STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395556	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shenandoah Senior Living Community	101 E. Washington St Shenandoah, PA 17976

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of clinical records and select investigation reports and staff interview, it was determined that the facility failed to develop and consistently implement a person-centered care plan to address a resident's known risk factors for falls for one resident out of 11 sampled. Findings include: Clinical record revealed that Resident B1 was admitted to the facility on [DATE], with diagnoses of dementia, difficulty walking and a history of falls in the facility. An admission Minimum Data Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated March 4, 2024, revealed that the resident was cognitively impaired with a BIMS score of 7 and required staff assistance with activities of daily living. The resident's care plan, initiated October 14, 2022, indicated that the resident may be out of bed to the wheelchair with gel cushion, auto lock brakes and anti-tippers. On October 21, 2022, the resident's care plan noted that the resident was at risk falls and planned interventions included wearing non-skid footwear at all at times, and auto lock brakes and antitippers on the wheelchair. The resident's care plan dated October 20, 2022, also included approaches of toileting every 2 hours, a sensor alarm to bed and chair to monitor safety, call bell in reach, encourage resident to use it and the resident needs a safe environment with; even floors free from spills and/or clutter, adequate, glare-free light, a working and reachable call light, the bed in low position at night, side rails as ordered, handrails on the walls, personal items with within reach. A facility investigation report and nursing documentation dated December 13, 2023, at 8:10 PM revealed that Resident B1 was seated in her wheelchair at the nurses station. The resident threw crushed potato chips on the floor, leaned over in her wheelchair in an attempt to pick up the chips and fell to the floor. No injuries were noted. A review of a facility investigation report and nursing documentation dated January 19, 2024, at 8 PM revealed that Resident B1 was self-propelling in her wheelchair in the hallway. She leaned forward in her wheelchair, reaching for the hallway hand railing and fell out of the chair. The resident sustained an abrasion on the back, right side of her head measuring 1 cm x 1 cm. The resident was assisted back to her wheelchair. (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility investigation report and nursing documentation dated February 2, 2024, at 1:45 PM revealed that Resident B1 was seated in her wheelchair in her room. The resident attempted to self-transfer from her wheelchair to the bed. It was noted that staff found the resident on the floor with her head next to the bedside table. The resident was not wearing any footwear at the time of the fall as care planned. Prior to the fall, she was observed self propelling in the hallway, in her wheelchair with her sneakers on her feet. No injuries were sustained. After these three falls from the wheelchair, there was no indication that the facility had timely developed and implemented specific measures to address the resident's wheelchair safety, to include supervision of the resident while seated or self-propelling in the wheelchair, and alternate seating arrangements while the resident was unsupervised in her room, to prevent repeated falls during the resident's wheelchair use, or attempting access to the wheelchair, and attempts to self-transfer from the wheelchair. Interview with the ADON and NHA on March 27, 2024, confirmed the resident's unsafe and impulsive behaviors while seated in a wheelchair, including leaning forward and transfer attempts, and that the resident's care plan did not specifically address the resident's need for increased supervision while seated in the wheelchair or timely plans for alternate seating arrangements or adaptive devices to maintain the resident's safety when unsupervised in her room. 28 Pa. Code (d)(3)(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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on clinical record review and staff interview, it was determined that the facility failed to timely identify and address a resident's decline in food and fluid consumption with significant weight loss for one resident out of eight sampled. Findings included: A review of clinical record revealed Resident C1 was admitted to the facility on [DATE], with diagnoses that included congestive heart failure [(CHF) is a weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs with symptoms that include shortness of breath, fatigue, arrhythmias, and edema], cardiomyopathies [an acquired or inherited disease of the heart muscle which makes it difficult for the heart to pump blood to other parts of the body], dysphagia (difficulty swallowing), and cognitive communication deficit [may occur after a stroke, tumor, brain injury, progressive degenerative brain disorder, or other neurological damage that may result in deficits with thinking and how someone uses language]. A review of the resident's admission nutritional risk assessment completed by the facility's Registered Dietitian (RD) dated February 14, 2024, at 8:46 p.m., and locked February 20, 2023, at 12:35 p.m., revealed that Resident C1's diet order was a CCHO (consistent carbohydrate diet used for diabetic management) heart healthy (diet to assist in the management of heart related diseases) diet mechanical soft texture (comprises soft-textured foods that a person has mashed or blended to use for individuals that experience difficulty chewing or swallowing) with thin liquids with a house supplement (high calorie/high protein supplement used to supplement oral intakes for individuals experiencing decreased meal intakes) 120 ml twice per day. No meal intake history noted. Height was 69-inches, weight recorded 2/15/2024, at 10:13 a.m. , at 146.2-pounds, and body mass index [(BMI) is a screening tool for overweight and obesity] was 21.6 (normal). Skin conditions were noted that the resident had a wound to his right dorsal (top) foot and sacrum (a large, triangular bone at the base of the spine that forms by the fusing of the sacral vertebrae) deep tissue injury [(DTI) The National Pressure Ulcer Advisory Panel defines a deep tissue injury as A pressure-related injury to subcutaneous tissues under intact skin]. Nutrition related medications were noted as multivitamin, vitamin C, zinc, ferrous sulfate, and Lasix (a diuretic used to remove fluid accumulation due to the heart failure) that was ordered by the physician at 40 mg twice per day. The RD estimated Resident C1's nutritional needs at 1659 - 1991 calories per day, 66 grams of protein per day, and required 1327 - 1991 milliliters (ml) of fluid per day. The care plan was updated and updated as needed and supplement initiated, will monitor. A review of the resident's amount eaten summary report dated February 15, 2024, breakfast through February 18, 2024, dinner meal revealed that the refused or consumed 0 (zero) - 25% at five meals out of 12 meals served (or 41.6% meals served), consumed 26-50% of meals for three out of 12 meals served, consumed 51-75% of meals for three out of 12 meals served and consumed 76-100% of meals at only one one meal out of 12 meals served over these three days. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident C1's amount eaten summary report dated February 19, 2024, breakfast through February 23, 2024, dinner meal revealed that the refused or consumed 0 (zero) - 12 of 15 meals served (or 80% meals served, with consecutive meal refusals), consumed 26-50% of meals for 2 out of 15 meals served and consumed 76-100% of meals at only one meal out of 15 meals served (or 6.7%). There was no documented evidence that the registered dietitian had assessed the adequacy of the resident's oral intake of food and fluids in response to the multiple days of decreased oral intake from February 15, 2024, through February 18, 2024, which continued from February 19, 2024, through February 23, 2024. The RD did not assess the resident until February 20, 2024, as the result of a physician ordered diet consult. A progress note completed by Employee 4, a Registered Nurse (RN) dated February 19, 2024, at 1:43 p.m., revealed that the resident's attending physician was aware of lab results and requested a dietary consult due to low albumin (is a protein made by your liver. Albumin enters your bloodstream and helps keep fluid from leaking out of your blood vessels into other tissues]. A dietary note completed by the RD on February 20, 2024, at 12:32 p.m., noted weight that the resident's weight was 146.5-pounds, CCHO Heart Healthy Mech soft diet. Labs reviewed. Appetite varied. 120 ml House supplement BID (twice per day) was initiated to supplement intake and support nutrition/hydration and wound healing/prevention. Will continue POC (plan of care). A nursing progress note completed by the Assistant Director of Nursing (ADON) dated February 21, 2024, at 1:09 p.m., revealed that she spoke to the resident's niece (representative) regarding her concerns with the resident's appetite and reviewed lab results and physician's orders. A dietary note completed by the facility's Certified Dietary Manager (CDM) on February 22, 2024, at 8:27 a.m. , noted that the resident's prealbumin 6 (low) with supplements in place, preferences updated, continue to monitor. A dietary progress notes completed by the RD on February 26, 2024, at 5:00 p.m., revealed that the resident's weekly weight was down to 127-pounds, a significant weight loss of 19.2-pounds since admission weight. A re-weight was requested. Appetite varied, receives 120 ml of house supplement BID; 120 ml acceptance. Labs reviewed. Receives Lasix BID as ordered. Treatment to sacrum and right food as ordered. Will increase house supplement to 120 ml three times per day offerings as accepts best. The dietitian failed to timely re-evaluate and revise Resident C1's nutrition plan of care with new interventions due to consistently poor meal intakes that contributed to a significant weight loss. A review of Resident C1's hospital record indicated that the resident was admitted to the hospital on February 29, 2024, at 7:55 p.m., and diagnosed with septic shock likely related to sepsis [is an infection of the blood stream resulting in a cluster of symptoms such as drop in a blood pressure, increase in heart rate and fever] and volume depletion (dehydration) and hypotension (low blood pressure). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the ADON on March 27, 2024, at approximately 1:15 p.m., confirmed that the facility was unable to provide documented evidence that Resident C1's nutrition plan of care was timely re-evaluated and revised based on consistently poor meal intakes with days of consecutive meal refusals that contributed to significant weight loss and clinical decline. 28 Pa. Code 211.5(f) Medical records

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 43944 Based on review of clinical records, facility contracts and select policies and procedures and interview with facility staff, it was determined that the facility failed to provide residents with timely intravenous fluids as prescribed and consistent with professional standards of practice for one resident (Resident C1) out of eight residents reviewed. Findings include: A review of Resident C1's clinical record revealed that the resident tested positive for COVID-19 on March 18, 2024, and displayed a progressive decline in medical status and meal intakes during the month of February 2024. A nursing progress note completed by Employee 1, a Registered Nurse (RN), dated February 23, 2024, at 12:34 p.m., revealed that Resident C1 was assessed by Employee 1 and vital signs were obtained (blood pressure (BP) was Blood Pressure: BP 86/58, pulse P: 80, Pulse Oximetry: O2 82.0 %) and the resident was noted to have been hypotensive [is a blood pressure reading below the specified limit (90/60 mmHg) that can cause dizziness, blurred vision, and tiredness] and had incontinent episodes of foul smelling and tarry stools. The resident's attending physician was present at the facility and ordered 1 litter of 0.9% normal saline solution (NSS) intravenous (IV) and then discontinue when completed. A review of the resident's medication administration record (MAR) dated February 2024, revealed that there was no documented evidence that the physician ordered IV fluids were timely initiated when ordered on February 23, 2024. A review of the resident's clinical intake and output (I & O) report dated February 2024, revealed that there was no documented evidence that Resident C1 received the total volume of IV fluids ordered by the attending physician. The I & O report dated February 24, 2024, at 10:30 a.m., indicated that the resident had only received 320 ml out of 1000 ml fluids ordered by the physician on the prior day, February 23, 2024. A review of a nursing heath status progress note completed by Employee 2, RN, dated February 24, 2024, at 5:52 a.m., revealed that she assessed the resident and he was awake and confused. The resident stated that he was thirsty and requested something to drink. Employee 2 noted Requesting something to drink. Out to check orders. Assessed saline lock at that time, saline found out, catheter intact. Resident C1's clinical record failed to reveal that the physician ordered IV fluids were initiated in a timely manner and failed to reveal that the resident received the prescribed fluid volume. During an interview with the Assistant Director of Nursing (ADON) on March 27, 2024, at 1:30 p.m., confirmed that at the time of the survey the facility could not provide documented evidence that Resident C1's IV fluids were timely initiated as ordered and that the resident received the prescribed fluid volume as prescribed (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.12 (c)(d)(1)(3)(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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on clinical record review and staff interview it was determined that the facility failed to timely obtain prescribed laboratory services for one resident out of eight residents sampled (Resident C1). Findings included: A review of clinical record revealed Resident C1 was admitted to the facility on [DATE], with diagnoses that included congestive heart failure (CHF) is a weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs with symptoms that include shortness of breath, fatigue, arrhythmias, and edema), cardiomyopathies (disease of the heart muscle which makes it difficult for the heart to pump blood to other parts of the body), dysphagia (difficulty swallowing), and cognitive communication deficit (may occur after a stroke, tumor, brain injury, progressive degenerative brain disorder, or other neurological damage that may result in deficits with thinking and how someone uses language). Resident C1 tested positive for COVID-19 on [DATE]. A review of nursing health status progress note in the resident's clinical record completed by Employee 1, a Registered Nurse (RN), dated February 23, 2024, at 12:34 p.m., revealed that Resident C1 fell and was assessed without any injuries. Employee 1 obtained vital signs and noted hypotension (is a blood pressure reading below the specified limit (,d+[DATE] mmHg) that can cause dizziness, blurred vision, and tiredness) post fall and noted that the resident had large incontinent episodes of foul smelling and tarry stools. Resident C1's attending physician was present at the facility making rounds and ordered 1 litter of 0.9% normal saline solution (NSS) intravenous (IV) and then discontinue when completed, and obtain stools for occult blood (a lab test used to check stool samples for hidden {occult} blood) times three related to large incontinent episodes of foul tarry stool. A change in condition assessment post fall completed by Employee 1, RN, dated February 23, 2024, at 1:19 p.m., noted that the resident's blood pressure (BP) at 9:04 a.m. was ,d+[DATE] (ideal/normal blood pressure range less than ,d+[DATE] mm Hg (millimeters of mercury) as recommended by the American Heart Association) and diarrhea and decreased appetite and fluids. Resident C1's primary care physician was notified and responded with the following feedback for staff: obtain stools for occult blood times three, infuse 1 Litter of 0.9% NSS then discontinue when completed, and repeat a complete blood count (CBC - a set of medical laboratory tests that provide information about the cells in a person's blood), complete metabolic panel (CMP - is a panel of 14 blood tests that serves as an initial broad medical screening tool that assesses kidney function, liver function, diabetic and parathyroid status, and electrolyte and fluid balance), and an iron panel (several lab values to help determine whether the cause of anemia is iron deficiency or chronic inflammation). A review of Resident C1's laboratory results dated [DATE], revealed that the resident's hemoglobin (HGB - protein containing iron that facilitates the transport of oxygen in red blood cells; adult male normal range: 13. 2 to 18.0 g/dL) was low at 7.8 g/dl and hematocrit (HCT - measures the proportion of red blood cells in the blood and carry oxygen throughout the body; adult male normal range: 41% to 50%) was low at 27. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress noted completed by Employee 3, a RN, on February 29, 2024, at 4:45 p.m., revealed that the resident had an altered mental status from his baseline and that the resident's family would like the resident transferred to the emergency department for further evaluation. A review of Resident C1's hospital admission record dated February 29, 2024, at 7:55 p.m., revealed that the resident had septic shock likely related to sepsis and volume depletion (dehydration) and hypotension (low blood pressure). Resident C1's emergency treatment plan upon admission to the hospital included a blood transfusion due to a HGB of 6.9 g/dL, intravenous (IV) fluid resuscitation for rehydration to improve hypovolemia (low blood volume) and hypotension., and administration of Remdesivir (used to treat COVID-19, for certain patients who are in the hospital), Vancomycin (antibiotic that is used to treat serious bacterial infections), Rocephin (is used to treat a wide variety of bacterial infections), and Levophed (norepinephrine bitartrate -a vasoconstrictor, similar to adrenaline, used to treat life-threatening low blood pressure). Resident C1's hospital record revealed that the resident was expired at the hospital on [DATE], at 11:28 a.m. A review of Resident C1's task summary report (an electronic report of assigned resident care needs/tasks that are entered by nurse aides/nursing staff) dated February 2024 revealed that the resident had documented bowel movements (BM) sample opportunities as follows: [DATE] at 4:48 p.m., large BM, [DATE], at 12:08 a.m., large BM, [DATE] at 10:38 a.m., large BM, [DATE] at 5:35 p.m., large BM, and [DATE] at 1:04 p.m., medium BM. At time of survey ending on [DATE], there was no documented evidence that the facility obtained any stool samples to test for occult blood required for diagnostic testing as prescribed by Resident C1's attending physician on February 23, 2024. During an interview with on Assistant Director of Nursing (ADON) on [DATE], at 1:35 p.m., the ADON confirmed that the facility was unable to provide evidence that staff attempted or obtained a stool sample to complete the physician ordered testing, stools for occult blood times three. The ADON confirmed that the facility failed to obtain the three ordered stool samples to be tested for occult blood to determine if blood was present in Resident CR1's stools to assist the physician in diagnosing the resident's low hemoglobin lab values. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services