order for Resident 73, dated July 3, 2024, indicated that the resident's wound to her left heel was to be cleansed with normal saline (a sterile solution used for the moistening of wound dressings and wound debridement), apply santyl (a wound debridement treatment) to wound base, top with Calcium alginate (a dressing used to wounds with a high amount of drainage), and cover with a dry dressing daily. Physician's order for Resident 73, dated July 3, 2024, indicated that the resident's wound to her coccyx was to be irrigated with Vashe (a wound cleanser that promotes healing), pat dry, fill with Vashe-soaked gauze, and cover with a dry dressing twice daily. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clinical record review for Resident 73 revealed that she had a care plan, dated February 9, 2024, for skin impairments and pressure ulcers (localized skin and soft tissue injuries that form as a result of prolonged pressure). The care plan indicated that the left heel wound was to be cleansed with normal saline, apply polysporin (antibiotic ointment used to treat minor wounds and skin infections), cover with kerlix/kling (used to secure dressings) to secure daily. The care plan indicated that the Stage 4 pressure ulcer to the coccyx was to be irrigated with Dakin's solution (a solution used to treat and prevent tissue infections), pack wound with Dakin's solution moistened kerlix, cover with abdominal pad, and secure with minimal tape daily and as needed. There was no documented evidence that the care plans were updated to reflect current treatment orders as of July 3, 2024. A wound note for Resident 73, dated April 26, 2024, indicated that the wound to the left calf was resolved. There were no current treatment orders for a pressure ulcer to the left lower buttocks. Clinical record review for Resident 73 revealed that she had a care plan, dated February 10, 2024, for a Stage 2 pressure ulcer (pressure wound with superficial skin loss) to her left lower buttock and a vascular ulcer (ulcers caused by problems with blood flow in the leg veins) to her left central calf. There was no documented evidence that the care plans were updated to reflect that the wounds to the left calf and left lower buttocks were resolved. Interview with the Corporate Compliance Officer on July 25, 2024, at 12:09 p.m. confirmed that the care plans for Resident 73 were not revised to reflect that the current treatments to the wounds on the left heel and coccyx and were not revised to reflect that the left central calf vascular ulcer and pressure ulcer to the left lower buttocks were resolved. 28 Pa. Code 201.24(e)(4) Admission Policy. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 43856 Based on a review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to follow physician's orders for four of 48 residents reviewed (Residents 43, 58, 65, 125). Findings include: A Quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 43, dated April 17, 2024, revealed that the resident was cognitively impaired, required extensive assistance for daily care needs, and had diagnoses that coronary artery disease, hypertension (high blood pressure), and was on Eliquis (a medication to prevent blood clots). The resident's care plan, dated April 11, 2024, indicated that the resident was to be assessed for alterations in skin conditions and bleeding. Physician's orders for Resident 43, dated April 11, 2024, included an order for the physician to be notified of side effects of Eliquis such as bruising, bleeding, or complications. A nursing note for Resident 43, dated May 28, 2024, at 9:31 a.m., revealed that staff observed a new bruise to the resident's right arm. There was no documented evidence in Resident's 43 clinical record to indicate that the physician was notified of the new bruise per physician's orders. Interview with the Director of Nursing on July 25, 2024, at 1:54 p.m. confirmed that the physician was not notified regarding Resident 43's new bruise per physician orders and should have been. An Annual MDS assessment for Resident 58, dated June 14, 2024, revealed that the resident was cognitively intact, required extensive assistance for daily care needs, and had diagnoses that included atrial fibrillation (a medical condition where the heart beats are out of sync), hypertension (high blood pressure), and kidney disease. Physician's orders for Resident 58, dated March 15, 202, revealed that the resident was to receive 5 milligrams (mg) of midodrine for hypotension (low blood pressure) three times a day, and the medication was to be held if the resident's systolic blood pressure (top number) was greater than 130 millimeters of mercury (mm/Hg) or diastolic blood pressure (bottom number) was greater than 70 mm/Hg. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The medication administration record or MAR for May and June 2024 for Resident 58 revealed that the resident's blood pressure was 119/74 mm/Hg at 2:00 p.m. on May 4, 2024; 128/75 mm/Hg at 8:00 p.m. on May 5, 2024; 127/74 mm/Hg at 8:00 p.m. on May 9, 2024; 113/76 mm/Hg at 2:00 p.m. on May 10, 2024; 118/78 mm/Hg at 8:00 p.m. on May 10, 2024; 124/79 mm/Hg at 2:00 p.m. on May 11, 2024; 120/71 mm/Hg at 8:00 p.m. on May 12, 2024; 116/72 mm/Hg at 4:00 a.m. on May 15, 2024; 119/80 mm/Hg at 8:00 a.m. on May 16, 2024; 124/78 mm/Hg at 2:00 p.m. on May 16, 2024; 110/74 mm/Hg at 8:00 p.m. on May 16, 2024; 114/71 mm/Hg at 8:00 a.m. on May 19, 2024; 106/71 mm/Hg at 4:00 a.m. on May 20, 2024; 140/88 mm/Hg at 4:00 a.m. on May 24, 2024; 126/78 mm/Hg at 8:00 a.m. on May 25, 2024; 151/64 mm/Hg at 8:00 a.m. on June 1, 2024; 138/66 mm/Hg at 2:00 p.m. on June 1, 2024; 155/74 mm/Hg at 4:00 a.m. on June 3, 2024; 110/79 mm/Hg at 8:00 p.m. on June 5, 2024; 106/76 mm/Hg at 8:00 a.m. on June 6, 2024; 101/72 mm/Hg at 2:00 p.m. on June 6, 2024; 105/72 mm/Hg at 8:00 p.m. on June 7, 2024; 130/77 at 8:00 p.m. on June 11, 2024; no vital signs were taken at 2:00 p.m. and 8:00 p.m. on June 14, 2024; 128/76 mm/Hg at 8:00 p.m. on June 17, 2024; 122/81 mm/Hg at 2:00 p.m. on June 18, 2024; 118/73 mm/Hg at 8:00 p.m. on June 18, 2024; 99/77 mm/Hg at 2:00 p.m. on June 19, 2024; 110/73 mm/Hg at 4:00 a.m. on June 21, 2024; 106/84 mm/Hg at 8:00 p.m. on June 25, 2024; and 133/65 mm/Hg at 2:00 p.m. on June 30, 2024. The resident received 5 mg of midodrine on the above dates and times; however, the medication should have been held since the blood pressures were outside of the parameters. Interview with the Director of Nursing on July 25, 2024, at 11:54 p.m. confirmed the above medication should not have been administered and should have been held A quarterly MDS assessment for Resident 65, dated July 25, 2024, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, and had a diagnosis of hypoxia (low levels of oxygen in body tissue). Physician's orders for Resident 65, dated August 26, 2023, included an order for a pulse oximetry (a measurement of oxygen in the blood) to be obtained every shift. The treatment administration record or TAR for July 2024 for Resident 65 revealed that there was no documented evidence that the pulse ox was obtained on July 6, 7, 14 and 20, 2024, as ordered by the physician. Interview with the Director of Nursing on July 24, 2024, at 12:38 p.m. confirmed that there was no documented evidence that Resident 65's pulse oximetry was obtained on the above mentioned dates. An annual MDS assessment for Resident 125, dated July 3, 2024, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included high blood pressure and chronic kidney disease (kidneys are damaged and cannot filter blood properly). Physician's orders for Resident 125, dated June 28, 2024, included an order for intake and output to be obtained every shift. The TAR for July 2024 for Resident 125 revealed no documented evidence that the intake and output was obtained on July 1, 2 ,3, 5 and 6, 2024, as ordered by the physician. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Nursing on July 24, 2024, at 3:33 p.m. confirmed that there was no documented evidence that Resident 65's intake and output was obtained on the above mentioned dates. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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	395539	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Anne Home	685 Angela Drive Greensburg, PA 15601

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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. 48809 Based on review of policy and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that the residents' environment remained as free of accident hazards as possible by transporting a resident without leg rests for one of 48 residents reviewed (Resident 26). Findings include: The facility's policy for transportation, dated October 13, 2023, revealed that footrests must be used when staff, family, volunteers and healthcare partners are assisting residents who are transported by wheelchair, broad chair or any other chair with attachable footrests to prevent accident/injury. A quarterly Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 26, dated July 2, 2024, revealed that the resident was cognitively impaired, required maximum assistance for all of her care, and used a broda chair (a wheelchair with the ability to tilt and recline). Observations on July 22, 2024, at 2:30 p.m. revealed that Nursing Assistant 10 pushed Resident 26 in a broda chair from her room through the hallway and into the dining room without any leg/footrests while the resident elevated her feet. The leg/footrests were not on the resident's wheelchair. An interview with Nursing Assistant 10 on July 22, 2024, at 2:33 a.m. revealed that she was aware that leg rests were to be used when transporting Resident 26 in her wheelchair. An interview with the Director of Nursing on July 24, 2024, at 8:52 a.m. confirmed that staff, agency staff, and hospice staff should be using leg/footrests on wheelchairs when residents are being transported in their wheelchairs. 28 Pa. Code 211.12(d)(5) Nursing Services.

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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. 48941 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders for monitoring output were followed for one of 48 residents reviewed (Resident 73) who had an indwelling urinary catheter. Findings include: The facility's policy regarding measuring output, dated October 13, 2023, indicated that output is to be monitored for residents that receive tube feedings, have a foley catheter, edema, dehydration, vomiting, IV fluids, specific diagnoses that require intake and output, and anyone that has a physician's order. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 73, dated May 8, 2024, revealed that the resident was cognitively impaired, required assistance from staff for her daily care needs, and had an indwelling urinary catheter (a thin, flexible tube inserted into the bladder to drain urine from the bladder). Physician's orders for Resident 73, dated February 9, 2024, included an order for staff to monitor intake and output every shift. Resident 73's Treatment Administration Records (TAR's) dated April, May, June and July 2024 revealed that there was no documented evidence that the resident's indwelling catheter output was monitored on all three shifts for the entire month of April; on all three shifts for the entire month of May with the exception of May 8 and May 22 on the night shift; on all three shifts for the entire month of June; and on all three shifts for the entire month of July through and including July 23 with the exception of July 5 on the day shift, July 6 on the evening shift, and July 23 on the night shift. Interview with the Director of Nursing on July 25, 2024, at 3:46 p.m. confirmed that there was no documented evidence that Resident 73's indwelling catheter output was monitored on the dates and shifts noted above. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 48809 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that fluid restrictions were being followed for one of 48 residents reviewed (Resident 58) and failed to ensure that a resident's weight was obtained and documented as per physician's order for a resident with a documented history of weight loss for one of 48 residents reviewed (Resident 73). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 58, dated June 14, 2024, indicated that the resident was cognitively intact, required assistance from staff for care, and had a diagnosis of kidney failure. A care plan for Resident 58, dated March 14, 2024, revealed that the resident was to be on a 1500 cc/day fluid restriction allowing 960 cc of fluid from dietary, 240 cc of fluid for day shift, 240 cc of fluid for evening shift, and 60 cc of fluid for night shift. A review of Resident 58's medical record revealed no documented evidence that the fluid restriction was being followed. Interview with the Director of Nursing on July 25, 2024, at 2:29 p.m. confirmed that there was no documented evidence that the fluid restriction was being followed and should have been. A quarterly MDS assessment for Resident 73, dated May 8, 2024, revealed that the resident was cognitively impaired, required assistance from staff for her daily care needs, had a Stage 4 pressure ulcer (pressure wound with full thickness tissue loss with exposed bone, tendon or muscle), and had a significant weight loss. A physician's order for Resident 73, dated April 2, 2024, included an order to obtain weekly weights. A dietician note for Resident 73, dated April 23, 2024, at 11:10 a.m. revealed that the resident had a significant weight loss of 22.8 pounds (15.3 percent) in the last six months. The resident's weight on April 21, 2024 was 126.2 pounds; on March 24, 2024, the weight was 127.2 pounds; and on November 28, 2023, the weight was 149 pounds. Her body mass index was considered normal but her weight loss was not desirable (advanced age). She had an inadequate intake (an average of 35 percent) of mechanical soft meals. She was ordered supplements to help meet nutritional needs and promote weight maintenance and was taking 100 percent of all supplements, and she appeared to be maintaining weight. She was ordered snacks between meals for added calories. She has a Stage 4 pressure area to coccyx and an unstageable pressure ulcer (full-thickness pressure injuries in which the base is obscured by slough and/or eschar) to her left heel and was taking vitamins and supplements to promote wound healing. She was ordered weekly weights to monitor for changes. A review of Resident 73's clinical record, including the Treatment Administration Record (TAR) for April and May 2024, revealed that weights were not obtained as ordered on April 14, April 28, May 12, May 19, and May 26. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing on July 24, 2024, at 3:37 p.m. confirmed that there was no documented evidence that weights were obtained as ordered for Resident 73 on the dates listed above. 28 Pa. Code 211.12(d)(3)(5) Nursing services.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 48941 Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that residents who were receiving tube feedings received appropriate treatment and services to prevent complications for one of 48 residents reviewed (Resident 30). Findings include: The facility's policy regarding Enteral Feeding, dated October 13, 2023, indicated that prior to administering enteral feedings, the peg tube should be checked for placement. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 30, dated April 25, 2024, revealed that the resident was cognitively impaired, was usually understood and usually understood others, required assistance with care needs, and had a feeding tube (a mechanical device surgically implanted into the stomach to provide nutrition, fluids and medications to a person who is unable to eat or drink by mouth). The current care plan for Resident 30 indicated that the resident had a need for a feeding tube and that it should be checked for placement. Review of the clinical record for Resident 30 revealed no documented evidence that the feeding tube was being checked for placement per the resident's care plan and per facility policy. Interview with the Director of Nursing on July 25, 2024, at 1:16 p.m. confirmed that there was no documented evidence that Resident 30's feeding tube was being checked for placement as care planned and as per facility policy, and it should have been. 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. 48809 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that dialysis residents had an active physician's order to attend dialysis, failed to obtain physician's orders for the care and monitoring of dialysis sites, and failed to provide communication with dialysis facility for one of 48 residents reviewed (Resident 58). Findings include: The facility's policy regarding care for residents who receive dialysis (mechanical process that cleanses the blood when the kidneys are not functioning properly), dated October 13, 2023, indicated that a physician's order would be obtained for dialysis to establish the days of the week that the dialysis will be given. Observation and a communication form that has been completed by the dialysis clinic will be scanned into the resident's electronic medical record. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 58, dated July 14, 2021, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, had diagnoses that included kidney failure, and required dialysis treatments. The resident's care plan, dated March 14 2024, indicated that he required dialysis related to renal failure. The current dialysis agreement between the facility and dialysis clinic revealed that the facility will provide care and education for emergency situations regarding the dialysis site for Resident 58. Observations of Resident 58 on July 25, 2024, at 8:20 a.m. revealed that he had a dry gauze dressing on his left inner arm/wrist area. An interview with the resident at that time revealed that he had a fistula (surgical dialysis access site) for dialysis access, but there was no kit in the resident's room for emergency situations. Resident 58 also stated that he does not take any paperwork with him to dialysis but brings back a piece of paper to give to the registered nurse supervisor. Interview with Licensed Practical Nurse 1 on July 25, 2024, at 8:25 a.m. revealed that she was not aware of an emergency kit for Resident 58's room and was not aware of protocol in an emergency situation for Resident 58's fistula. There was no documented evidence in Resident 58's clinical record of a physician's order for dialysis, for the care of his fistula, and no documented evidence of continued communication between the facility and dialysis center. Interview with the Director of Nursing on July 25, 2024, at 2:30 p.m. confirmed that there was no documented evidence of active physician's orders for Resident 58 to attend dialysis, no orders for the care and monitoring of the dialysis site, and no evidence of continued communication between the dialysis center and the facility. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 43856 Based on review of personnel files, as well as staff interviews, it was determined that the facility failed to ensure that nurse aide performance evaluations were completed at least annually for two of five nurse aides reviewed (Nurse Aides 11 and 12). Findings include: A list of nurse aides provided by the facility revealed that based on their months and days of hire, annual performance evaluations for Nurse Aides 11 and 12 were due between November 2023 and February 2024. As of July 24, 2024, there was no documented evidence that annual performance evaluations were completed as required for Nurse Aides 11 and 12. Interview with the Director of Nursing on July 24, 2024, at 2:35 p.m. confirmed that she could not provide evidence that annual performance evaluations were completed as required for Nurse Aides 11 and 12. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 201.20(a)(c) Staff Development.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 48941 Based on clinical record reviews and staff interviews, it was determined that the facility failed to provide appropriate treatment and services for residents with dementia-related behaviors and failed to develop and implement an individual person-centered plan to address dementia-related behavioral symptoms displayed for one of 48 residents reviewed (Resident 3) who had dementia. Findings include: An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated July 3, 2024, revealed that the resident was cognitively impaired; was clearly understood and able to understand others; required assistance with care needs; was receiving antidepressant, antianxiety and antipsychotic medications; and had diagnoses that included depression, anxiety, and dementia. The current care plan for behavior for Resident 3, dated October 30, 2023, revealed inappropriate behaviors related to dementia that included screaming, hitting at staff, and refusing care and medications. Interventions included to monitor behaviors and attempt to identify patterns, precursors and causes of behaviors; use a consistent, calm, firm approach during periods of inappropriate behavior; attempt to determine the source of agitation by asking opened-ended questions and seek to resolve; maintain a calm environment with limited clutter/distraction; allow resident time and opportunity to express self and verbalize frustrations; and review abnormal behaviors with the interdisciplinary team. Physician's order for Resident 3, dated February 1, 2022, included an order that the resident's behaviors were to be monitored and documented on the Medication Administration Record (MAR) every shift for monitoring as follows: 1-Combative, 2-Resistive, 3-Verbally Aggressive, 4-Socially Inappropriate, 5-Wandering and 6-Disrobing. Interventions for behaviors were to be documented on the MAR every shift as follows: 1-one to one, 2-Activities, 3-Quiet area, remove from situation, 4-Diversional Activity, 5-Food/drink, 6-Medicate, 7-re-approach and 8-Toilet. Physician's order for Resident 3, dated March 31, 2024, included an order for 75 milligrams (mg) of Effexor extended release (an antidepressant medication), two capsules (to equal 150 mg) daily for dementia with psychosis. Physician's order for Resident 3, dated April 2, 2024, included an order for 5 mg of Olanzapine (an antipsychotic medication) daily for Sundowning Dementia with Behaviors. Physician's order for Resident 3, dated April 22, 2024, included an order for 0.5 mg of Lorazepam (an antianxiety medication) three times daily for restlessness/anxiety. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note for Resident 3, dated April 22, 2024, at 1:39 p.m., revealed that the resident was extremely confused and agitated that day. She went into another resident's room and was going through all of her belongings. When asked to leave she stated. I'm taking all of this stuff. I want to put it in my room, and was especially fixated on a clock stating that it was her mother's clock. Resident 3 was in that resident's room approximately a dozen times and got physical with staff when she was asked to leave. A nurse aide asked the nurse to remove the resident as she had a pair of tweezers and told her that she would stab her with them if she got any closer. The nurse was able to talk with the resident and calm her down and was able to get the resident to give her the tweezers. She was removed from the room and brought down to the dining room with the nurse. While in the dining room, Resident 3 grabbed onto another resident's chair and started pulling it. The other resident raised her voice and asked her to stop, and Resident 3 raised her voice back. The other resident then struck Resident 3 with a closed fist to her right arm and Resident 3 struck her back with a closed fist to her left arm. Staff intervened and they were immediately separated. Resident 3 was still very agitated and insisted on going back into another resident's room to take her clock. The doctor was notified, and medication changes were made. A nursing note for Resident 3, dated April 22, 2024, at 2:37 p.m revealed that the registered nurse was called to Resident 3's room at 10:00 a.m. Resident 3 had an altercation with another resident. No injuries were noted. No bumps or bruises were noted. Residents were separated by the licensed practical nurse on duty. The Medical Director examined the resident and made changes to the resident's Ativan (Lorazepam) order. An Electronic Event Report that was submitted on April 23, 2024, related to the incident, indicated that a recent dose reduction of Ativan was thought to be a contributing factor for Resident 3's behaviors and the Medical Director changed the Ativan order so Resident 3 would receive 0.5 mg of Ativan three times daily. Review of Resident 3's MAR for April 2024 revealed that on April 22, 2024, staff did not attempt to implement any of the interventions in place for her behaviors as per physician's orders. There was no documented evidence that an individualized behavior plan was developed with specific, person-centered, or individualized interventions included in the plan to address the resident's behaviors. There was no documented evidence that new behavioral interventions were put in place related to incident on April 22, 2024, to keep other residents safe from Resident 3, who has a history of behaviors related to dementia. Interview with the Director of Nursing on July 25, 2024, at 4:08 p.m. confirmed that staff did not attempt to implement any of the interventions in place for behaviors as per physician's orders related to the incident with Resident 3 on April 22, 2024, there was no individualized behavior plan developed for the resident with specific, person-centered, or individualized interventions included in the plan to address her behaviors and no new behavioral interventions were put in place related to incident on April 22, 2024, to keep other residents safe from Resident 3, who has a history of behaviors related to dementia. 28 Pa. Code 201.24(e)(4) Admission Policy. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 28177 Based on review of clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure a medication error rate of less than five percent. Findings include: Observations during medication administration on July 24, 2024, at 9:59 a.m. revealed that eight medication administration errors were made during 28 opportunities for error, resulting in an error rate of 28.57 percent. Current physician's orders for Resident 12 included orders for the resident to receive 35 milliliters (ml) of Valproic acid 250 milligram (mg)/5 ml oral solution twice a day by mouth for a seizure disorder; 30 ml of Lactulose 220 grams/30 ml oral solution (a medicine used as a laxative) twice a day via gastric tube; 1 mg of Klonopin (a medicine used as a sedative) twice a day via gastric tube (tube inserted through the belly that brings nutrition or medication directly to the stomach) for profound mental retardation with agitation; 1 mg of Risperdal (a medicine used as an antipsychotic) twice a day via gastric tube for profound mental deficiency secondary to mental retardation with psychosis; 400 mg of magnesium oxide (a medicine used as a mineral supplement) four times a day via gastric tube for a supplement; 0.125 mg of Levsin (a medicine used as an antispasmodics) twice a day via gastric tube for excessive secretion; 500 mg of Carbamazepine (a medicine used as an anticonvulsant) twice a day via gastric tube; and 2.5 ml of Ferrous sulfate (220 mg/5 ml) oral solution (a medicine used as a mineral supplement) daily via gastric tube. Observations during A hall medication pass on July 24, 2024, at 9:53 a.m. revealed that Licensed Practical Nurse 13 prepared the following medications for Resident 12 to be administered via the gastrostomy tube (feeding tube): ferrous sulfate, Valproic acid, Lactulose, Risperdal, magnesium oxide, Levsin and Carbamazepine. She did not prepare the Klonopin. On July 24, 2024, at 10:01 a.m. Licensed Practical Nurse 13 checked the residual contents of Resident 12's gastrostomy tube via aspiration, resulting in one syringe of approximately 60 ml. Licensed Practical Nurse 13 stated that the amount of gastric residual was too much and did not administer the prepared medications. She contacted her supervisor. Interview with Licensed Practical Nurse 13 on July 24, 2024, at 10:18 a.m. revealed that she was unable to find an order to hold the medication if the residual met a certain amount but was still going to hold them. She also explained that she was not going to prepare the scheduled Klonopin just to waste the medication. Observations on July 24, 2024, at 10:34 a.m. revealed that Licensed Practical Nurse 13 and Registered Nurse Supervisor 14 wasted the seven prepared medications. Licensed Practical Nurse 13 said. I know I made mistakes and I am sorry. The July 2024 Medication Administration Record (MAR) for Resident 12 indicated that the 8:00 a.m. medications were not administered due to excess residual; however, there was no evidence in the clinical record of a physician's order to hold the medications based on a residual amount. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Registered Nurse Supervisor 14 on July 24, 2024, at 3:44 p.m. revealed that the nurse should have prepared all eight medications. She was also told that Licensed Practical Nurse 13 had two syringes full of gastric residual (120 ml) for Resident 12. Interview with Registered Nurse Supervisor 6 on July 25, 2024, at 10:07 p.m. revealed that she received report from Registered Nurse Supervisor 14 indicating that there had been 120 ml of residual for Resident 12. Interview with the Director of Nursing on July 24, 2024, at 5:03 p.m. confirmed that Licensed Practical Nurse 13 did not have over 100 ml of residual contents for Resident 12 and the medications should have been administered. She initiated a medication error report. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48809 Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to ensure that medications were properly secured in the medication cart, failed to label medications with the date they were opened in one of eight medication carts reviewed (B100 Room), and failed to ensure the narcotic box was properly affixed in the refrigerator. Findings include: The facility's policy regarding the security of the medication cart, dated October 13, 2023, indicated that the nurse was to secure the medication cart during the medication pass to prevent unauthorized entry, and the medication cart was to be securely locked at all times when out of the nurse's view. Observations on July 25, 2024, at 8:23 a.m. revealed that a medication cart in the hallway was unlocked and unattended by Licensed Practical Nurse 1 when she went into Resident 137's room to provide care to resident. Interview with Licensed Practical Nurse 1 on July 25, 2024, at 8:27 a.m. confirmed that her medication cart should have been locked when unattended. Interview with the Director of Nursing on July 25, 2024, at 11:43 a.m. confirmed that the medication cart should have been locked when unattended by Licensed Practical Nurse 1. The facility's policy regarding medication administration, dated October 13, 2024, revealed that once opened, a multi-dose vial was to have the date it was opened recorded on the container. An undated package insert for Lispro Insulin (used to treat diabetes) revealed that once entered/opened, the vial was to be discarded after 28 days. Observations in the B1001 Medication cart on July 24, 2024, at 9:16 a.m. revealed that an opened vial of Lispro Insulin was not properly labeled with the date it was opened. An interview with Registered Nurse 15 on July 24, 2024, at 9:16 a.m. confirmed that the opened vial of Lispro Insulin was not properly labeled with the date it was opened. An interview with the Director of Nursing on May 25, 2024, at 11:43 a.m. confirmed that an opened vial of Lispro Insulin was not properly labeled with the date it was opened, and it should have been. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Anne Home	685 Angela Drive Greensburg, PA 15601

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations of the medication refrigerator in the medication room on [NAME] wing on July 24, 2024, at 8:05 a.m. revealed that there was a locked apartment-size refrigerator. Inside the refrigerator was a clear plastic box that was secured to the refrigerator for the storage of narcotic medication; however, the box was not locked, and there was one bottle of Lorazepam oral concentrate (schedule IV anxiety medication) in the unlocked box for Resident 59. Interview with Licensed Practical Nurse 16 at the time of the observation confirmed that the box containing the Lorazepam was not locked because a key broke off in it and it would not lock. Interview with the Director of Nursing on July 24, 2024, at 8:52 a.m. confirmed that the bottle of Lorazepam was stored in an unlocked box. 28 Pa. Code 211.9(a)(1)(k) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 48941 Based on review of policies and clinical records, as well as resident and staff interviews, it was determined that the facility failed to provide dental services to meet the needs of each resident for one of 48 residents reviewed (Resident 8). Findings include: The facility's dental services policy, dated October 13, 2023, indicated that all residents are to be provided annual oral assessments by a licensed dentist/hygienist. A dental progress note for Resident 8, dated May 25, 2023, indicated that the resident was not seen by 360 dental due to her refusal for treatment. There was no documented evidence in the resident's clinical record to indicate a follow-up appointment was attempted. A nursing note for Resident 8, dated December 28, 2023, at 6:00 p.m., indicated that the resident was complaining of right-side facial pain. The resident was crying in pain when she asked for Tylenol. She stated the pain was from her ear to her mouth. A nursing note for Resident 8, dated January 26, 2024, at 1:34 p.m. indicated that the resident had no pain in the past five days and had upper and lower dentures but had not been wearing them. She stated they did not fit well and caused some discomfort. There was no documented evidence in the resident's clinical record to indicate that the resident was seen by a dentist for her ill-fitting dentures. Interview with Resident 8 on July 22, 2024, at 12:35 p.m. revealed that she had no teeth and no dentures in her mouth. She stated that she had dentures but did not have them in because her mouth hurt when she put them in. She stated that she had pain to the right side of her mouth and jaw. Interview with the Corporate Compliance Officer on July 25, 2024, at 6:45 p.m. confirmed that Resident 8 was not seen by the dentist for complaints of ill-fitting dentures or annually and she should have been. 28 Pa. Code 211.12(c)(d)(3)(5) Nursing Services. 28 Pa. Code 211.15(a) Dental Services.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48941 Based on facility records and observations, as well as resident and staff interviews, it was determined that the facility failed to serve food items at palatable temperatures. Findings include: Facility grievance logs revealed no grievances related to food; however, resident council meeting minutes on April 29, 2024, revealed that Resident 5 had concerns with hot food. She documented that it would be nice to have the hot meal cart at all meals. The meals are hotter and taste better. A memo from the Director of Resident and Community Engagement, dated May 2, 2024, revealed that she had spoken with the Dietary Director regarding food concerns, including temperatures of food. She stated she would have dietary check to make sure the temperatures are properly done and food is served at correct temperatures. A memo with attached education from the Dietary Director, dated May 4, 2024, revealed that she had spoken to dietary staff to make sure temperatures are taken for each meal. She had attached a list of employees educated. Observations of the meal trayline in the kitchen on July 24, 2024, at 12:14 p.m. revealed that the last tray for [NAME] Court was placed on the food cart at 12:17 p.m. and the test tray was put on the food cart at 12:18 p. m. The trays were delivered to [NAME] court on a metal open cart on warmed plates covered by a warmed plate cover. The cart was not enclosed or insulated. Trays arrived on the unit at 12:19 p.m. The first tray was passed at 12:20 p.m. and the last tray was passed at 12:25 p.m. A test tray tested for palatable temperature was sampled at 12:25 p.m. The temperature of the foods were as follows: French fries were 108 degrees Fahrenheit (F), hamburger was 116 degrees (F), soup was 153 degrees (F), milk was 57 degrees (F), juice was 67 degrees (F), and the water was 66 degrees Fahrenheit. The fries and hamburger were cool to taste and not palatable. The cold liquids were warm to taste and not palatable. Interview with Dietary Aide 2, who was temping the foods at the time of the test tray, stated that the food could always be heated up in the microwave if needed. Interview with the Chef Manager on July 24, 2024, at 12:35 p.m. confirmed that the food was not served at a palatable temperature. 28 Pa. Code 201.18(b)(1)(2)(e) Management. 28 Pa. Code 211.6(c) Dietary Services.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 42079 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that the designated interdisciplinary team member obtained the required information from the contracted hospice provider for two of 48 residents reviewed who were receiving hospice services (Residents 36, 45). Findings include: An agreement between the facility and the hospice provider (end-of-life services) indicated that the hospice provider would maintain medical records for each hospice patient. Such records will be prepared and maintained with federal and state law, rules, regulations, procedures, policies, guidelines, and generally accepted medical record practices. A record of all services provided to the patient and events regarding the patient's care will be located at the facility. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 36, dated June 11, 2024, indicated that the resident was cognitively impaired, required extensive assistance with daily care needs including transfers, was receiving hospice services, and had diagnosis that included Alzheimer's disease, heart failure, and Parkinson's disease (a progressive disorder that affects the nerves). Physician's orders for Resident 36, dated March 14, 2024, revealed that the resident was to receive hospice services from the facility's contracted hospice provider. As of July 24, 2024, there was no documented evidence in the resident's clinical record, or in the hospice provider's clinical record, that the facility obtained updated nursing notes from hospice. Interview with the Director of Nursing on July 24, 2024, at 10:36 a.m. confirmed that Resident 36 did not have updated nursing notes on the hospice chart and that there should have been. A hospice contract, dated March 28, 2023, revealed that the company would promptly and accurately record all physician's orders and medical services, as appropriate, and will provide signed medical record entry for each service. A quarterly Minimum Data Set (MDS) assessment for Resident 45, dated July 8, 2024, indicated that the resident was cognitively impaired, required assistance for her daily care needs, had diagnoses that included cerebral atherosclerosis, and was receiving hospice services. The care plan for Resident 45, dated February 15, 2022, included that the resident was receiving hospice services and hospice staff were to coordinate the resident's care to facilitate the resident's and/or the family's wishes for comfort and symptom management with respect and dignity. As of July 23, 2024, at 3:10 p.m. there was no documented evidence readily available in Resident 45's clinical record, or in the hospice provider's clinical record, that the facility had documentation of the hospice's registered nurse and nurse aide progress notes. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Director of Nursing on July 23, 2024, at 3:10 p.m. confirmed that the communication should be part of the hospice provider's clinical record on the unit but were not. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 48809 Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficient practices. Findings include: The facility's deficiencies and plans of correction for State Survey and Certification (Department of Health) survey ending, September 14, 2023, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending July 25, 2024, identified repeated deficiencies related to unresolved grievances, the accuracy of Minimum Data Set (MDS) assessments (federally-mandated assessments of residents' abilities and care needs), initiating residents' care plans, revising residents' care plans, quality of care, accident hazards, maintaining proper nutrition and hydration status, and hospice care. The facility's plan of correction for a deficiency regarding unresolved grievances, cited during the survey ending September 14, 2023, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F585, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding unresolved grievances. The facility's plan of correction for a deficiency regarding accurate MDS assessments, cited during the survey ending September 14, 2023, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F641, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding completing accurate MDS assessments. The facility's plan of correction for a deficiency regarding the development of resident care plans to reflect their current care needs, cited during the survey ending September 14, 2023, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F656, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding developing residents' care plans. The facility's plan of correction for a deficiency regarding revising residents' care plans to reflect their current care needs, cited during the survey ending September 14, 2023, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F657, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding revising residents' care plans. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's plan of correction for a deficiency regarding quality of care, cited during the survey ending September 14, 2023, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding quality of care. The facility's plan of correction for a deficiency regarding accident hazards, cited during the survey ending September 14, 2023, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F689, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding accidents hazards. The facility's plan of correction for a deficiency regarding proper nutrition and hydration, cited during the survey ending September 14, 2023, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F692, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding maintaining proper nutrition and hydration status. The facility's plan of correction for a deficiency regarding hospice care, cited during the survey ending September 14, 2023, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F849, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding hospice care. Refer to F585, F641, F656, F657, F684, F689, F692, F849. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 43856 Based on review of established infection control guidelines, facility policy, and residents' clinical records, as well as observations and staff interviews, it was determined that the facility failed to follow infection control guidelines from the Centers for Medicare/Medicaid Services (CMS) and the Centers for Disease Control (CDC) to reduce the spread of infections and prevent cross-contamination for one of 48 residents reviewed (Resident 5). Findings include: CDC guidance on isolation precautions and Implementation of Personal Protective Equipment (PPE) use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated July 12, 2022, indicates that multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. CMS updated its infection prevention and control guidance effective April 1, 2024. The recommendations now include the use of EBP during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, in addition to residents who have an infection or colonization with a CDC-targeted or other epidemiologically important MDRO when contact precautions do not apply. The facility's policy regarding Enhanced Barrier Precautions (EBP), dated April 30, 2024, indicated that before performing high-contact resident care activity which includes transferring, gloves and a gown must be used and properly discarded before exiting the resident room to contain pathogens. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated July 10, 2024, revealed that the resident was cognitively intact, required extensive assistance from staff for daily care needs, and had a history of CRE (Carbapenem Resistant Enterobacterales - a bacteria that causes infection in people and animals) in her urine. A care plan for Resident 5 regarding EBP, dated July 14, 2024, revealed that the resident had EBP in place due CRE in her urine. Observations of Resident 5 on July 24, 2024, at 10:55 a.m. revealed that the resident had signage at the entrance to her room to indicate that infection control measures for EBP were in place related to a history of CRE in her urine. Nurse Aide 17 had placed Resident 5 in a sling in preperation to use a mechanical lift for a transfer. Nurse Aide 17 had gloves on her hands; however, she was not wearing a gown at the time of the transfer. Interview with Nurse Aide 17 on July 24, 2024, at 10:58 a.m. revealed that she did not wear a gown when transferring Resident 5 and she should have. Interview with the Director of Nursing on July 24, 2024, at 3:32 p.m. confirmed that Resident 5 had EBP, and staff should have been wearing a gown and gloves while transferring the resident. 28 Pa. Code 201.14(a) Responsibility of Licensee. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 43856 Based on a review of employee education records, as well as staff interviews, it was determined that the facility failed to ensure that nurse aides completed the required annual education for two of five nurse aides reviewed (Nurse Aides 12, 18) Findings include: A facility policy regarding Orientation/Training/Evaluation, dated October 13, 2023, indicated that a minimum of 12 hours of in-service education will be provided to nurse aides annually based on their anniversary hire date (day and month). Review of the employee education file for Nurse Aides 12 and 18 revealed that there was no documented evidence to indicate that a minimum of 12 hours of in-service education was completed annually based on their anniversary hire date (day and month). Interview with the Director of Nursing on July 24, 2024, at 2:35 p.m. confirmed that there was no documented evidence to indicate that Nurse Aides 12 and 18 completed a minimum of 12 hours of in-service education based on their anniversary hire date (day and month) as required. 28 Pa. Code 201.18(b)(3)(e)(1) Management. 28 Pa. Code 201.19 Personnel Policies and Procedures.