

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395556	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/15/2024
NAME OF PROVIDER OR SUPPLIER  Shenandoah Senior Living Community		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>39235</p> <p>Based on review clinical records and resident and staff interviews, it was determined that the facility failed to provide care in a manner and environment that promotes each resident's quality of life by failing to respond timely to residents' requests for staff assistance as evidenced by experiences reported by six residents out of eight interviewed (Residents 21, 62, 81, 39, 49, 69, 101, and 61).</p> <p>Findings include:</p> <p>A review of resident clinical records and a facility provided BIMS (brief interview mental status - a tool that assesses cognitive status) report and random interviews conducted on May 15, 2024, with 8 alert and oriented residents, revealed that 6 of the 8 residents interviewed voiced concerns regarding staff's failure to respond to their requests for assistance from staff and provide requested and needed care and services in a timely manner.</p> <p>During interviews, the residents relayed that they feel the facility is not adequately staffed because they wait extended periods of time for staff to respond to their requests for assistance, including untimely responses to their requests via the nurse call bell system.</p> <p>An interview with Resident 62 on May 15, 2024, at 10:05 AM revealed that he consistently waits over 15 minutes for staff to respond to his call bell rings for assistance. He explained that sometimes the wait is up to an hour. He stated that it has been going on for a while now and that he has given up on bringing it up with staff and during resident meetings because nothing has been done to resolve the issue. The resident stated that it is like beating a dead horse. The only thing we get in response is that we are working on it. Resident 62 explained that there is not enough nursing staff to help the residents that need assistance with care. Resident 62 shared that when his family recently came to visit, he wished to spend time with them outside. However, due to insufficient staffing to help him into his chair promptly, he had to have the visit in his room instead. Resident 62 indicated that the wait times for staff assistance continues to be a problem.</p> <p>An interview with Resident 81 on May 15, 2024, at 10:50 AM revealed she sometimes needs staff's assistance but will not ring her call bell because she knows that staff are busy assisting the other residents and will not respond timely.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with Resident 69 on May 15, 2024, at approximately 12:05 PM revealed that she waits 30 minutes for staff to answer her call bell. The resident stated that these waits occur anytime, but mostly on the 3rd shift (night shift) of nursing duty, and that there have been times she has soiled herself while waiting for the call bell to be answered to provide assistance with toileting. She further stated that she feels that short staffing is a problem in the facility that creates these long waits for residents to receive personal assistance when requested.</p> <p>Interview with Resident 49 on May 15, 2024, at approximately 12:15 PM, revealed that the resident stated she waits awhile for staff to answer her call bell. The long waits can occur at any time of day or shift and there have been times she has soiled herself while waiting for the call bell to be answered.</p> <p>Interview with Resident 39 on May 15, 2024, at approximately 12:20 PM, revealed that she feels that short staffing is a problem in the facility because she waits up to an hour for staff to answer her call bell. The resident stated that these waits occur daily, and are mostly during mealtimes.</p> <p>An interview with Resident 61 on May 15, 2024, at approximately 1:02 PM revealed that he waits 30 minutes for staff to answer his call bell. The resident stated that these waits occur mostly on the 2nd shift (evening shift) of nursing duty.</p> <p>An interview on May 15, 2024, at approximately 1:25 PM with the Nursing Home Administrator (NHA) verified that it is his expectation that all residents be treated with dignity and respect. The NHA was unable to explain why multiple residents are reporting untimely staff response times, resulting in the residents' feelings that the facility is not adequately staffed, which was negatively affecting the residents' quality of life in the facility.</p> <p>28 Pa. Code 201.18 (e)(1) Management.</p> <p>28 Pa. Code 201.29 (a) Resident rights.</p> <p>28 Pa Code 211.12 (d)(5) Nursing services</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48276</p> <p>Based on observation, a review of select facility policy, clinical records, the minutes from resident group meetings and grievances lodged with the facility, and resident and staff interviews, it was determined that the facility failed to demonstrate their response to resident complaints and grievances, including those raised at group meetings, including resident complaints and grievances raised during two of the two resident group meeting minutes reviewed (March 2024 and April 2024),</p> <p>Findings include:</p> <p>A review of the facility policy titled Grievances, last reviewed by the facility on June 30, 2023, revealed that the facility has a system in place to ensure the residents right to prompt efforts to resolve grievances. The policy specifies that residents can expect a completed review of the grievance within five to seven business days. The policy also indicates that all written grievance decisions include a summary statement of the resident's grievance, steps taken to investigate the grievance, a summary of pertinent findings or conclusions, and any corrective action taken or to be taken by the facility as a result of the grievance.</p> <p>A clinical record review revealed a BIMS (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact) assessment dated [DATE]. The assessment indicated that Resident 62 is cognitively intact with a BIMS score of 15.</p> <p>An interview with Resident 62 on May 15, 2024, at 10:05 AM revealed that he consistently waits over 15 minutes for staff to respond to his call bell rings for assistance. He explained that sometimes the wait is up to an hour. He indicated that it has been going on for a while now and that he has given up on bringing it up with staff and during resident meetings because nothing has been done to resolve the issue. The resident indicated that it is like beating a dead horse. The only thing we get in response is that we are working on it. Resident 62 explained that there is not enough nursing staff to help the residents that need assistance with care. Resident 62 shared that when his family recently came to visit, he wished to spend time with them outside. However, due to insufficient staffing to help him into his chair promptly, he had to have the visit in his room instead. Resident 62 indicated that the wait times for staff assistance continue to be a problem.</p> <p>A clinical record review revealed a BIMS (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact) assessment dated [DATE]. The assessment indicated Resident 81 is cognitively intact with a BIMS score of 13.</p> <p>An interview with Resident 81 on May 15, 2024, at 10:50 AM revealed that she consistently has concerns about the temperature and quality of food. She explained that she has brought this issue up repeatedly, and it may be good for a day or two, but then the issue continues. Specifically, she indicated that breakfast is the worst because her eggs are cold nine out of ten times. Resident 81 said that it is discussed during resident meetings, but it has not been resolved. She also indicated that she sometimes needs staff's assistance but will not ring her call bell because she knows that staff are busy assisting the other residents.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A clinical record review revealed a BIMS (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact) assessment dated [DATE]. The assessment indicated that Resident 21 is cognitively intact with a BIMS score of 15.</p> <p>An interview with Resident 21 on May 15, 2024, at 11:15 AM revealed that she has concerns that she has brought up to staff and during meetings, but the facility has not resolved her concerns. She explained that there was a resident meeting about a month ago. Resident 21 indicated that she expressed concerns about the food temperature and her bedroom window not opening. She explained that the facility has not resolved the problem.</p> <p>A review of Resident Council meeting minutes dated March 21, 2024 revealed that residents stated food needs to be warmer. Residents at the meeting indicated that hot coffee and hot tea are served cold. Residents indicated that the menu needs more variety. Also, the meeting minutes indicated that nursing staff are not answering residents' call bell rings.</p> <p>There was no documented evidence that grievances were filed on behalf of residents' concerns following the March 21, 2024, meeting or that the facility took action to respond to the residents' concerns regarding the temperature of food or nursing staff's untimely response to residents' call bell rings for assistance.</p> <p>A review of Resident Council meeting minutes dated April 18, 2024, revealed that residents in attendance at the meeting expressed concerns that the food needs to be warmer.</p> <p>There was no documented evidence that grievances were filed on behalf of residents' concerns following the April 18, 2024, meeting or that the facility took action to respond to the residents' concerns regarding the temperature of food.</p> <p>During an interview on May 15, 2023, at approximately 2:30 PM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) were unable to provide evidence that the facility responded to residents' concerns raised at resident group meetings in regards to the temperature of food and the timeliness of staff's response to residents' call bell rings for assistance. The NHA and DON were unable to provide evidence that the facility made efforts to resolve the concerns raised by residents during group meetings and communicated any follow-up actions to residents regarding those concerns. The DON and NHA confirmed that it is the policy of the facility to respond to resident concerns raised during resident group meetings and to provide resident groups with responses, actions, and rationale taken to resolve grievances and concerns.</p> <p>Refer F804</p> <p>28 Pa. Code: 201.18 (e)(1) Management.</p> <p>28 Pa. Code: 201.29 (a) Resident Rights.</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48276</p> <p>Based on a review of clinical records and the facility's grievance/concern log, staff and resident interviews it was determined that the facility failed to demonstrate prompt efforts to resolve resident grievances as evidenced by one resident out of eight sampled (Resident 69) and maintain accurate and complete evidence of the implementation of the facility's grievance process from receipt to resolution.</p> <p>Findings included</p> <p>A review of Resident 69's clinical record, indicated she was admitted to the facility on [DATE], and was cognitively intact.</p> <p>A Social Services note dated April 26, 2024, at 8:20 AM, indicated that Social Services spoke with the resident's power of attorney (POA) regarding an invitation to a care plan meeting scheduled for May 1, 2024. During the conversation, the POA voiced some concerns regarding complaints Resident 69 had shared with the POA about the resident's care and facility services. The resident's POA mentioned that Resident 69 had stated she was sitting on the bed pan for 1 hour and 45 minutes and was not receiving proper care after using the bathroom.</p> <p>A review of the April 2024, resident concern log conducted at the time of the survey on May 15, 2024, revealed only two concerns were noted, and Resident 69's complaint regarding being left on the bed pan for 1 hour and 45 minutes, voiced by the resident's POA to Social Services on April 26, 2024, was not included.</p> <p>A review of a Social Services note dated May 6, 2024, at 10:18 AM, indicated that meeting was held on May 6, 2024 from 9:30 - 10:00 AM with the Assistant Director of Nursing (ADON), therapy, Social Services, POA, and Resident 69 to address the concerns in regards to her care, the food, and the facility. During this meeting, the resident's POA and Resident 69 expressed other concerns regarding the resident's care, including with a nurse aide and the food. According to this entry the ADON stated she will address the issue with the nurse aide and remove resident from the aide's assignment. The resident's complaints regarding the food was that the resident was served a raw hamburger and cold food. The ADON said she would follow up with Dietary Manager. The meeting ended and all concerns were addressed according to this social service documentation.</p> <p>A review of the May 2024, resident concern log, at the time of the survey on May 15, 2024, revealed the word NONE, written on it, and did not include the complaints raised by Resident 69 and the resident's representative during the resident's care plan meeting on May 6, 2024.</p> <p>(continued on next page)</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Resident 69 on May 15, 2024, at approximately 12:05 PM, revealed that she waits 30 minutes for staff to answer her call bell, and these waits occur anytime, but mostly on 3rd shift (nightshift) of nursing duty. The resident stated there have been times she has soiled herself while waiting for the call bell to be answered to provide assistance with toileting. She further stated she feels that short staffing is a problem in the facility that creates these long waits for residents to receive personal assistance when requested. Resident 69 further stated that the food served is cold and is at times unpalatable. The resident stated she has told staff about her concerns and filed complaints with the facility. The resident stated that she no longer has a problem with the specific nurse aide, but the food is still a problem.</p> <p>During an interview on May 15, 2024, at approximately 11:00 AM with the Nursing Home Administrator (NHA), the survey team requested any grievances filed on behalf of Resident 69, and none were provided.</p> <p>Interview with the NHA on May 15, 2024, at approximately 1:25 PM revealed that the NHA stated that the facility had not logged any grievances, concerns, or complaints filed by Resident 69 or on the resident's behalf and that any concerns the resident and POA had were resolved during the resident's care plan meeting.</p> <p>28 Pa. Code 201.18 (e)(1) Management</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48276</p> <p>Based on a review of clinical records, information submitted by the facility, and select facility reports, and staff interviews, it was determined that the facility failed to provide necessary supervision and effective safety measures to monitor the whereabouts and activities of one resident out of the 13 sampled (Resident CR1).</p> <p>Findings include:</p> <p>A clinical record review revealed that Resident CR1 was admitted to the facility on [DATE], with diagnoses that included cerebral infarction (brain damage that results from a lack of blood) and chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe).</p> <p>An elopement assessment dated [DATE], indicated that Resident CR1 was alert and oriented, understands the need to be in nursing home placement for short term rehabilitation, and is a low risk for elopement.</p> <p>A physician's order indicated that Resident CR1 may go out on a leave of absence with medications initiated on April 15, 2024.</p> <p>A review of an admission comprehensive Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 22, 2024 revealed that Resident CR1 is cognitively intact with a BIMS score of 14 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). The Admission MDS dated [DATE], Section GG 0170 Mobility, indicated that Resident CR1 can independently use a wheelchair to ambulate 150 feet in a corridor or similar space.</p> <p>Resident CR1's care plan dated April 25, 2024, indicated that the resident may leave the facility with medications.</p> <p>A progress note dated May 1, 2024, at 2:35 PM indicated that staff observed Resident CR1 getting out of a car at the front entrance around 12:45 PM. The resident stated that he had gone to the car wash to look at an engine. The note indicated that the resident had no injuries, was educated that he needs to notify staff when he leaves the facility, and should not go alone. Resident CR1 stated that he was not aware of needing to tell anyone where he was.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on May 15, 2024, at 12:15 PM revealed that Employee 1, a Licensed Practical Nurse (LPN), was assigned to administer medications on May 1, 2024, on Resident CR1's unit. Employee 1, LPN, stated that Resident CR1 was not in his room for the medication pass at around 10:00 AM on May 1, 2024. Employee 1, LPN, indicated that she continued with the morning medication pass and, when finished, went back to administer Resident CR1's medication. She stated that around 11:45 AM, she identified that Resident CR1 was not in his room and that his lunch tray was on his bedside table and uneaten. She alerted the nurse aides on her unit to locate Resident CR1. During the interview, she stated that Resident CR1 enjoyed sitting outside in front of the building. When the nurse aides were not able to locate Resident CR1, Employee 1 notified facility administration.</p> <p>An interview with Employee 2, LPN, on May 15, 2024, at 12:28 PM revealed that her assignment on the morning of May 1, 2024, was as a receptionist. She stated that she monitors employees, residents, and visitors when they enter or leave the building. Employee 2, LPN, stated that she leaves the desk to use the restroom and to assist residents in the dining room during lunch. She stated that she last saw Resident CR1 at approximately 10:00 AM on May 1, 2024, in the hallway, heading towards the dining room. Employee 2, LPN, stated that she did not see Resident CR1 leave the building or sign out to leave the building on May 1, 2024.</p> <p>An interview with Employee 3, Nurse Aide (NA), on May 15, 2024, at 12:55 PM revealed that she recalled that Resident CR1 was not in his room when his lunch tray was delivered on May 1, 2024, at around 12:00 PM. She stated that the resident likes to sit outside in front of the building. Employee 3, NA, explained that it was normal for the resident to not be in his room.</p> <p>An interview with Employee 4, NA, on May 15, 2024, at 1:15 PM revealed that on May 1, 2024, she went outside to search for Resident CR1. She stated that sometime after 12:00 PM, she saw him exiting a vehicle in front of the building. Employee 4, NA, explained that she approached the vehicle and told the driver that he needed to report to the facility when taking the resident. Employee 4, NA, stated that the person said he did not know the resident and found the resident at a car wash. Resident CR1 was brought back into the facility for assessment.</p> <p>An interview with the Nursing Home Administrator (NHA) on May 15, 2024, at 1:30 PM revealed that the facility had video footage of Resident CR1 leaving the facility. However, the NHA stated that the video footage was no longer available to view. The NHA stated that he reviewed the video footage initially but was unable to remember exactly the time that Resident CR1 left the building or if the receptionist was present. The NHA stated that it may have been around 11:00 AM on May 1, 2024. The NHA was unaware of which car wash the resident visited, but stated that the closest car wash identified was approximately a half a mile away from the facility.</p> <p>A witness statement dated May 1, 2024, provided by the Director of Nursing (DON), indicated that she spoke with the resident upon his return. She stated that she saw him coming through the front entrance and asked him where he went. The DON stated that Resident CR1 explained three times that he went to work on an engine and was brought back to the facility by someone he met at the car wash because he needed to come back to the facility for therapy.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility elopement report dated May 1, 2024, at 2:59 PM indicated that the resident was unable to be located around lunchtime. Resident CR1 was seen exiting a car at the front entrance. No injuries were noted, and he was brought back to his nursing unit. Resident CR1 was noted to be appropriately dressed for the weather and wearing proper footwear. The report indicated that Resident CR1 was assessed and his BIMS was a 10 (a BIMS score of 8-12 indicated moderate cognitive impairment). Resident CR1 was given a wanderguard (a device utilized to alert caregivers if a resident attempts to exit the facility). A urine analysis, culture and sensitivity were ordered by the physician to rule out a urinary tract infection.</p> <p>A clinical record review revealed Resident CR1 was discharged to a personal care setting on May 10, 2024.</p> <p>The facility was unaware that Resident CR1 left the facility without authorization and was unable to state how long the resident was gone. Staff did not begin looking for the resident until approximately 12 PM, although he was not available for morning medication administration at 10 AM.</p> <p>During an interview on May 15, 2024, at 2:15 PM, the NHA confirmed that it is the facility's responsibility to provide necessary supervision and implement effective safety measures to monitor the whereabouts and activities of residents. The NHA confirmed that the facility had no knowledge that Resident CR1 exited the building on May 1, 2024, and could not confirm when the resident left, how long the resident was gone and where the resident went, and its distance from the facility which the resident traveled by means of self-propelling in a wheelchair.</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services</p> <p>28 Pa. Code 201.18 (e)(1) Management</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>48276</p> <p>Based on resident and staff interviews and a review of temperature logs and clinical records revealed that the facility failed to serve appetizing food at palatable temperatures as discerned by residents including five of eight residents interviewed (Resident 21, 101, 61, 81, and 69).</p> <p>Findings included:</p> <p>An interview with Resident 21 on May 15, 2024, at 11:15 AM revealed that the resident stated that the food served is not palatable and is often served cold. The resident stated that the vegetables are overcooked and often mushy.</p> <p>An interview with Resident 101 on May 15, 2024, at approximately 12:40 PM revealed that the resident stated that the food is served cold, and mostly the breakfast meal.</p> <p>An interview with Resident 61 on May 15, 2024, at approximately 1:02 PM revealed that the food could be warmer.</p> <p>A review of a Social Services note dated May 6, 2024, at 10:18 AM, indicated that meeting was held on May 6, 2024 from 9:30 - 10:00 AM with the Assistant Director of Nursing (ADON), therapy, Social Services, POA, and Resident 69 to address the concerns in regards to her care, the food, and the facility. During this meeting, the resident's POA and Resident 69 expressed concerns regarding the food. The resident's complaints regarding the food was that the resident was served a raw hamburger and cold food. The ADON said she would follow up with Dietary Manager. The meeting ended and all concerns were addressed according to this social service documentation.</p> <p>However, Resident 69 stated during interview on May 15, 2024, at 12:05 PM that the food continues to be served cold and is often unpalatable. The resident stated she has told staff about her concerns in the past, with the food and filed complaints, but it remains unresolved.</p> <p>A review of Resident Council meeting minutes dated March 21, 2024 revealed that residents stated that the food needs to be warmer. Residents at the meeting indicated that hot coffee and hot tea are cold. Residents also stated that the menu needs more variety.</p> <p>A review of Resident Council meeting minutes from April 18, 2024, revealed that residents in attendance indicated that the food needs to be warmer.</p> <p>An interview with Resident 81 on May 15, 2024, at 10:50 AM revealed that she consistently has concerns about the temperature and quality of food at group meetings. She explained that she has brought this issue up repeatedly, and it may be good for a day or two, but then the issue continues. Specifically, she stated that breakfast is the worst because her eggs are cold nine out of ten times. Resident 81 said that the problem with cold food is discussed during resident meetings, but it has not been resolved.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395556	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/15/2024
NAME OF PROVIDER OR SUPPLIER  Shenandoah Senior Living Community		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation of the kitchen on May 15, 2024, at approximately 1:45 PM, revealed dietary department temp log, dated March/April 2024, indicating the tray line temperatures for the breakfast, lunch and supper meals. On March 30, and 31, 2024, the breakfast and lunch temperatures were blank, not documented.</p> <p>The log for the tray line temperatures for April 2024, revealed on April 4, 5, 7, 8, 9, 13, 14, 21, 22, 23, 24, 25, 27, and 28, 2024, the breakfast and lunch temperatures were blank, not documented.</p> <p>A review of the tray line temperatures for May 2024, revealed on May 4, 5, 9, 11 and 12, 2024, the breakfast and lunch temperatures were blank, not documented. When reviewed on May 15, 2024, at approximately 1:48 PM, the temperatures were already documented, (in advance), for the supper meal for May 15, 2024.</p> <p>During an interview on May 15, 2024, at approximately 1:55 PM with Employee 5, Dietary Manager, confirmed the lack of temperatures documented on dietary logs (tray line temperature log), and had no explanation of why the temperatures were documented in advance for the supper meal this evening. She acknowledged awareness of the multiple resident complaints of cold food temperatures, and that she spoke with the resident council president, who had no concerns of the temperatures, but had no evidence that she spoke with other residents for their input. She further stated that no additional actions were taken to include point of service temperatures or test trays to evaluate the problem and address the residents' continued complaints.</p> <p>An interview on May 15, 2024, at approximately 1:25 PM with the Nursing Home Administrator (NHA) was unable to explain why numerous residents complained of cold food temperatures and unpalatable food.</p> <p>28 Pa. Code 201.18 (e)(1)(3) Management</p> <p>28 Pa. Code 201.29 (a) Resident rights</p>		