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	09/13/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on observations and resident and staff interviews it was determined the facility failed to accommodate residents' need and preference for access to the call bell system in order to request staff assistance for one resident (Resident 79). Findings include: A review of Resident 79's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included cerebral infarction (also known as an ischemic stroke, is the pathologic process that results in an area of necrotic tissue) with hemiplegia (is a symptom that involves one-sided paralysis. Hemiplegia affects either the right or left side of your body) and hemiparesis (is one-sided muscle weakness and occurs due to disruptions in the brain, spinal cord or the nerves that connect to the affected muscles) to the right dominant side, dysphagia (difficulty swallowing), and muscle weakness. A quarterly Minimum Date Set assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated August 26, 2024, revealed the resident was dependent on staff for all care and ADL's (activities of daily living). During an observation of Resident 79, on September 12, 2024, at 10:00 a.m., the resident was sleeping in his bed. The resident's call bell was observed on the floor and not within the resident's reach. Further observation at 10:30 a.m., revealed Resident 79's call bell remained on the floor. During an interview, at the time of the observation, with Employee 1, a Licensed Practical Nurse (LPN), confirmed the resident's call bell was not in his reach. Interview with the Director of Nursing on September 12, 2024, at 1:35 p.m., the inability to reach the call for Resident 79 was discussed and the DON confirmed residents' call bells should be within reach to alert staff of the need for assistance. 28 Pa Code 211.12 (c)(d)(3)(5) Nursing services

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on a review of clinical records and the Resident Assessment Instrument and staff interview, it was determined that the facility failed to ensure that the Minimum Data Set Assessments (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) accurately reflected the status of one resident out of 20 sampled (Residents 95). Findings included: A review of Resident 95's clinical record revealed that the resident was admitted to the facility on [DATE], and discharged from the facility on August 16, 2024. A review of Resident 95's Discharge MDS assessment dated [DATE], revealed in Section A2105 Discharge Status that Resident 95 was discharged to a short term general hospital. A review of the skilled nursing note dated August 14, 2024, at 1429 hours (2:29 PM) indicating the resident is being discharged on [DATE]. A review of the resident's Discharge Plan and Instructions revealed the resident was discharged home, on August 16, 2024. Review of physician orders dated August 16, 2024, stating discharge to home with all appropriate medications. Interview with Employee 3 (Registered Nurse Assessment Coordinator - RNAC) on September 12, 2024, at approximately 2:20 PM confirmed resident 95 went home, and confirmed the MDS Assessment was inaccurate. Interview with the Nursing Home Administrator on September 12, 2024, at approximately 2:40 PM, confirmed the MDS Assessment was inaccurate. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.12(c)(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 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** 48276 Based on observation, clinical record review, facility investigation reports, and staff interviews, it was determined the facility failed to develop and implement a person-centered care plan to meet the specific needs of one resident out of 20 sampled (Resident 70). Findings including: A clinical record review revealed Resident 70 was admitted to the facility on [DATE], with diagnoses that included dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). Resident 70 has a documented history of falls, as noted in facility investigations and a clinical record review, occurring on the following dates: February 24, March 2, March 29, and June 2, 2024. Resident 70's care plan initiated September 26, 2023, indicated he is deficient in his ability to carry out activities of daily life, such as eating and personal hygiene, related to a lack of coordination, and his diagnoses of dementia. Resident 70's care plan initiated on September 26, 2024, indicated he has limited physical mobility related to difficulty walking, his lack of coordination, and his unsteadiness when on his feet. Resident 70's care plan initiated on September 26, 2024, indicated he is at risk for falling related to his history of falling and his difficulty walking. Interventions implemented to mitigate Resident 70's risk of falling and protect him from injury included ensuring his bed is in the lowest position, bilateral floor mats, a bed alarm, and ensuring his call bell is within reach, initiated on September 26, 2023. A fall risk assessment dated [DATE], identified that Resident 70 is at a high risk for falling. An observation on September 10, 2024, at 11:35 AM revealed Resident 70 was in his bed. His bed was observed not in the lowest position, and a floor mat was only on one side of his bed. An additional observation on September 11, 2024, at 9:45 AM revealed Resident 70 was in his bed. His bed was observed not in the lowest position, and a floor mat was only on one side of his bed. Resident 70's call bell was not within reach, and his bed alarm was disconnected. During an interview on September 11, 2024, at 10:50 AM, Employee 4, Nurse Aide, confirmed that Resident 70's bed was not in the lowest position, a floor mat was only on one side of his bed, his call bell was not within reach, and his bed alarm was disconnected. Employee 4 connected Resident 70's bed alarm. However, the bed alarm did not sound when the resident was assisted out of bed. Employee 4, NA, confirmed the bed alarm was not functioning. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on September 13, 2024, at approximately 10:00 AM, the Nursing Home Administrator (NHA) confirmed it is the facility's responsibility to implement each resident's person-centered care plan. The NHA confirmed that it is the facility's responsibility to ensure that all interventions identified in Resident 70's are implemented to mitigate resident 70's risk for falls and injury. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(c)(d)(5) Nursing services.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on review of clinical records and resident and staff interviews, it was determined that the facility failed to provide restorative nursing services planned to maintain mobility and functional abilities of one of the 20 residents sampled (Resident 77). Findings included: A clinical record review revealed Resident 77 was admitted to the facility on [DATE], with diagnoses that include unsteadiness on feet (walking that is unstable), muscle weakness, and difficulty in walking. A review of an admission Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 18, 2024, revealed that Resident 77 is moderately cognitively impaired with a BIMS score of 10 (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 8-12 indicates cognition is intact). A review of Resident 77's Physical Therapy Discharge Summary dated August 29, 2024, revealed that Resident 77 was receiving physical therapy services from August 12, 2024, to August 29, 2024, and discharged with recommendations to receive restorative nursing services, including bi-lateral active range of motion exercises and ambulation of 200 feet with a roller walker (mobility device) and with a caregiver and gait belt (a safety device to help hold a resident while walking). During an interview on September 11, 2024, at 10:35 AM, Resident 77 indicated that he was not currently receiving therapy services. A Documentation Survey Report for September 2024 revealed that Resident 77 did not receive restorative nursing services until 10 days after he was discharged from physical therapy on August 29, 2024. An interview with Employee 18, Physical Therapist (PT), on September 12, 2024, at 12:00 PM confirmed the facility failed to provide Resident 77 with restorative nursing services until 10 days following discharge from physical therapy. Employee 18, PT, indicated that the facility should have promptly included Resident 77 into the restorative nursing program. During an interview on September 13, 2024, at approximately 12:00 PM, the Nursing Home Administrator (NHA) confirmed that Resident 77 was not provided restorative nursing services until 10 days following his discharge from physical therapy. The NHA confirmed it is the facility's responsibility to provide restorative nursing services planned to maintain residents' mobility and functional abilities. 28 Pa. Code: 211.12(d)(3)(5) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on review of clinical records, information submitted by the facility, select facility reports, and staff interviews it was determined the facility failed to provide a resident who sustained repeated falls the necessary supervision and/or effective fall interventions to prevent a fall with a monor injury for one out of five sampled residents for accidents (Resident 7). Findings include: A review of a facility policy entitled Falls Management that was last reviewed by the facility on June 21, 2024, indicated that each resident is assisted in attaining or maintaining their highest practicable level of function through providing the resident adequate supervision, assistive devices, and functional programs, as appropriate, to prevent accidents. It is the policy of this center to provide each resident with appropriate evaluation and interventions to prevent falls and minimize complications if a fall occurs. A review of Resident 7's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included dementia (a general decline in cognitive abilities that affects a person's ability to perform everyday activities), generalized anxiety (fear characterized by behavioral disturbances), dysphagia (difficulty swallowing), and behavior disturbances (common behaviors associated with dementia include hoarding, restlessness, and accusatory behaviors). A review of a quarterly Minimum Date Set assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated March 11, 2024, revealed the resident's BIMS was a 4 (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 0-7 indicates severe impairment) indicating severe cognitive impairment. A review of the resident's fall risk evaluation dated February 22, 2024, at 5:41 PM, revealed she was at a high for falls. A review of a behavior progress note completed by Employee 9, a Licensed Practical Nurse (LPN), dated April 5, 2024, at 6:52 PM, revealed at the beginning of the shift, Resident 7 had extreme agitation, anxiety, restlessness, and was screaming and yelling making derogatory remarks. The resident was propelling herself in her Broda chair (chair or wheelchair that provides comfort, support, and mobility throughout the day) throughout the unit and she was wandering in other resident's rooms. The resident was redirected out of other resident's rooms and required much encouragement to leave resident the rooms. Occasionally, the resident was leaning forward attempting to pick up things from the floor that were not there causing the chair alarm system to sound and alert staff of her unsafe movements. In response to her behaviors Employee 9 noted the resident was not receptive to taking oral medication and the resident threw the water and swung at Employee 9 and it was noted she was not receptive to conversation, snack, or fluids. The resident continued to propel herself throughout unit within direct supervision. Numerous interventions attempted and continued with periods of anxiety, restlessness, and agitation with no effect (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's comprehensive person-centered care plan for falls, initiated on April 8, 2021, identified that Resident 7 was at risk for falls due to deconditioning and gait balance (refers to a person's pattern of limb movement while walking) problems with a goal to be free of falls. Planned fall prevention interventions included an alarm to her chair to alert staff of unassisted transfers, the alarms placement and function was to be checked on each shift and prn (as needed), ensure proper fitting gripper socks on at all times, low bed for safety, nonskid footwear at all times, and staff to anticipate and meet the resident's needs. Additionally, a review of Resident 7's cognitive impairment plan of care indicated the resident had impaired thought processes related to dementia with mood swings and behaviors with a planned intervention to cue, reorient and supervise her as needed. A review of the facility documentation revealed the Resident sustained an unwitnessed fall from her Broda chair on April 5, 2024 at 10:30 PM and sustained purpura (small blood vessels burst) tear to her right lateral forearm 5.0 centimeters. It was noted the resident was asleep in the Broda chair and when she awoke she sustained a fall. The resident's alarm sound and she was heard calling out Oh! Oh! An intervention after this fall was to place the resident at the nursing station for closer observation. A review of a rehabilitation screen completed by Employee 12, an Occupational Therapist (OT), dated April 11, 2024, at 11:32 AM, revealed that the screen was completed in response Resident 7's unwitnessed fall on April 5, 2024. Employee 12 commented that the resident utilized a Broda chair with sheep wool, Dycem (nonskid material), chair alarm, and reclined position and recently received occupational therapy services for previous fall and provided left lateral support. No change was made to the wheelchair set up and nursing was made aware to provide periodic checkup secondary to noted confusion, agitation, and hallucinations. A review of an investigative report completed by the Director of Nursing (DON), dated April 18, 2024, at 12:23 AM, revealed Resident 7 was observed laying on the floor of the hallway on her right side. Resident denied pain and physical assessment did not reveal any other injury. Redness was noted to the right shoulder, however the resident stated it was red from her scratching the area. The resident had Crocs (slip on rubber shoes) on her feet and staff noted that she was asleep in her Broda chair when a loud snore was heard and then she fell to the floor. The Broda chair was not fully reclined. Immediate action taken was to assist the resident back into her Broda chair and reclined it back. Resident 7 refused to go into her bed and stated, I have not slept in a bed for fifteen years. Further it was indicated the facility will have therapy evaluate seating and remind staff to keep Broda chair reclined when she was in it. A review of a rehabilitation screen that was initiated by the DON on April 18, 2024, at 12:38 AM, and completed by Employee 12, a Physical Therapist (PT), on April 23, 2024 (five days post her fall on April 18, 2025), revealed that skilled physical therapy was not indicated at this time due to circumstances of fall and that the resident's history of delusions, hallucinations, and agitation contributing to falls. A nursing progress note for behavior monitoring completed by Employee 2, LPN, on April 22, 2024, at 12:13 PM, indicated that Resident 7 was yelling out while self-propelling up and down hallways and was exit seeking and trying to get out of the doors. Redirection attempts for safety resulted in agitation and yelling from the resident telling staff to get away from her. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additionally, nursing progress notes reiterated Resident 7's continued behaviors (yelling and cursing staff since start of shift, hitting, attempting to bite and scratch staff) throughout the day shift. A review of an incident report completed by Employee 10, RN, dated April 22, 2024, at 5:00 PM, revealed that while in the hallway Resident 7 tumbled out of her Broda chair on to the floor. Employee 10 assessed the resident and found an 8-centimeter hematoma (is an area of blood that collects outside of the larger blood vessels due to injury or trauma) on the left side of her hairline and a 3-centimeter-long skin tear under the hematoma (a collection of blood underneath the skin). Resident was screaming to leave her alone and was resistant to all verbal conversations. The immediate action taken was cleansed skin tear and hematoma. The physician was notified and new orders noted to obtain an x-ray of head due to the possibility of serious injury. Vitals and neuro check within normal limits and X-ray results unremarkable. Further review of a witnessed fall investigation completed by Employee 16, a RN, dated May 11, 2024, at 5:00 PM, revealed that Employee 15 NA, alerted Employee 9 LPN, that the resident was in her room and slid to the floor from her Broda chair. Employee 15 stated that she walked into the resident's room and observed her reaching for her popcorn and slid out of her chair and onto her buttocks and did not bump head. All fall prevention interventions noted to be in place. Post fall intervention was to issue a reacher (devise used to pick up items without need to bend over) but it had to be removed due to Resident 7 swinging it at people. A review of an unwitnessed fall investigation completed by Employee 17, a RN, dated May 17, 2024, at 10:00 AM, revealed that the resident was found by Employee 18, a Physical Therapist (PT), on the floor in the resident dining room. The resident refused a body assessment multiple times was unable to obtain to complete an assessment due to the resident's agitation/restlessness. The resident able to standup from floor to wheelchair with extensive assistance of two-persons with no signs or symptoms of discomfort noted. Immediate intervention put in place was to not to leave resident alone in the dining room. A review of a witness statement completed by Employee 18, PT, dated May 17, 2024, at 10:15 AM, regarding the aforementioned incident, noted that she was alerted by a visitor that Resident 7 had fallen in the dining room, but had not seen it happen. The resident was observed sitting on the floor with Broda chair approximately five feet from the resident. No alarm was sounding but her non-skid socks were in place. The resident refused interventions or an assessment, yelling to leave her alone, The resident was returned to the Broda chair with assistance of two staff. While the employee was waiting for the RN supervisor, the employee observed the resident reaching toward the floor for nothing. The employee attempted to redirect and offer her the reacher to facilitate safety. The resident became agitated so the employee returned resident to the nurses' station to await further evaluation. Additionally, Resident 7 had another fall from her Broda chair on May 22, 2024, without injuries and every fifteen-minute checks were implemented. During an interview with Employee 18, a PT, on September 12, 2024, at approximately 10:30 AM, discussed Resident 7's repeated falls from her Broda chair and indicated that resident had two different wheelchairs since admission and that the Broda chair was chosen due to not wanting to compromise her mobility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to provide sufficient supervision to a resident that was a high fall risk with known unsafe behaviors and repeated falls from the Broda chair. Additionally, the facility failed to develop and implement effective fall interventions to deter repeated falls. An interview with the Director of Nursing (DON) on September 13, 2024, at 10:15 AM, confirmed that the facility failed to provide sufficient supervision to a resident that was a high fall risk with known unsafe behaviors and repeated falls and that the facility failed to develop and implement effective fall interventions to deter Resident 7's repeated falls. 28 Pa. Code 201.18 (e)(2.1) Management 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on review of select facility policy, clinical records and staff interview, it was determined the facility failed to consistently and accurately monitor resident weights to timely identify changes in nutritional parameters for a resident with an identified significant weight loss and gain for 1 of 20 residents sampled (Resident 31). Findings include: A review of the policy titled Weight Assessment and Intervention Policy Statement, last reviewed by the facility on April 21, 2024, revealed the nursing staff will weigh the resident on admission, then weekly for four weeks. If there are any weight changes, the weight will be retaken for confirmation. Any weight change of five pounds or greater since the last weight assessment will be retaken for confirmation. A review of the residents' clinical record revealed the resident was admitted on [DATE], with the diagnosis to include paroxysmal fibrillation (a type of abnormal heart rate), cerebral vascular disease (a disease that affects the blood vessels and blood supply to the brain), and dysphagia (difficulty swallowing). A review of Resident 31's weight record revealed that on May 21,2024 the resident weighed 150.2 lbs. and then on May 30, 2024, the resident's weight was 135.6 lbs., which was a 9.72% significant weight loss in nine days. Further review of Resident 31' s' weight record revealed the next recorded weight was obtained, on June 12, 2024 (thirteen days after the last documented weekly weight) and the resident weighed 122.8 lbs, which was an additional 9.4% loss in weight in thirteen days. Additionally, the resident was reweighed on June 13, 2024, and weighed 116.4 lbs., which was an additional 14.1% significant weight loss. A review of Resident 31's clinical record revealed no documented evidence the facility obtained weekly weights to timely identify and deter progressive significant weight loss. During an interview on September 13, 2024, at approximately 12:30 PM, the Registered Dietician confirmed the staff failed to obtain and record resident 31's weekly weights as planned to provide the necessary information to accurately assess the resident's nutritional status and needs and evaluate the adequacy of the resident's nutritional intake and plan nutritional support as necessary. During an interview on September 13, 2024, at approximately 12:00 PM, the Nursing Home Administrator (NHA) confirmed that Resident 31's reweights were not obtained and recorded weekly to provide the necessary information to accurately assess the resident's nutritional status. The NHA confirmed it is the facility's responsibility to monitor the nutritional parameters of a resident with an identified significant weight loss. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on observation, a review of clinical records, a review of nurse staffing, and interviews with staff and residents, it was determined the facility failed to provide sufficient nursing staff to provide timely and quality care for residents that sustained falls, for three residents out of 20 sampled (Residents 7, 70, and 90) and failed to provide timely care expressed by residents during a resident group interview (Residents 1, 35, 52, 65, and 71). Findings included: The facility failed to provide sufficient supervision and implement effective fall prevention interventions for two residents at high risk for falls, Resident 7 and Resident 70, both of whom experienced repeated falls despite being identified as high fall risks. A review of Resident 7's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included dementia and severe cognitive impairment. Resident 7 has a documented history of falls from her Broda chair, often accompanied by agitation and behaviors. Despite various care plan interventions (e.g., chair alarms, non-skid footwear), the resident continued to experience falls, including incidents on April 5, April 18, April 22, and May 22, 2024. Staff repeatedly documented the resident's agitated behaviors and attempts to get out of her chair unassisted, yet adequate supervision and effective fall interventions were not sustained. A clinical record review revealed Resident 70 was admitted to the facility on [DATE], with diagnoses that included dementia and a documented fall history. Despite various care plan interventions to mitigate Resident 70's risk of falling and protect him from injury (e.g., ensuring his bed is in the lowest position, bilateral floor mats, a bed alarm, and ensuring his call bell is within reach), the resident continued to experience falls, including incidents on February 24, March 2, March 29, and June 2, 2024. A clinical record review revealed Resident 90 was admitted to the facility on [DATE], with diagnoses that included orthopedic aftercare and with inflammation and infection to an internal right hip prosthesis (hip replacement). A review of an admission Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated September 4, 2024, revealed that Resident 90 is cognitively intact with a BIMS score of 15 (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). During an interview on September 10, 2024, at 12:05 PM, Resident 90 reported experiencing pain and stated that he had been waiting to be helped into bed to rest since 11:00 AM. He explained that he is new to the facility and has been experiencing long wait times for care. He mentioned that he typically waits 30 minutes to an hour, and last night, he waited for over an hour. Resident 90 clarified that he does not blame the staff, as they are doing their best, but there aren't enough staff members to assist the residents promptly. He expressed frustration with the long wait times for care. (continued on next page)

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Shenandoah Senior Living Community	101 E. Washington St Shenandoah, PA 17976

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on September 10, 2024, at 12:18 PM, Employee 6, Nurse Aide, confirmed that Resident 90 had been waiting for about 45 minutes to be assisted into bed. She explained that she is the only staff member in the area at the time and needs assistance to safely transfer him. Employee 6 emphasized that she is doing her best, but there are not enough staff to meet the residents' needs in a timely manner. She also noted that there are about 27 residents in the hallway and only two staff members available to care for them. While she is busy with resident care now, she mentioned the evening shift often faces even greater staffing shortages. During an interview on September 10, 2024, at 12:20 PM, Employee 5, Nurse Aide, reported that Resident 90 had requested to be transferred into bed around 11:30 AM. She explained that it requires two staff members to transfer him, but no one was available to help her at that moment because staff were busy serving meals. At 12:31 PM on September 10, 2024, Employees 5 and 6 were observed entering Resident 90's room to assist him into bed. During a resident group interview, with alert and oriented residents, on September 11, 2024, at 10:00 AM, Residents 1, 35, 52, 65, and 71 indicated the lack of nursing staff has negatively affected the care services they receive at the facility. During the resident group interview, Resident 1 indicated that he often waits 30 minutes to an hour for care, and the wait times are the longest on the evening and night shifts. He explained that when the facility uses agency staff because of staff shortages, the care is not any better. Resident 1 indicated that facility staff will give him a bed bath instead of a shower because they are low on staffing. He indicated that a few times this week he was not offered a snack because the nurse aides were busy providing care to other residents. During the resident group interview, Resident 35 indicated that she is independent and does not need to rely on staff for assistance with care. However, she indicated that two or three times this week there were not enough staff to pass out evening snacks. She explained that when the facility uses agency staff, they do not know that snacks need to be offered to residents. During the resident group interview, Resident 52 indicated that she sometimes waits 30 minutes or longer for care after ringing her call bell for assistance. She indicated that sometimes there is only one nurse aide assigned to her hallway and that the one staff is not able to take care of all the residents needs. During the resident group interview, Resident 65 indicated that he waits 30 minutes on the evening and night shift for staff to respond to his call bell after he rings for assistance. During the resident group interview, Resident 71 expressed concerns about staffing levels at the facility, stating that there is not enough staff. She explained that staff members never ask or remind her about taking her scheduled shower. Resident 71 reported that if she does not inform the staff that it is her shower day, she missed her shower for the week, resulting in a two-week gap between showers. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's nurse staffing from September 5, 2024, to September 11, 2024, revealed that the facility failed to meet the state's minimum requirement for direct care hours per patient on all seven days. The required direct care hours represent the minimum amount of care each resident must receive daily, which may increase based on individual resident needs. The facility provided an average of 2.72 hours of care per resident per day, falling short of the state-mandated minimum of 3.2 hours. A review of the facility's nurse staffing from September 5, 2024, to September 11, 2024, revealed the facility failed to meet the required minimum state ratio for nurse aides on 9 of the 21 shifts reviewed. The facility failed to meet the required minimum state ratio for licensed practical nurses on 6 of the 21 shifts reviewed. The facility failed to meet the state minimum required nursing staff direct care hours per day for each resident on 7 out of 7 days reviewed. During an interview on September 13, 2024, at approximately 10:30 AM, the Nursing Home Administrator (NHA) confirmed that the facility failed to meet the state minimum requirements for nurse aides, licensed practical nurses, and nurse staff direct care hours for residents per day. The NHA confirmed that it is the facility's responsibility to provide sufficient nursing staff to provide timely and quality care to each resident. Furthermore, the NHA confirmed the facility is responsible to ensure that there is sufficient nurse staffing to provide adequate supervision to residents who are at risk of falling, to protect residents from injury, and mitigate residents' risk of falling. Refer F656 F689 28 Pa. Code 201.18 (b)(1)(3)(e)(1)(2)(3)(6) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12 (c)(d)(4)(5)(f.1)(4)(i)(2) Nursing services.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records and staff interviews, it was determined the facility failed to ensure the resident's drug regimen was free of unnecessary antibiotic medication for one out of 20 residents sampled (Resident 2). Findings included: A clinical record review revealed Resident 2 was admitted to the facility on [DATE], with diagnoses that included dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A progress note dated June 24, 2024, at 9:30 PM indicated a urine sample was obtained from Resident 2 directly from her Foley catheter (an indwelling catheter is a flexible tube used for draining urine from the bladder and having an inflatable part at the bladder end that allows the tube to be kept in place for variable time periods). The urine sample was placed in refrigeration, while awaiting transfer to the laboratory. A review of Resident 2's clinical record revealed no documented evidence capturing Resident 2's symptoms or clinical justification to collect a urine sample for a culture and sensitivity test. A Urine Culture and Sensitivity report report (a urine culture is a method to grow and identify bacteria that may be in the urine. The sensitivity test helps select the best medicine to treat the infection) dated June 29, 2024, revealed that Resident 2's urine tested positive for the following organisms: Escherichi Coli (E. coli- a type of bacteria) with organism quantities greater than 100,000 colonies/mL Escherichi Coli (2) type with organism quantities between 10,000 and 100,000 colonies/mL. Pseudomonas aeruginosa (a type of bacteria) with organism quantities greater than 100,000 colonies/mL. The Urine Culture and Sensitivity report dated June 29, 2024, revealed that all three organisms were resistant to the Ampicillin class of antibiotics. A progress note dated June 29, 2024, at 4:26 AM, indicated the physician ordered Amoxicillin 500 mg (ampicillin and amoxicillin are aminopenicillins derived from the parent drug penicillin) three times a day for five days. A physician's order for Amoxicillin Oral Capsule 500 mg with direction to give one capsule three times a day for a urinary tract infection (UTI) initiated on June 29, 2024. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated June 29, 2024, at 2:59 PM, indicated Resident 2 began receiving Amoxicillin as ordered for a urinary tract infection. The resident had no adverse reaction, no complaints of urinary discomfort, and her Foley catheter is intact and draining clear yellow liquid. There was no documented evidence the resident had experienced any symptoms of a urinary tract infection, such as fever, chills, mental changes/confusion, fatigue, nausea/vomiting, pressure in the lower part of the pelvis, or an increase in urination from June 24, 2024, through June 29, 2024. A review of the medication administration record for June 2024 revealed that Resident 2 was administered Amoxicillin oral capsule 500 mg on: June 29, 2024, at 10:00 PM June 30, 2024, at 6:00 AM June 30, 2024, at 2:00 PM June 30, 2024, at 10:00 PM During an interview on September 13, 2024, at approximately 9:30 AM, the Director of Nursing (DON) confirmed that Resident 2's culture report dated June 29, 2024, indicated the organisms present were resistant to Ampicillin antibiotics. The DON was unable to provide the clinical justification for Resident 2 to receive Amoxicillin Oral Capsule 500 mg. The DON confirmed it is the facility's responsibility to ensure that residents' drug regimen is free of unnecessary use of antibiotic. 28 Pa. Code 211.2 (d)(3) Medical director. 28 Pa. Code 211.9 (k) Pharmacy services. 28 Pa. Code 211.12 (d)(3) Nursing services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on clinical record review, observations, and staff interview, it was determined the facility failed to maintain infection control practices to prevent potential spread of infection for two out of 20 residents sampled (Resident 77 and 83) and failed to offer and/or provide SARS-CoV-2 (COVID-19) immunization, unless the immunization was medically contraindicated or the resident has already been immunized, to one of five residents reviewed (Resident 2). Findings include: A review of facility policy titled Coronavirus Disease (COVID-19)-Infection Prevention and Control Measures, last reviewed by the facility on June 21, 2024, revealed the facility follows infection prevention and control practices recommended by the Centers for Disease Control and Prevention to prevent the transmission of COVID-19 within the facility. A review of the CDC ' s Use of an Additional Updated 2023-2024 COVID-19 Vaccine Dose for Adults Aged greater than or equal to [AGE] years: Recommendations of the Advisory Committee on Immunization Practices-United States, 2024, revealed according to the Advisory Committee on Immunization Practices (ACIP) recommendations as of February 28, 2024, all persons aged [AGE] years and older should receive one additional dose of an updated (2023-2024 Formula) COVID-19 vaccine (Moderna, Novavax, or Pfizer-BioNTech). This dose should be given at least four months after their previous updated dose to enhance immunity and reduce the risk of severe COVID-19-associated illness. A review of the CDC's Testing and Management Considerations for Nursing Home Residents with Acute Respiratory Illness Symptoms when SARS-CoV-2 (COVID-19) and Influenza Viruses are Co-circulating, lasted reviewed November 14, 2023, revealed that residents confirmed to have SARS-CoV-2 infection should be placed in a single room, if available, or housed with other residents with only SARS-CoV-2 infection. A review of the COVID-19 Infection Control and Outbreak Response Toolkit for Long Term Care Published July 2023 by the Pennsylvania Department of Health indicates; Dedicating an area within the facility to cohort residents on isolation for confirmed COVID-19 during their infectious period is best practice for decreasing the likelihood of transmission. Components of a COVID-19 Care Unit ideally include the following: Physical separation from other rooms and spaces where residents are not confirmed with COVID-19; Single-person room(s) with designated bathroom(s); Place a resident with suspected or confirmed COVID-19 in a single- person room. The door should be kept closed, if safe to do so. The resident should have a dedicated bathroom. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	If limited single rooms are available, or if numerous residents are simultaneously identified to have symptoms concerning for COVID-19, residents may remain in their current location until cause of symptoms is determined. If cohorting, only residents with the same pathogen should be housed in the same room. Multidrug-resistant organism (MDRO) colonization or infection status, and/or presence of other communicable disease should also be taken into consideration during the cohorting process. A clinical record review revealed Resident 77 was admitted to the facility on [DATE], with diagnoses that included aftercare following digestive system surgery. A clinical record review revealed Resident 83 was admitted to the facility on [DATE], with diagnoses that included dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A clinical record review revealed Resident 77 and Resident 83 shared resident room Blue Wing 07. Facility infection control tracking records indicate that Resident 77 tested positive for SARS-CoV-2 (COVID-19) on September 3, 2024. A clinical record review failed to find documented evidence that the facility attempted to isolate Resident 77 in a single room. A clinical record review failed to find documented evidence that the facility provided Resident 83 or Resident 83's representative information regarding the risks of sharing a room with a resident that tested positive for SARS-CoV-2 (COVID-19), including current CDC recommendations. There was no documented evidence in the clinical record the facility provided Resident 83 or Resident 83's representative with an opportunity to make an informed decision to change rooms. Facility infection control tracking records indicate that Resident 83 tested positive for SARS-CoV-2 (COVID-19) on September 5, 2024. During an interview on September 13, 2024, at approximately 9:30 AM, the Director of Nursing (DON) was unable to provide evidence the facility attempted to isolate Resident 77 in a single resident room or in a room with only other residents that tested positive for SARS-CoV-2 (COVID-19). The DON confirmed there was no documented evidence the facility provided Resident 83 or Resident 83's representative with an opportunity to make an informed decision to change rooms. A review of the DON's Nursing Home Infection Preventionist Training credentials revealed that she was not certified as an infection preventionist until August 27, 2024. During an interview on September 13, 2024, at approximately 10:30 AM, the Nursing Home Administrator (NHA) confirmed that the facility did not currently have an infection preventionist. The NHA explained that the Director of Nursing (DON) has been covering the duties of the infection preventionist since July 18, 2024. The NHA confirmed that the DON was not certified as an infection preventionist until August 27, 2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A clinical record review revealed Resident 2 was admitted to the facility on [DATE], with diagnoses that included dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A clinical record review revealed no evidence that Resident 2 or Resident 2's representative received education regarding the benefits and potential side effects of SARS-CoV-2 (COVID-19) immunization. The clinical record did not contain evidence that Resident 2 was offered SARS-CoV-2 (COVID-19) immunization since May 19, 2022. Resident 2's clinical record did not indicate that receiving SARS-CoV-2 (COVID-19) immunization is medically contraindicated. During an interview on September 13, 2024, at approximately 9:30 AM, the Director of Nursing (DON) was unable to provide evidence Resident 2 or Resident 2's representative received education regarding the benefits and potential side effects of SARS-CoV-2 (COVID-19) immunization, evidence Resident 2 was offered SARS-CoV-2 (COVID-19) immunization since May 19, 2022, or evidence that SARS-CoV-2 (COVID-19) immunization is medically contraindicated for Resident 2. The DON confirmed that the facility is responsible for ensuring residents/resident representatives are afforded the opportunity to make informed decisions regarding SARS-CoV-2 (COVID-19) immunization. Refer F882 28 Pa. Code 211.10(a)(d) Resident care policies 28 Pa code 211.12 (c)(d)(1)(5) Nursing Services

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 48276 Based on review of employee personnel records and staff interview, it was determined the facility failed to have an Infection Preventionist (IP) that worked at least part time at the facility. Findings Include: A review of facility policy review and observations determined the facility failed to ensure infection control practices were maintained to prevent the spread of infection as evidenced by the transmission of the COVID-19 virus between two residents on September 5, 2024. During an interview on September 13, 2024, at approximately 10:30 AM the Nursing Home Administrator (NHA) confirmed that the facility did not currently have an infection preventionist. The NHA explained that the Director of Nursing (DON) has been covering the duties of the infection preventionist since July 18, 2024. A review of the DON's infection preventionist credentials revealed a certification titled Training Plan Proof of Completion that acknowledges the DON successfully completed the Nursing Home Infection Preventionist Training Course on August 27, 2024. The NHA confirmed the DON was not certified as an infection preventionist until August 27, 2024. The NHA indicated that an infection preventionist is scheduled to begin in September 2024. The facility failed to ensure that proper infection control was implemented appropriately by the acting Infection Preventionist to prevent the spread of the COVID 19 virus from one resident to the resident's roommate. Refer F880 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management.