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	07/02/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical records, and staff interviews, it was determined the facility failed to ensure physician orders were consistent in reflecting a resident's elected code status for two of 23 residents reviewed (Residents 29 and 80). Findings include: A review of a facility policy titled Advanced Directives, last reviewed by the facility on [DATE], revealed it is the facility policy that the resident has the right to formulate an advanced directive, including the right to accept or refuse medical or surgical treatment, and advanced directives are honored in accordance with state law and facility policy. Further review revealed Physician Orders for Life Sustaining Treatment, or POLST, is a form designed to improve resident care by creating a portable medical order form that records the resident's treatment wishes so that emergency personnel know what treatments the resident wants in the event of a medical emergency, taking the resident's current medical condition into consideration. A review of the clinical record of Resident 29 revealed the resident was admitted to the facility on [DATE], with diagnoses that included dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces). A review of Resident 29's current physician orders, revealed an order dated [DATE], in the electronic health record, and identified the resident's code status as Full Code, indicating CPR (cardiopulmonary resuscitation) was to be performed in the event of cardiopulmonary arrest (if breathing stops or if the heart stops beating). Further review of Resident 29's clinical record revealed a completed and signed POLST dated [DATE]. The POLST indicated the resident elected DNR status (Do Not Resuscitate, a medical order directing that cardiopulmonary resuscitation, a life-saving procedure performed when the heart or breathing stops, should not be attempted), with a goal of allowing a natural death. Following surveyor questions, there was a physician's order dated [DATE], for DNR (Do Not Resuscitate-a medical order directing that CPR should not be attempted) for Resident 29. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the clinical record of Resident 80 revealed the resident was admitted to the facility on [DATE], with diagnoses that included dementia and urine retention (difficulty urinating and completely emptying the bladder). A review of Resident 80's current physician orders, revealed an order dated [DATE], in the electronic health record, and identified the resident's code status as DNR, indicating CPR was not to be performed in the event of cardiopulmonary arrest. Further review of Resident 80's clinical record revealed a completed and signed POLST dated [DATE]. The POLST indicated the resident elected CPR and to attempt resuscitation. Following surveyor questions, there was a physician's order dated [DATE], for Full Code (attempt CPR) for Resident 80. An interview with the Regional Nurse Consultant on [DATE], at approximately 10:00 AM, confirmed the physician orders did not align with the most current, signed POLST for Resident 29 and 80. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.5 (f)(i) Medical records. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the facility's abuse prohibition policy, select investigative reports and clinical records, and staff interview, it was determined the facility failed to ensure the provision of care and services necessary to prevent a fall and maintain the physical health of one resident out of 23 residents reviewed (Resident 30). Findings include: A review of the facility policy titled Abuse Policy last reviewed by the facility on June 13, 2025, revealed it is the facility's policy that the resident has the right to be free from abuse, neglect, misappropriation or resident property, and exploitation. The policy defines neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. A clinical record review revealed that Resident 30 was admitted to the facility on [DATE], with diagnoses that included above-the-knee right leg amputation, dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), and cognitive communication deficit. A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 28, 2025, revealed Resident 30 was severely moderately 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 moderate cognitive impairment). A physician's order dated May 19, 2025, specified that Resident 30 required assistance from two staff members, using a two-wheeled walker and gait belt (a safety device used to assist residents with mobility issues during transfers and ambulation) for all transfers. The resident's Kardex (a nursing information system used to obtain specific care information for each resident) also indicated two-person assistance was required for transfers. Nursing documentation dated May 24, 2025, at 12:00 PM indicated the nurse was notified that Resident 30 had fallen on the floor in the bathroom. Preliminary assessment was completed in the bathroom and no injuries were noted. Vital signs were obtained. A full head to toe assessment was performed once the resident was back in bed. Plus (+)1 edema (swelling of an area where pressure forms at the site when pressed leaving a depth that disappears at a +1) was noted in the left foot and ankle. The resident complained of pain rated 2/10 (pain rated as one being least amount of pain and ten being the worst amount of pain) in the left ankle. The resident did not have a previous injury to that ankle. The LPN provided pain medication. An x-ray of the ankle was ordered and the resident's sister was notified. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility investigative report dated May 24, 2025 determined that Employee 2 (nurse aide) transferred the resident alone, in violation of the physician's order and Kardex instructions requiring two-person assist. A witness statement dated May 24, 2025, (no time indicated) provided by Employee 2, revealed the resident had asked to go to the bathroom. Employee 2 asked the resident if he required a one or two-person assist, and he said one. She asked if he used a wheelchair or walker, and he said walker. During transfer in front of the toilet, the resident's leg slid, resulting in a fall onto the floor. A review of the facility document titled Post Fall Root Cause Analysis dated May 24, 2025, concluded that Employee 2 failed to follow the resident's documented transfer status as indicated on the Kardex, contributing to the fall. During an interview on July 2, 2025, at approximately 9:30 AM, the Nursing Home Administrator confirmed the above information indicating that Employee 2 did not follow established protocols for safe transfers, placing the resident at risk of injury. The facility failed to implement appropriate care interventions and ensure staff compliance with the physician-ordered transfer protocol. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident Rights. 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of the facility's abuse prohibition policy, clinical records, select facility investigations, and staff interview, it was determined the facility failed to timely report an instance of resident neglect to the State Survey Agency for one out of the 23 residents reviewed (Resident 30). Findings include: A review of the facility policy titled Abuse Policy indicated as last reviewed by the facility on June 13, 2025, revealed all reports of abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and/or injuries of unknown source shall be promptly reported to local, state, and federal agencies. The policy indicates that the nature of the allegations and the names of the resident(s) and individual(s) implicated will be reported to the appropriate agencies within five (5) working days of the incident. A clinical record review revealed that Resident 30 was admitted to the facility on [DATE], with diagnoses that included above-the-knee right leg amputation, dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), and cognitive communication deficit. A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 28, 2025, revealed that Resident 30 was severely moderately 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 moderate cognitive impairment). A physician's order dated May 19, 2025, specified that Resident 30 required assistance from two staff members, using a two-wheeled walker and gait belt (a safety device used to assist residents with mobility issues during transfers and ambulation) for all transfers. The resident's Kardex (a nursing information system used to obtain specific care information for each resident) also indicated two-person assistance was required for transfers. Nursing documentation dated May 24, 2025, at 12:00 PM indicated the nurse was notified that Resident 30 had fallen on the floor in the bathroom. Preliminary assessment was completed in the bathroom and no injuries were noted. Vital signs were obtained. A full head to toe assessment was performed once the resident was back in bed. Plus (+)1 edema (swelling of an area where pressure forms at the site when pressed leaving a depth that disappears at a +1) was noted in the left foot and ankle. The resident complained of pain rated 2/10 (pain rated as one being least amount of pain and ten being the worst amount of pain) in the left ankle. The resident did not have a previous injury to that ankle. The LPN provided pain medication. An x-ray of the ankle was ordered and the resident's sister was notified. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility investigative report dated May 24, 2025 determined that Employee 2 (nurse aide) transferred the resident alone, in violation of the physician's order and Kardex instructions requiring two-person assist. A witness statement dated May 24, 2025, (no time indicated) provided by Employee 2, revealed that the resident had asked to go to the bathroom. Employee 2 asked the resident if he required a one or two-person assist, and he said one. She asked if he used a wheelchair or walker, and he said walker. During transfer in front of the toilet, the resident's leg slid, resulting in a fall onto the floor. A review of the facility document titled Post Fall Root Cause Analysis dated May 24, 2025, concluded that Employee 2 failed to follow the resident's documented transfer status as indicated on the Kardex, contributing to the fall. During an interview on July 2, 2025, at approximately 9:30 AM, the Nursing Home Administrator confirmed the incident of neglect involving Resident 30 which occurred on May 24, 2025 was never reported to the state agency, neither at the time of the incident and including the date of this interview. The incident was not reported within the required five day time frame for reporting allegations of neglect. Refer to F600 28 Pa Code 201.1 (a) Responsibility of licensee. 28 Pa Code 201.18 (e)(1) Management.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and staff interviews, it was determined the facility failed to provide nursing services consistent with professional standards of quality to ensure that licensed nurses properly evaluated and provided nursing care according to physician orders for 2 residents out of 23 residents sampled (Resident 56 and 80). According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates that the Registered Nurse (RN) was to collect complete ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health care team by exercising sound judgment based on preparation, knowledge, skills, understandings, and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) document and maintain accurate records. According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care: Assessments Clinical problems Communications with other health care professionals regarding the patient Communication with and education of the patient, family, and the patient's designated support person and other third parties. A review of facility policy titled Anticoagulation Clinical Protocol, last reviewed by the facility on June 13, 2025, revealed the physician will prescribe anticoagulation therapy(commonly known as a blood thinner, is a chemical substance that prevents or reduces the coagulation of blood, prolonging the clotting time) appropriately consistent with recognized guidelines and should adjust the anticoagulant dose or stop, taper, or change medications that interact with the anticoagulant and/or monitor the PT/INR (a blood test that tells you how long it takes for your blood to clot) very closely while the individual is receiving warfarin (a blood thinner) to ensure that the PT/INR stabilizes within a therapeutic range. Further review revealed the physician will order appropriate lab testing to monitor anticoagulant therapy and potential complications, for example, periodically checking hemoglobin, hematocrit, platelets, and PT/INR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A clinical record review revealed Resident 56 was admitted to the facility on [DATE], with diagnoses that included atrial fibrillation (a condition that causes the heart to beat irregularly and sometimes much faster than normal) and hypertension (blood pressure that is higher than normal). A review of a state Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 12, 2025, revealed that Resident 56 had moderately impaired cognition with a BIMS score of 9 (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 moderately impaired). A review of Resident 56's clinical record revealed a physician's order, dated May 29, 2025, for Warfarin 2.5 mg, one tablet daily at bedtime, for treating/preventing blood clots. A review of Resident 56's clinical record revealed a laboratory result on June 2, 2025, of a PT/INR, which was 1.9 (the therapeutic range is 2.0-3.0). A review of a nurse progress note for Resident 56, dated June 2, 2025, revealed the nurse spoke with the doctor regarding the June 2, 2025, PT/INR results and noted to keep the Coumadin (brand name for warfarin) dose the same with repeat PT/INR in one week. A review of Resident 56's clinical record revealed a physician's order dated June 2, 2025, and noted an order for PT/INR on June 9, 2025. A review of the clinical record revealed no evidence that a PT/INR resulted on June 9, 2025, as ordered by the physician, and the facility was unable to provide evidence of the result. Following surveyor inquiry, a physician's order for Resident 56, dated July 1, 2025, revealed an order for a PT/INR. A review of the clinical record of Resident 80 revealed the resident was admitted to the facility on [DATE], with diagnoses that included dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and urine retention (difficulty urinating and completely emptying the bladder) and had an indwelling Foley catheter (small flexible tube inserted into the urethra to drain urine from the bladder). A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 18, 2025, revealed that Resident 80 had moderately impaired cognition with a BIMS score of 9 (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 moderately impaired). A review of Resident 80's clinical record revealed a physician's order, dated February 19, 2025, to consult urology and the resident would need an appointment due to heavy calcifications (significant mineral deposits composed of salt crystals) at the end of Foley causing bleeding when the Foley was dislodged. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 80's clinical record revealed no evidence that any consults were called to urology and no evidence that an appointment was made for Resident 80. A review of a nurse progress note for Resident 80, dated February 19, 2025, revealed that urine was collected for urinalysis (UA a test of urine used to detect and manage a wide range of disorders, such as urinary tract infections, kidney disease and diabetes; urinalysis involves checking the appearance, concentration and content of urine) and culture and sensitivity (C & S-analysis helps find the most effective antibiotic to kill an infecting microorganism; sensitivity analysis is a test that determines the sensitivity of bacteria to an antibiotic) via catheter after it was changed, and it was noted that the collected urine was described as a blood-tinged, milky urine. A review of Resident 80's clinical record revealed a laboratory result of a UA on February 20, 2025, which was abnormal due to over 50 white blood cells, over 50 red blood cells, 26-50 bacteria cells, a large amount of blood, and turbid color (not clear or cloudy) urine. A review of a nurse's progress note, dated February 20, 2025, revealed the physician was aware of the UA result and no new orders were noted and was awaiting the culture result. A review of Resident 80's clinical record revealed a laboratory result of a urine C & S on February 24, 2025, which was abnormal and showed growth of greater than 100,000 colonies of Proteus vulgaris (type of bacteria), greater than 100,000 colonies of Morganella morganii (a type of bacteria), and 10,000 to 100,000 colonies of Serratia marcescens (a type of bacteria). A review of a nurse's progress note for Resident 80, dated February 24, 2025, revealed the physician was made aware of the urine C&S results and noted an order to follow up with infectious disease and urology. It was noted that results were faxed to urology, and follow-up with infectious disease was to be scheduled. A review of Resident 80's clinical record revealed no evidence of any new orders for urology or infectious disease consults. A review of Resident 80's clinical record revealed no evidence that any consults were called to urology and infectious disease and no evidence that appointments were made for Resident 80. A review of a nurse's progress note dated on April 3, 2025, revealed the resident's urine was noted to be thick and brown in color with a foul smell and that the nurse practitioner in the facility was made aware. A review of a nurse's progress note, dated April 4, 2025, at 9:00 A.M., revealed the nurse was called to assess the resident who was diaphoretic (sweating) with a low blood pressure of 82/52 (normal is 120/80) and a high pulse of 112 (normal is 60-100). It was noted the resident was alert but confused and unable to follow simple instructions. It was also noted the Foley had minimal urine output, and the lower abdomen was distended and tender to touch. The primary doctor evaluated Resident 80 at the bedside, and he was then sent to the emergency room. A review of a nurse's progress note, dated April 4, 2025, at 9:40 P.M., revealed the resident was being admitted to the hospital for sepsis (a life-threatening complication of an infection that leads to a bloodstream infection) and renal failure (kidney failure). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 80's clinical record revealed that during the hospitalization it was noted the resident underwent placement of bilateral nephrostomy tubes (a tube that is put into the kidney to drain urine directly from the kidney) and required a PICC (Peripherally Inserted Central Catheter) line with the requirement of intravenous antibiotics. An interview with the Regional Nurse Consultant on July 2, 2025, at approximately 12:00 PM confirmed the above findings regarding Residents 56 and 80's treatment and care were not` in accordance with physician orders. 28 Pa Code 211.12 (d)(1)(3)(5) Nursing Services. 28 Pa. Code 211.10 (c) Resident care policies.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on review of select facility policy, employee files, and staff interview it was determined that the facility failed to timely train one agency employee out of four employees reviewed on the facility's abuse prohibition policy and procedures. Findings include: A review of the facility policy titled Abuse Policy last reviewed by the facility on June 13, 2025, revealed the facility's abuse prevention program provides training for mandated staff and others that includes topics such as abuse prevention, identification, and reporting requirements and to support an environment in which covered individuals report a reasonable suspicion of a crime, freedom from retaliation or reprisal, stress management, dealing with violent behavior or catastrophic reactions, etc. training is provided at the time of hire, annually, and as needed. A review of Employee 1's personnel file, who was employed as an agency licensed practical nurse (LPN) with a documented start date of November 19, 2022, revealed no evidence that the facility provided the required training on the facility's abuse prohibition policy prior to Employee 1 (LPN) assuming resident care responsibilities. Furthermore, there was no documentation to show that Employee 1 received the training on an annual basis or as needed as required by the facility policy. During an interview conducted on August 26, 2025, at 1:20 PM, the Nursing Home Administrator (NHA) confirmed that there was no documentation verifying Employee 1 (LPN) received the required training on the facility's abuse prohibition policy and procedures either prior to beginning assigned duties or thereafter.28 Pa. Code 201.20(b) Staff development 28 Pa Code 201.18 (e)(1) Management 28 Pa Code 201.10 (d) Resident Care Policies