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	01/07/2026

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 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policies, applicable state professional nursing standards, and staff interviews, it was determined the facility failed to provide nursing services in accordance with professional standards of practice, resulting in actual harm. Specifically, the facility failed to initiate cardiopulmonary resuscitation (CPR, an emergency lifesaving procedure consisting of chest compressions and rescue breathing used when an individual is found unresponsive and not breathing normally) for one out of 10 residents reviewed (Resident CR1) who had documented wishes for Full Code status (meaning the resident wanted all possible life-saving measures, including CPR, if their heart or breathing stopped). This failure resulted in actual harm, as life-sustaining interventions consistent with the resident's documented treatment preferences and accepted nursing standards were not provided during a cardiopulmonary arrest.Findings A review of 49 Pa. Code S21.11(a)(4) (relating to general functions of a registered nurse) indicated that a registered nurse is responsible for carrying out nursing care actions that promote, maintain, and restore the well-being of individuals. A review of 49 Pa. Code S21.13(1) (relating to resuscitation and respiration) indicated that a licensed registered nurse shall only perform external cardiac resuscitation and artificial respiration, when respiration or pulse, or both, cease unexpectedly. A review of Section 21.15 of the Pennsylvania Code Title 49 Pa. Code S21.15 (relating to monitoring, defibrillating, and resuscitation) by registered nurses provides instruction that the Registered Nurse can perform resuscitation therapy when (1) the employer through written policy, has agreed that the registered nurse may administer the therapy. (5) The registered nurse has demonstrated competency in administering the therapy to the satisfaction of the employer. A review of the facility policy titled Emergency Procedure-Cardiopulmonary Resuscitation and Basic Life Support last reviewed [DATE], revealed that when an individual (resident, visitor, or staff) is found unresponsive and not breathing normally, licensed or certified staff are to initiate CPR unless a valid Do Not Resuscitate (DNR) order specifically prohibiting CPR exists or there are clear signs of irreversible death (such as rigor mortis, which is post-death muscle stiffening). A review of Resident CR1's closed clinical record revealed admission to the facility on [DATE], at 7:00 PM with diagnoses including chronic obstructive pulmonary disease (a progressive lung condition causing airflow blockage, inflammation, and breathing difficulties, often from smoking), hyperlipidemia (when there are too many fats in the blood), and hypertension (common condition where the force of blood against artery walls is consistently too high/ high blood pressure). A review of Resident CR1's closed clinical record revealed that a face sheet from the referring facility was scanned into the facility's electronic medical record on [DATE], at 1:52 PM, one day prior to the resident's admission. The face sheet, which is routinely provided by the transferring facility as part of the admission process, contained key resident information used to guide care upon arrival, including the resident's code status. Review of this document confirmed that at the referring facility, Resident CR1 was (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

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 01/07/2026
NAME OF PROVIDER OR SUPPLIER Shenandoah Senior Living Community		STREET ADDRESS, CITY, STATE, ZIP CODE 101 E. Washington St Shenandoah, PA 17976	

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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 0658 Level of Harm - Actual harm Residents Affected - Few	designated as Full Code, indicating the resident's preference to receive cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. A nursing progress note dated [DATE], at 7:00 PM documented that Resident CR1 was admitted with baseline confusion, required oxygen therapy, and exhibited dyspnea (shortness of breath). The note documented that attempts to complete admission documentation were unsuccessful due to inability to reach family to confirm the resident's code status. At approximately 2:30 AM on [DATE], Employee 2 (Nurse Aide) and Employee 3 (Nurse Aide) entered Resident CR1's room and found the resident unresponsive.A nursing progress note dated [DATE], at 2:30 AM documented by Employee 1 (Registered Nurse) revealed the resident was unresponsive to verbal commands and sternal rub (a painful stimulus applied to the breast bone to assess responsiveness), had no apical pulse upon auscultation (listening to the heart with a stethoscope), and staff were unable to obtain blood pressure or oxygen saturation using a pulse oximeter (a device that measures blood oxygen levels). The note documented that one respiration was observed, the resident's pupils were fixed and dilated, and the resident's skin was warm and dry to touch. The nursing supervisor was notified. A subsequent nursing progress note dated [DATE], at 3:55 AM documented by the registered nurse supervisor, indicated that upon assessment the resident was unresponsive, pale, without measurable blood pressure, without respirations, and without detectable apical or carotid pulse (the carotid pulse is felt in the neck and reflects central circulation). No DNR order or POLST (Provider Orders for Life-Sustaining Treatment, a medical order translating a resident's treatment preferences into actionable medical orders) was located in the medical record or electronic system at that time. The physician was contacted regarding the resident's death at 2:34 AM. Review of the clinical record revealed no documentation of rigor mortis, dependent lividity (purplish skin discoloration that occurs after prolonged absence of circulation), or other findings indicative of irreversible death at the time the resident was found unresponsive. An interview with Employee 2, Nurse Aide, conducted on [DATE], at 12:45 PM revealed that Employee 2 was not certified in cardiopulmonary resuscitation (CPR) or use of an Automated External Defibrillator (AED, a device that analyzes heart rhythm and delivers an electrical shock during certain types of cardiac arrest) and therefore did not initiate CPR. Employee 2 stated that she observed Employee 1, Registered Nurse, assessed Resident CR1 and directed Employee 3, Nurse Aide, to check the resident's code status; however, this direction was not documented in the clinical record. Employee 2, Nurse Aide, further stated that Employee 4, Registered Nurse Supervisor, arrived in the resident's room and CPR was not initiated. Employee 2 confirmed that at no time during the event did she observe CPR being initiated by either Employee 1, Registered Nurse, or Employee 4, Registered Nurse Supervisor. A review of Employee 1's, Registered Nurse, employee record revealed that Employee 1 successfully completed the cognitive and skills evaluation in accordance with the American Heart Association Basic Life Support (CPR and AED) Program on [DATE], confirming that Employee 1 held current certification and was qualified to initiate CPR to Resident CR1. A review of Employee 4's employee record revealed that Employee 4 successfully completed CPR certification requirements through the American Red Cross, confirming that Employee 4 also held current certification and was qualified to initiate CPR at the time of the incident involving Resident CR1. Phone call attempts were made to Employee 1, Registered Nurse; Employee 3, Nurse Aide; and Employee 4, Registered Nurse Supervisor, on [DATE], at 10:58 AM, 10:59 AM, 11:09 AM, and 11:59 AM, for the purpose of obtaining interviews related to the incident involving Resident CR1 on [DATE]. All initial contact attempts were unsuccessful. A return telephone call was received on [DATE], at 12:15 PM, from legal counsel representing Employee 4, Registered Nurse Supervisor, who declined the interview at that time and indicated that any future requests to interview Employee 4 would need to be submitted in writing (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	through a judicial authority. Based on review of the closed clinical record, staff statements, and training documentation, Employee 1, Registered Nurse, and Employee 4, Registered Nurse Supervisor, failed to initiate CPR for Resident CR1 despite hospital documentation indicating the resident's preference for Full Code status. An interview with the Regional Manager of the facility conducted on [DATE], at 3:38 PM confirmed that initiation of CPR is the responsibility of licensed nursing staff when a resident is found unresponsive and no Do Not Resuscitate (DNR) order exists. The Regional Manager further indicated that licensed nurses are expected to act within their professional scope of practice in accordance with Title 49 Pennsylvania Code, Professional and Vocational Standards. The facility failed to ensure that professional standards of nursing practice were followed when licensed nursing staff did not initiate cardiopulmonary resuscitation (CPR) for a resident who was found unresponsive and without a palpable pulse and who did not exhibit documented clinical indicators of irreversible death. As a result, the resident did not receive timely, potentially life-sustaining interventions required under generally accepted nursing standards and Basic Life Support principles. Because CPR was not initiated, the opportunity to attempt resuscitative measures consistent with the resident's Full Code status was not provided. The facility remains responsible for ensuring that nursing services are delivered in accordance with professional standards of practice. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.10(c) Resident care policies. 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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility investigative documentation, facility policies, American Heart Association (AHA) guidelines, facility-provided witness statements, and staff interviews, it was determined that the facility failed to ensure that cardiopulmonary resuscitation (CPR) was initiated for a resident in accordance with the resident's advance directives and nationally recognized standards of practice. This failure placed one of 10 residents sampled (Resident CR1) and 47 other residents (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, and 47) who desired CPR, out of the facility's 101 resident census, in Immediate Jeopardy to their health and safety with the potential for death as a result of a similar occurrence.Findings include: A review of the facility policy titled Emergency Procedure-Cardiopulmonary Resuscitation and Basic Life Support revealed the document identified Med Pass 2001 at the footer, indicating original policy development by an external vendor. The facility documented review of the policy on [DATE]. This current policy revealed that if an individual (resident, visitor, staff) is found unresponsive and not breathing normally a licensed/certified staff member will initiate CPR (Cardiopulmonary Resuscitation) defined as an emergency lifesaving procedure consisting of chest compressions and rescue breathing, when an individual is found unresponsive and not breathing normally, unless it is known that a Do Not Resuscitate (DNR) order that specifically prohibits CPR and external defibrillation exist for that individual or there are obvious signs or irreversible death (e.g., rigor mortis). The policy further revealed if the resident's DNR status is unclear, CPR will be initiated and continued until it is determined there is a DNR or a physician's order to not administer CPR. The policy further outlined Preparation for Cardiopulmonary Resuscitation, requiring the facility to maintain systems to ensure CPR can be provided during an emergency. These requirements included, but were not limited to: Obtaining and maintaining Basic Life Support (BLS)/CPR certification for all clinical staff in accordance with AHA guidelines (BLS is a level of medical care used for victims of life-threatening illnesses or injuries until full medical treatment can be provided)Maintaining CPR certification through a provider that includes hands-on practice and skills assessmentProviding periodic drills, defined as simulated cardiac arrest events used to practice emergency responseSelecting and identifying a CPR team for each shift, including:Designating a team leader responsible for coordinating rescue effortsEnsuring at least two licensed nurses (Registered Nurse or Licensed Practical/Vocational Nurse) and two certified nurse aides are available and CPR-certified Maintaining CPR equipment and suppliesProviding information on advanced directives upon admission and documenting them in the medical recordEducating staff on how to determine and locate resident code status during an emergency. The policy also required staff to follow American Heart Association guidelines for CPR and defibrillation, including recognition of cardiac arrest, initiation of resuscitation, and airway management.According to American Heart Association guidelines presumptive Signs of Death include unresponsiveness, absence of respirations, absence of a detectable pulse, fixed and dilated pupils (black center of eye enlarged and does not react to light), cool skin relative to baseline, and generalized cyanosis (bluish discoloration due to lack of oxygen).AHA guidelines for Conclusive (irreversible) Signs of Death are presence of livor mortis (venous pooling of blood in dependent body parts causing purple discoloration of the skin).While these signs of irreversible death would not be expected to be seen in most practice settings, the American Heart Association also includes the following irreversible signs of death: decapitation (separation of the head from the (continued on next page)

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	body),decomposition (decay or putrefaction of the body), rigor mortis (stiffness of the limbs and body that develops 2 - 4 hours after death and may take up to 12 hours to fully develop) Clinical record reviews of Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, and 47 revealed current physician orders regarding code status to receive CPR in the event of cardiac arrest. A review of Resident CR1's closed clinical record revealed admission to the facility on [DATE], at 7:00 PM with diagnoses including chronic obstructive pulmonary disease (a progressive lung condition causing airflow blockage, inflammation, and breathing difficulties, often from smoking), hyperlipidemia (when there are too many fats in your blood), and hypertension (common condition where the force of blood against artery walls is consistently too high). A review of Resident CR1's closed clinical record revealed that a face sheet from the referring facility was scanned into the facility's electronic medical record on [DATE], at 1:52 PM, one day prior to the resident's admission. The face sheet, which is routinely provided by the transferring facility as part of the admission process, contained key resident information used to guide care upon arrival, including the resident's code status. Review of this document confirmed that at the referring facility, Resident CR1 was designated as Full Code, indicating the resident's preference to receive cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. A nursing progress note dated [DATE], at 7:00 PM documented that Resident CR1 was admitted with baseline confusion, required oxygen therapy, and exhibited dyspnea (shortness of breath). The note documented that attempts to complete admission documentation were unsuccessful due to the inability to reach family to confirm the resident's code status and to obtain the resident's CPAP (continuous positive airway pressure) machine (a common treatment for sleep apnea that uses a mask and gentle, constant air pressure to keep airways open during sleep, preventing breathing pauses and improving oxygen levels, which reduces risks for heart disease, stroke, and daytime sleepiness). At approximately 2:30 AM on [DATE], Employee 2 (Nurse Aide) and Employee 3 (Nurse Aide) entered Resident CR1's room and found the resident unresponsive. A nursing progress note dated [DATE], at 2:30 AM documented by Employee 1 (Registered Nurse) revealed the resident was unresponsive to verbal commands and sternal rub (a painful stimulus applied to the breast bone to assess responsiveness), had no apical pulse upon auscultation (listening to the heart with a stethoscope), and staff were unable to obtain blood pressure or oxygen saturation using a pulse oximeter (a device that measures blood oxygen levels). The note documented that one respiration was observed, the resident's pupils were fixed and dilated, and the resident's skin was warm and dry to touch. The nursing supervisor was notified. Review of a nursing progress note dated [DATE], at 3:55 AM written by Employee 4 (Registered Nurse Supervisor) documented when she entered the room the resident was unresponsive, pale, pupils blown (informal term for a pupil that is fixed and abnormally dilated (large), failing to constrict in bright light, signaling a severe, life-threatening neurological emergency), no blood pressure, no pulse oximetry reading, no apical or carotid pulse, and no respirations. Sternal rub produced no response. No DNR or POLST (Provider Orders for Life-Sustaining Treatment, a medical order documenting end-of-life care wishes into actionable medical orders for doctors, nurses, and emergency responders, covering interventions like CPR, ventilation, and feeding tubes, and ensuring these preferences travel with the patient across different care settings) was located in the chart or electronic system. The physician was contacted at 2:34 AM regarding the resident's death. A review of the closed clinical record revealed documentation indicating that the resident was last turned, repositioned, and checked for incontinence (involuntary leakage of urine or stool) on [DATE], at 11:23 PM. At that time, the resident was noted to be incontinent of urine. Interview with Employee 2 (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(Nurse Aide) on [DATE], at 12:45 PM confirmed she was not CPR or AED (Automated External Defibrillator, a device that analyzes heart rhythm and delivers an electrical shock during cardiac arrest) certified and did not initiate CPR. Employee 2 stated Employee 1 assessed the resident and directed Employee 3 to check code status, which was not documented. Employee 4 arrived, and CPR was not initiated. Interview with Employee 2 NA (Nurse Aide) on [DATE], at 12:45 PM confirmed that she was the assigned nurse aide to Resident CR1's unit and had found the resident unresponsive on the morning of [DATE]. Employee 2 confirmed that she was not CPR and AED certified, so she did not initiate CPR for Resident CR1 upon finding her unresponsive. Employee 2 stated she and Employee 3 (nurse aide) entered Resident CR1's room at 2:30 AM. Employee 3 stated I was unaware of her baseline because she was new to the facility, when I walked in, she blinked her eyes one time but then just stared and did not respond when I called her name. I had Employee 3 get Employee 1 (RN) who came and assessed Resident CR1. Employee 1 directed Employee 3 to check Resident CR1's code status in the computer. When Employee 3 returned, she stated Resident CR1 did not have a code status documented in the chart. Employee 2 NA further revealed as Employee 3 was checking the code status for Resident CR1, Employee 1 directed Employee 2 to call Employee 4 (RN supervisor). Employee 2 stated Employee 4 arrived and no CPR was initiated. Phone call attempts were made to Employees 1, 3, and 4 on [DATE], at 10:58 AM, 10:59 AM, 11:09 AM, and 11:59 AM for the purpose of obtaining interviews related to the incident involving Resident CR1 that occurred on [DATE]. All contact attempts were unsuccessful. A return telephone call was received on [DATE], at 12:15 PM from legal counsel representing Employee 4. Counsel declined the interview at that time and stated that any future requests to speak with Employee 4 would need to be submitted in writing through a judicial authority. Review of facility-provided witness statements revealed that Employee 3 documented upon entering Resident CR1's room, the resident was unresponsive and exhibiting signs of respiratory distress, prompting Employee 3 to leave the room and notify Employee 1 to assess the resident. Review of facility-provided witness statements revealed that Employee 1 documented entering Resident CR1's room and finding the resident unresponsive to verbal and tactile stimulation, with no apical pulse upon auscultation, inability to obtain blood pressure or oxygen saturation, absence of respirations, and pupils fixed and dilated. The witness statement further documented that the Registered Nurse Supervisor Employee 4, was notified. The witness statement did not document that cardiopulmonary resuscitation (CPR) was initiated by Employee 1 despite the absence of a documented Do Not Resuscitate (DNR) order or other medical order prohibiting CPR. Review of facility-provided documentation revealed that Employee 4 documented entering Resident CR1's room and observing the resident to be unresponsive, pale, without detectable blood pressure, pulse, respirations, or response to sternal rub, and without a documented DNR or POLST in the medical record or electronic system. The documentation further indicated the physician was notified regarding the resident's death. The documentation did not reflect that cardiopulmonary resuscitation (CPR) was initiated by Employee prior to contacting the physician, despite the absence of documented irreversible signs of death. An interview with the Director of Nursing (DON) on [DATE], at 10:00 AM revealed that Employee 4 refused to provide the facility with a witness statement following the incident. The DON confirmed education was initiated and provided to staff on [DATE], related to the facility's existing cardio-pulmonary resuscitation (CPR) policy. At the time the education was conducted, the CPR policy had not been revised, despite concerns regarding the policy's inclusion of a designated CPR team and the absence of clearly defined signs of irreversible death. An interview with Employee 5, Licensed Practical Nurse (LPN), conducted on [DATE], at 2:39 PM revealed that at no time throughout employment at the facility had the employee been informed of a CPR team assignment while on shift. The employee (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stated they were unaware that a CPR team was part of the facility's CPR policy, despite education reportedly provided on [DATE]. An interview with Employee 6, LPN, conducted on [DATE], at 2:32 PM revealed that at no time during employment was the employee aware of a CPR team being utilized within the facility. The employee stated a text message regarding CPR was provided on [DATE], and upon entrance to the building for the next shift, the employee signed documentation indicating education had occurred. The employees stated they were not provided with the CPR policy and were unable to reference any information within the policy regarding a CPR team. A review of Resident CR 1's closed clinical record revealed that on the morning of [DATE], nursing staff found the resident unresponsive and documented the resident had no heartbeat and no lung sounds auscultated. The resident was identified as full code status. The facility was unable to provide justification for Employee 1, RN, and Employee 4, RN Supervisor, not initiating CPR upon finding Resident CR1, despite the resident not exhibiting documented signs of irreversible death. As of the survey date of [DATE], the facility had not revised the CPR policy that was in effect on [DATE]. After the Immediate Jeopardy was identified, the facility revised the CPR policy to include detailed signs of irreversible death, defined as physical findings that indicate death has occurred and resuscitation is no longer medically appropriate, and removed references to the assignment of a CPR team. An interview with the facility's clinical consultant, conducted on [DATE], at 2:00 PM revealed the facility does not assign a CPR team during shifts due to staffing availability. The facility provided documentation indicating education on the revised CPR policy was conducted on [DATE], after the policy update. An interview with Employee 7 (LPN) on [DATE], at 5:46 PM revealed that upon arrival to work at 3:00 PM, the employee was asked to sign documentation confirming education on the revised CPR policy. When asked to identify signs of irreversible death, the employee was unable to do so, despite the information being included in the revised policy. The employee stated, I did not actually read the policy, I just signed the sheet. An interview with Employee 8 (LPN) conducted on [DATE], at 5:48 PM revealed that upon arrival to work at 3:00 PM, the employee was asked to review the revised CPR policy. When asked to identify signs of irreversible death, the employee stated they were not educated on any irreversible signs of death, despite the revised policy including detailed guidance. These findings demonstrated the facility failed to ensure staff were able to initiate cardio-pulmonary resuscitation (CPR) in accordance with resident wishes and facility policy, placing residents who desired CPR at risk for serious harm or death. These failures placed residents who desired CPR in the event of cardiac arrest in immediate jeopardy (IJ). The facility was notified of the Immediate Jeopardy on [DATE], at 11:35 AM and the IJ template was provided to the facility at 11:41 AM. An immediate plan of correction was requested and received on [DATE], and accepted on [DATE], at 7:06 PM The IJ removal plan included: Employee 1 (RN) and Employee 4 (Agency RN Supervisor) have been educated concerning the Emergency Procedure - Cardiopulmonary Resuscitation policy and the need to initiate CPR immediately in accordance with resident wishes and were immediately suspended. On [DATE], the Facility educated Licensed Clinical staff on Revisions of the CPR policy, which included updates on how to respond when someone is unresponsive and when not to initiate CPR such as obvious signs of irreversible death and if no code status documented they are a full code. Licensed staff education was initiated immediately, including staff currently located in the facility. The facility also utilized payroll system to send the updated CPR policy to be reviewed and acknowledged by staff electronically. Nursing education related to the updated policy and irreversible signs of death will continue to be completed with licensed staff prior to their next shift starting on [DATE], with 11pm to 7am shift staff. Starting with 11 PM - 7 AM shift on [DATE], Licensed staff education will be completed regarding the need to initiate CPR immediately in (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	accordance with resident wishes, where staff can locate the code status for each resident in Point Click Care (PCC), on the resident face sheet, and in the orders. Facility will ensure each licensed staff member is educated on irreversible signs of death to ensure staff is properly educated on when it is acceptable not to initiate CPR. Education will continue prior to each licensed staff member's next shift. Residents code statuses are reflected in PCC on the resident's face sheet and in the resident's orders. Completed as of survey date [DATE].Director of Nursing or designee will complete an audit EMR (electronic medical record) code status to validate consistency of records for staff reference. Completed as of Survey date [DATE]. DON or designee will complete an audit of CPR certification on Licensed Facility staff. Completed as of Survey date [DATE], revealing as of incident date [DATE], 7 licensed nursing staff were unable to produce a valid CPR certification. The facility conducted a CPR class on [DATE], and again on [DATE], for employees who were unable to produce up to date certification information. The Immediate Jeopardy was lifted on [DATE], at 7:20 PM, upon receipt of the facility's immediate action plan and verification that the actions had been implemented. 28 Pa. Code 211.2(d)(7) Medical Director. 28 Pa. Code 211.12 (d) Nursing care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services. 28 Pa. Code 201.18 (e)(1) Management.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policies and procedures, facility-provided investigative documentation, job descriptions, witness statements, and staff interviews, it was determined that the facility failed to administer the facility in compliance with federal requirements to ensure resident health and safety. Specifically, the Administrator and Director of Nursing failed to establish, implement, oversee, and enforce an effective cardiopulmonary resuscitation (CPR) system, resulting in licensed nursing staff not initiating CPR for one resident (Resident CR1) out of 10 residents sampled who desired full resuscitative measures and did not exhibit documented irreversible signs of death. This failure resulted in Immediate Jeopardy.Findings included:A review of the facility policy titled Emergency Procedure -Cardiopulmonary Resuscitation, last reviewed [DATE], required licensed or certified staff to initiate CPR, defined as an emergency lifesaving procedure consisting of chest compressions and rescue breathing, when an individual is found unresponsive and not breathing normally, unless a valid Do Not Resuscitate (DNR) order exists or there are obvious irreversible signs of death. The policy further required that if code status is unclear, CPR must be initiated until a DNR or physician order not to resuscitate is confirmed. The policy also required administrative systems to ensure CPR readiness, including staff education, competency, and adherence to American Heart Association (AHA) guidelines. According to AHA guidelines, presumptive signs of death (such as unresponsiveness, absent respirations, absent pulse, fixed and dilated pupils, or cyanosis) do not preclude initiation of CPR. Irreversible signs of death, which indicate resuscitation is no longer appropriate, include livor mortis, rigor mortis, decomposition, or decapitation. A review of Resident CR1's clinical record revealed admission on [DATE], at 7:00 PM with diagnoses including chronic obstructive pulmonary disease, hyperlipidemia, and hypertension. The record contained a physician order identifying the resident as Full Code, and a face sheet from the referring facility, scanned into the electronic medical record on [DATE], confirmed the resident's preference to receive CPR. On [DATE], at approximately 2:30 AM, staff found Resident CR1 unresponsive. Nursing documentation reflected the resident was unresponsive to verbal and painful stimuli, had no detectable pulse, no obtainable blood pressure or oxygen saturation, fixed and dilated pupils, and no documented DNR or POLST (Provider Orders for Life-Sustaining Treatment, which converts treatment preferences into medical orders). CPR was not initiated by licensed nursing staff prior to physician notification. Documentation did not reflect the presence of irreversible signs of death. Facility-provided witness statements and staff interviews confirmed that licensed nursing staff deferred CPR while attempting to verify code status, despite policy requirements to initiate CPR when code status is unclear. Interviews further revealed staff lacked understanding of irreversible signs of death and were unaware of any functional CPR team, despite policy language indicating such systems existed. Interviews with the Director of Nursing confirmed that, at the time of the incident, the CPR policy had not been revised to clarify irreversible signs of death and that staff education was conducted without ensuring comprehension or competency. As of [DATE], the facility had not demonstrated that staff were competent to initiate CPR in accordance with resident wishes and AHA guidelines. A review of the facility's Nursing Home Administrator job description, signed and dated [DATE], revealed that the Administrator is responsible for leading and directing the overall operations of the facility in accordance with applicable federal and state regulations, company policies, and resident care requirements. The job description identified the Administrator as accountable for ensuring regulatory compliance and maintaining a system that promotes quality care and resident safety while meeting the facility's operational objectives. The Administrator is (continued on next page)

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 01/07/2026
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)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	responsible for overseeing regular facility rounds to monitor the delivery of nursing care, the operation of support departments, the cleanliness and appearance of the facility, staff morale, and whether resident needs are being met. The job description further identified responsibility for leading the facility management team and consultants in the development and execution of a comprehensive business and operational plan, including setting priorities, assigning responsibilities, and participating in process improvement initiatives designed to improve care delivery, workflow efficiency, and the overall work environment.A review of the Director of Nursing (DON) job description, signed and dated [DATE], revealed that under the supervision of the Administrator and Medical Director, the DON is responsible for planning, organizing, developing, implementing, evaluating, and directing the overall operation of the Nursing Services Department in accordance with current federal, state, and local laws, regulations, and professional standards. The job description identified the DON as responsible for ensuring the highest practicable level of quality nursing care is provided at all times. The DON is further responsible for developing, maintaining, and periodically updating nursing policies and procedures that govern day-to-day nursing operations, as well as ensuring staff are educated on and compliant with those policies. The job description also identified responsibility for coordinating nursing services with other departments to ensure continuity of care and the resident's total plan of care is consistently implemented.The failure of the Administrator and Director of Nursing to administer the facility in a manner that ensured timely initiation of CPR placed residents who desired resuscitative measures at risk for serious harm or death. The facility's noncompliance resulted in a situation in which a resident requiring emergency life-saving intervention did not receive CPR in accordance with physician orders, resident wishes, facility policy, and accepted standards of practice. Immediate Jeopardy was identified on [DATE], at 11:35 AM, as the facility's actions and inactions caused or were likely to cause serious injury, harm, impairment, or death. Refer F678 28 Pa Code 211.10 (c) Resident care policies. 28 Pa. Code: 201.12 (a) Responsibility of licensee 28 Pa. Code: 201.18 (b)(1)(e)(1) Management 28 Pa. Code:211.12(c) Nursing Services