STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395564	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Ridge Rehabilitation & Healthcare Center	500 West Hospital Street Taylor, PA 18517

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of clinical records and select facility policy, observation and staff and resident interviews it was determined that the facility failed to provide care in a manner that maintains the personal dignity, privacy and quality of life of two residents out of 23 sampled (Resident 49 and 90). Findings include: A facility policy entitled Dignity with a review date of November 27, 2023, revealed that residents are always treated with dignity and respect. The facility culture supports dignity and respect for resident's by honoring resident goals, choices, preferences values, and beliefs. This begins on admission and continues throughout the resident's facility stay. Demeaning practices and standards of care that compromise dignity are prohibited staff are expected to promote dignity and assist residents by helping to promptly response to a resident's request for toileting assistance. An observation on May 8, 2024 at 9 AM, revealed no curtains, shades or blinds on the windows in resident room [ROOM NUMBER], occupied by Resident 49. The window in this resident room is at ground level facing the street and the resident and the interior of his room were clearly visible from the outside of the building Clinical record review revealed Resident 49 was admitted to the facility on [DATE], with diagnosis to include dementia and exhibited behaviors including moving the furniture in his room and removing window coverings as observed during the survey on May 8, 2024. During an interview May 8, 2024 at 1 PM, the acting Director of Nursing stated that in the past Resident 49 had removed the window coverings in his room and the facility had never replaced them or explored alternative window coatings or coverings that would maintain the resident's privacy and that he wouldn't be able to remove. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted May 7, 2024, at 10:11 AM with Resident 90, who was cognitively intact, alert, and oriented, the resident stated that a nurse aide who works on the 11:00 PM to 7:00 AM shift failed to assist her with care when the resident rang her call bell. The aide responded after approximately 45 minutes to say, I will be right back and then never returned leaving the resident incontinent of bowel and bladder for 15 hours. The resident stated that when she initially arrived at the facility she was man handled during transfers using a mechanical lift causing her increased anxiety, as she recently had a traumatizing experience with a transfer that led to her breaking her leg and requiring surgery. During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on May 10, 2024, at approximately 12:45 PM revealed that the facility failed to demonstrate that residents are consistently treated with dignity and respect, including timely response to their requests for assistance to promote their quality of life in the facility. 28 Pa. Code 211.12 (c)(d)(5) Nursing services 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 201.29 (a) Resident Rights

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on observation and staff interview, it was determined that the facility failed to provide housekeeping services to maintain a clean environment on one of three resident units (third floor dementia unit). Findings include: An observation May 8, 2024, at 10 AM in the large dining room floor on the third floor dementia unit revealed that the floor was sticky, dirty and soiled with dried liquid stains. Dirt, dried liquid stains and food crumbs were observed on the window sills in the dining room. The floor in resident room [ROOM NUMBER] was dirty and sticky. A strong urine odor emanated from the resident's mattress. In resident room [ROOM NUMBER] B, there was a broken floor tile under the resident's bed. On the wall next to the door was damaged with deep gouges in the surface and the wallpaper was heavily soiled. The floor in resident room [ROOM NUMBER] was dirty and sticky. The floor in resident room [ROOM NUMBER], was dirty, with dirt accumulated around the perimeter of the room. During an interview May 9, 2024, the interim Nursing Home Administrator stated that resident rooms and dining/activity areas should be maintained in a clean and sanitary manner. 28 Pa. Code 201.18 (e)(2.1) Management

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of clinical records and grievances filed with the facility and resident and staff interviews, it was determined that the facility failed to demonstrate timely and adequate efforts to resolve resident grievances including those voiced by two out of 23 residents sampled (Residents 76 and 90). The findings include: A review of clinical record revealed that Resident 76 was admitted to the facility on [DATE], with diagnoses that include gastroesophageal reflux disease ([GERD] occurs when stomach acid frequently flows back into the esophagus) with esophagitis (inflammation or irritation of esophagus, the pipe that carries food from mouth to stomach) and muscle weakness. An annual Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated February 14, 2024, revealed that the resident was cognitively intact, requiring moderate assistance with activities of daily living (ADL). A Grievance/Concern Form filed by Resident 76's guardian on May 3, 2024, on behalf of the resident revealed that the resident would like to talk to dietary staff about her current preferences. The facility's noted results and findings of the grievance were that the dietary manager went to discuss the resident's preferences. The facility resolution was that the dietary manager reviewed preferences with the resident, guardian and resident were informed. During an interview with Resident 76 on May 7, 2024, at 9:44 AM the resident stated that she was on a full liquid diet, and she was tired of the food/beverages the facility provided her to eat on this diet. She stated that she never receives a bedtime snack because of this diet, and she wanted to discuss her preferences with someone that could help her with this problem. During a follow-up interview with Resident 76 on May 9, 2024, at 11:10 AM the resident stated that no facility staff had yet visited her to discuss anything related to her food preferences with her, and she was upset. A review of clinical record revealed that Resident 90 was admitted to the facility on [DATE], with diagnoses that include irritable bowel syndrome - diarrhea ([IBS-D] frequent episodes of diarrhea with abdominal pain) and need for assistance with personal care. A quarterly MDS dated [DATE], revealed that the resident was cognitively intact, requiring extensive assistance ADLs. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Resident 90 on May 7, 2024, at 10:10 AM the resident stated that she had filed a grievance with the facility related to staff's failure to answer her call bell on the 11:00 PM to 7:00 AM shift three weeks ago. She stated that staff came in after about 45 minutes, after she initially rang the call bell, and said they would be right back, but never returned leaving her incontinent of bowel and bladder for 15 hours. The resident stated that to date she has not heard anything back from staff related to this grievance filed. There was no indication that the facility had timely evaluated the resident's complaints regarding untimely call bell response and improper incontinence care. There was no documented evidence at the time of the survey ending May 10, 2024, that the resident's grievance was addressed or investigated by the facility. At the time of the survey ending May 10, 2024, the facility was unable to provide documented evidence that it had determined if the residents' felt that their complaints or grievances had been resolved through any efforts taken by the facility in response to the residents' expressed concerns regarding food preferences, untimely call bell response and proper incontinence care. During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on May 10, 2024, at 12:30 PM, were unable to provide documented evidence that the facility had followed up with the residents to ascertain the effectiveness of the facility's efforts in resolving their complaints regarding dietary and nursing services. 28 Pa. Code 201.18 (e)(1)(2) Management 28 Pa. Code 201.29 (a)(c) Resident rights 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services

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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** 43944 Based on review of clinical records, select facility policy and investigative reports resident and staff interview, it was determined that the facility failed to ensure that one resident was free from physical abuse out of 23 sampled residents (Resident 85). Findings including A review of the current facility policy titled Abuse Policy, last reviewed by the facility November 27, 2023, revealed that residents have the right to be free from abuse. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting in physical harm, pain, or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The facility's goal is to achieve and maintain an abuse-free environment. A review of Resident 85's clinical record revealed that she was admitted to the facility on [DATE], with diagnoses that included Alzheimer's disease [is a gradually progressive type of brain disorder that causes problems with memory, thinking and behavior], symbolic dysfunction [is a concept that refers to the breakdown in communication caused by misinterpretation or misunderstanding of symbols that can significantly impact the ability to effectively communicate and understand one another] , and moderate depressive disorder [is a mental health disorder having episodes of psychological depression]. A quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident was severely cognitively impaired with a BIMS (brief interview for mental status - a tool to assess cognitive status) score of 4. Resident 85's plan of care initiated June 1, 2023, identified that the resident had behaviors related to Alzheimer's dementia, bipolar disorder, major depressive disorder. The resident was noted as physically aggressive toward others, verbally aggressive toward others, verbally aggressive towards staff when being redirected, and liked to incite chaos/[NAME] other peers. The resident's goal was to be free of harming self or others during periods of combativeness, display fewer episodes of behavior problems, remain injury free related to behaviors, and have no adverse effects related to behaviors. Planned interventions were to encourage the resident to stay in dayroom for increased supervision and activity, keep the resident safe during episodes of behaviors and attempt to redirect, provide a calm safe environment when the patient's frustrations escalate and allow time to voice feelings, and behavior tracking even fifteen minutes checks. A review of Resident 60's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included encephalopathy [is a medical term used to describe a disease that affects brain structure or function and causes altered mental state and confusion], amnesia (a condition characterized by the inability of a person to recall facts or previous experiences), and cerebrovascular disease [is a term for conditions that affect blood flow to your brain that can result in stroke, brain bleed, aneurysm (a bulge in the wall of an artery that can rupture and cause bleeding inside the body and often leads to death)]. A quarterly MDS assessment dated [DATE], indicated that the resident was severely cognitively impaired with a BIMS score of 5. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 60's plan of care dated August 23, 2023, identified that the resident has behaviors such as increased agitation as evidence by banging on door, delusional thoughts, accusatory towards others, exit seeking, combativeness, and physically aggressive with peers. The resident's goal was to be free of harming self or others during periods of combativeness and would have no adverse effects related to behaviors. Planned interventions were to approach the resident in a calm manner to avoid frustration and behavior escalation, attempt distraction during behavioral episodes (offering to watch sports, engaging in conversation about pets, offering music), Attempt to redirect resident when exhibiting behaviors, provide a calm safe environment when the patient's frustrations escalate. Additionally, when Resident 60's behavior escalates and unable to be redirected, assure safety, and attempt to remove other residents surrounding the resident. Nursing progress notes in Resident 60's clinical record completed by Employee 4, a licensed practical nurse (LPN) dated April 22, 2024, at 2:33 p.m., revealed that the resident {Resident 60} had been pacing about nurses' station with clothes in hand and demanding that the door be opened for her to go home. Staff attempted to redirect with calls to the resident's sister, change in environment to a quiet area, and encouraged the resident to participate in activities with effect. Resident 60 was seated in the resident's room at this time. An incident report completed by the Director of Nursing (DON) dated April 22, 2024, at 8:15 p.m., revealed that Resident 60 and Resident 85 were seated at different tables in the Dementia Unit Dayroom. Staff witnessed Resident 85 saying something to Resident 60 as she walked by her table, but staff did not hear what Resident 85 said to Resident 60. Resident 60 {perpetrator} was witnessed pulling Resident 85 by her hair. Staff intervened by separating and removing the residents from the dining dayroom. RN assessment completed with no injuries noted to either resident. Both residents offered no complaints of pain/injury and the responsible parties (RPs) and physicians for both residents notified. A review of an Employee Statement form completed by Employee 6, a nurse aide (NA), dated April 22, 2024, (no time noted), revealed that she last observed Resident 60 in the dining room at 8:00 p.m. and prior this incident Resident 60 was observed packing up her clothes and kept insisting that she {Resident 60} was going home, staff redirected to her room. Employee 6 indicated that the incident occurred at 8:15 p.m. in the dining room where she observed Resident 85 arguing with another resident. Resident 60 went over to Resident 85 and began yelling at her. Resident 85 had a plate in her hand and as I {Employee 6} went over to split the residents up, Resident 60 {perpetrator} grabbed Resident 85 by her hair and drug her to the ground. I separated both residents and got nurses. Employee 6's witness statement indicated that Resident 85 was on the floor after being released from the grip of Resident 60's hand on her hair. A review of an Employee Statement form completed by Employee 5, a LPN, dated April 22, 2024, (no time noted), revealed that she last observed Resident 60 at 8:10 p.m. sitting in the dining room eating snacks. Prior to the incident, Employee 5 indicated that the resident {Resident 60} had been constantly insisting that she was going home, and her clothes were packed by the door and resident redirected back to her room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of employee witness statements of the resident-to resident altercation completed by Employee 8, a NA, dated April 22, 2024, revealed that she last saw Resident 85 at 8:15 p.m. in the dayroom sitting in a chair. Employee 8 noted that another resident {Resident 60} pulled her by the fair and the resident went to the floor. A progress note in the clinical record completed by Employee 5, a LPN, dated April 22, 2024, at 10:04 p.m., revealed that residents {Resident 60 and Resident 85} were sitting at different tables in the dayroom. The resident {Resident 85}, was sitting at a table with another resident and one of the aides, disagreeing with a resident not involved in the incident. This was when the aggressor {Resident 60} came over to table and was yelling at the resident {Resident 85} before the aide {Employee 6} could get there to intervene and separate. She {Resident 60} pulled the resident {Resident 85} by the hair to the ground. Nurse aide immediately separated residents. The resident {Resident 85} went to her room. Responsible party (RP) and physician made aware. Further review of Resident 60's clinical record of a nursing progress note completed by Employee 9, a Registered Nurse (RN), dated April 22, 2024, at 10:10 p.m., revealed that she was made aware of a resident-to-resident incident that occurred at 8:15 p.m. RN came to floor to see the two residents involved separated and resident {Resident 85} who had hair pulled sitting by the nurse's station. The resident aggressor {Resident 60} was in her room pacing with no signs of being a harm to self or others. Residents assessed by RN, no signs of injury or distress noted. Vital signs within normal limits. Resident (victim) {Resident 85} stated in follow up that she feels safe in her environment and doesn't recall the incident events. Both families were called and notified. MD made aware with no new orders. The local police department was called, and a report was made, as well as the Aging Agency notified. The facility failed to protect and ensure that Resident 85 was safe and free from physical abuse perpetrated by Resident 60. The facility was aware Resident 60 behaviors had escalated prior to incident and it was known that Resident 60 has a history of physical aggression. During an interview with the Director of Nursing (DON) on May 9, 2024, at 1:15 p.m., confirmed that the facility was aware of Resident's 60's behaviors and that the facility failed toe ensure that Resident 85 was from physical abuse perpetrated by Resident 60, a resident with known aggressive behaviors and escalated behaviors prior to incident that occurred on April 22, 2024, at 8:15 p.m. 28 Pa. Code 201.29(a)(c)(d) Resident rights 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(e)(1) Management

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 39929 Based on a review of the facility's abuse prevention policy and clinical records and staff interview, it was determined that the facility failed to implement their established abuse prohibition policy and procedures for responding to incidents of resident abuse for one resident out of 23 sampled (Resident 85). Findings include: A review of the current facility policy titled Abuse Policy, last reviewed by the facility November 27, 2023, revealed that the facility's abuse prevention/intervention program included training all staff and practitioners' ways to resolve conflicts appropriately. Assessing, care planning, and monitoring residents with needs and behaviors that may lead to conflict or neglect and assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issues. The facility's response to abuse includes an assessment and assessment data will include injury assessment, signs of recent fall, pain assessment, current behavior, all current medications, vital signs, behaviors over the past 24-hours, all active diagnoses, and any recent labs. The nurse will report any findings to the physician. As a part of the initial assessment, the physician will help identify risk factors for abuse within the facility, for example, significant number of residents with unmanaged and problematic behaviors. An incident report completed by the Director of Nursing (DON) dated April 22, 2024, at 8:15 p.m., revealed that Resident 60 and Resident 85 were seated at different tables in the Dementia Unit Dayroom. Staff witnessed Resident 85 saying something to Resident 60 as she walked by her table, but staff did not hear what Resident 85 said to Resident 60. Resident 60 {perpetrator} was witnessed pulling Resident 85 by her hair. Staff intervened by separating and removing the residents from the dining dayroom. and removed both residents from the dayroom. RN assessment complete with no injuries noted. Both residents offered no complaints of pain/injury and the responsible parties (RPs) and physicians for both residents notified. A review of an Employee Statement form completed by Employee 6, a nurse aide (NA), dated April 22, 2024, (no time noted), revealed that she last observed Resident 60 in the dining room at 8:00 p.m. and prior this incident Resident 60 was observed packing up her clothes and kept insisting that she {Resident 60} was going home staff redirected to her room. Employee 6 indicated that the incident occurred at 8:15 p.m. in the dining room where she observed Resident 85 arguing with another resident. Resident 60 went over to Resident 85 and began yelling at her. Resident 85 had a plate in her hand and as I {Employee 6} went over to split the residents up, Resident 60 {perpetrator} grabbed Resident 85 by her hair and drug her to the ground. I separated both residents and got nurses. Employee 6 stated that Resident 85 was on the floor after being released from the grip of Resident 60's hand on her hair. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a nursing progress note in Resident 60's clinical record that was completed by Employee 9, a Registered Nurse (RN), dated April 22, 2024, at 10:10 p.m., revealed that she was made aware of a resident-to-resident incident that occurred at 8:15 p.m. RN came to floor to see the two residents involved separated and resident {Resident 85} who had hair pulled sitting by the nurse's station. The resident aggressor {Resident 60} was in her room pacing with no signs of being a harm to self or others. Residents assessed by RN, no signs of injury or distress noted. Vital signs within normal limits. Resident (victim) {Resident 85} stated in a follow up that she feels safe in her environment and doesn't recall the incident events. Both families were called and notified. MD made aware with no new orders. The local police department was called, and a report was made, as well as the Aging Agency notified. There was no documented evidence that the RN conducted and documented the results of a thorough physical assessment of Resident 85 after she was pulled to the ground by her hair by Resident 60 as indicated in the facility's Abuse Policy, to include documenting the results of the applicable assessment data, pain assessment, the resident's current behavior, all current medications, behaviors over the past 24-hours, all active diagnoses, and any recent labs. The nurse will report any findings to the physician. The RN solely noted no signs of injury or distress and vital signs within normal limits, and the resident feels safe in her environment. The facility failed ensure that their Abuse Policy was fully implemented by licensed nursing staff, a RN, as evidenced by the Employee 9's failure to conduct a thorough assessment of Resident 85, a victim of physical abuse. During an interview with the Director of Nursing (DON) on May 9, 2024, at 1:15 p.m., revealed that the facility failed to provide documented evidence that a thorough physical assessment was completed by a RN after an incident of physical abuse of Resident 85 as noted in the response procedures in their abuse prohibition policy. 28 Pa. Code 211.12 (c)(d)(1) Nursing services 28 Pa. Code 211.5 (f) Medical records

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on a review of clinical records, select facility incident reports, and the facility's abuse prohibition policy and staff interview it was determined that the facility failed to thoroughly investigate potential neglect of five residents out of 23 sampled (Residents 99, 43, 17, 46, and 97). Findings included: A review of the facility's policy, entitled Abuse Policy last reviewed by the facility November 2023, indicated that a complete investigation will be conducted. Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect occurs when the facility is aware of or should have been aware of goods or services that a resident requires but the facility fails to provide them to the resident, that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress. A review of medication errors in the facility for the month of April 2024, revealed that on April 27, 2024, Employee 10 (RN) left her shift at approximately 8:00 p.m. It was subsequently discovered, after Employee 10 left the facility, that the nurse did not administer all scheduled medications to five residents, (Residents 99, 43, 17, 46, and 97), during medication pass approximately between 4 PM - 5:30 PM on that date. Employee 10 signed the residents' Medication Administration Records indicating that all medications had been administered to the residents as scheduled but they were not administered as noted on the MAR as they were located in the medication cart. Further review of these medication errors from April 27, 2024, revealed: Resident 99, who was admitted to the facility on [DATE], with diagnoses to include dementia, did not receive two medications, atorvastatin 80 mg tab and metropolol tartrate 25 mg 1/2 tab, that Employee 10 signed out at 1700 (5 PM), the resident's medications were discovered in medication cart by other staff approximately between 8:00 and 9:00 p.m. Resident 43, who was admitted to the facility on [DATE], with diagnoses to include diabetes, did not receive one medication Sevelamer 800 mg 3 tabs, which was signed out at 1630 (4:30 PM) by Employee 10 and were discovered in medication cart between approximately 8:00 PM and 9:00 PM. Resident 17, who was admitted to the facility on [DATE], with diagnoses to include dementia, did not receive three medications: dipyridamole 25/100mg, atorvastatin 40 mg, and memantine 10 mg that Employee 10 signed out at 1700 (5 PM) and were later discovered in medication cart between approximately 8:00 PM and 9:00 pm. Resident 46, who was admitted to the facility on [DATE], with diagnoses to include cerebral infarction, did not receive three medications atorvastatin 40 mg, and Eliquis 5 mg that Employee 10 signed out at 1700 (5 PM), and hydroxyzine 25 mg Employee 10 signed out at 1800 (6 PM), and were discovered in remaining in the medication cart between approximately 8:00 PM and 9:00 PM. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 97, who was admitted to the facility on [DATE], with diagnoses to include diabetes, did not receive three medications Eliquis 5 mg, metformin 500 mg, and Toresmide 20 mg signed out at 1700 (5 PM) by Employee 10 were discovered in medication cart between approximately 8:00 PM and 9:00 PM on April 27, 2024. Review of above residents' clinical records revealed there was no documentation in any of the above resident records indicating that the residents did not receive their medications as prescribed and scheduled on April 27, 2024. At the time of the survey ending May 10, 2024, there was no documented evidence that the facility had investigated the potential neglect of these residents by Employee 10. The facility did not obtain any witness statements from staff working the evening in question or from cognitively intact residents. Interview with the administrator and director of nursing on May 10, 2024, at 10:00 a.m., were unable to provide evidence that the facility completed a thorough investigation to rule out neglect of Residents 99, 43, 17, 46, and 97. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a)(c) Resident Rights 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services

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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** 49782 Based on observation, clinical record review and staff interview, it was determined that the facility failed to identify a resident's need for monitoring of the resident's respiratory status and oxygen use on the resident's comprehensive care plan for one resident out of 23 sampled (Resident 102). Findings include: According to the American Thoracic Society, oxygen (O2) is a medication that requires a prescription from a healthcare provider. The provider will prescribe your O2 at a specific flow rate and a specific number of hours per day. It is very important that O2 is used as prescribed. Using too little O2 may put a strain on the heart and brain, causing heart failure, fatigue, or memory loss. Using too much O2 can also be a problem. For some patients, using too much O2 can cause them to slow their breathing to dangerously low levels. It is important to wear O2 as your provider ordered it. If the patient starts to experience headaches, confusion, or increased sleepiness after using supplemental O2, the patient may be getting too much. A review of the clinical record of Resident 102 revealed admission to the facility on [DATE], with diagnoses, which included shortness of breath ([SOB]labored breathing) and urinary retention (inability to voluntarily empty the bladder completely or partially). A review of the resident's plan of care, initially dated July 6, 2023, revealed that the resident has behaviors related to yelling out, verbally aggressive with care, taking oxygen off, unplugging oxygen, attempting to climb out of bed, attempts to wheel wheelchair down hall carrying oxygen, refuses treatments and strikes out at others. Interventions included administer medications per physician's orders, approach the resident in a calm manner, attempt to redirect, encourage the resident to ask questions when concerned with their medical condition, give support, keep safe, monitor and document episodes of inappropriate behaviors and notify the physician, observe and report changes in mental status caused by situational stressors, offer assistance, offer psychologist/psychiatric services as needed, offer choices to promote self-worth. However, the resident's care plan did not include interventions planned to monitor the resident's respiratory status related to his behaviors of unplugging the and removing the oxygen, such as observing for signs and symptoms of respiratory distress, checking the resident's oxygen saturation level (measurement of oxygen in blood normal limits are 95%-100%) or when to notify the nurse when the resident removes his oxygen therapy or turns off the concentrator. A quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated February 7, 2024, revealed that the resident was severely cognitively impaired. A physician order was noted April 18, 2024, at 2:25 AM for humidified oxygen liters, at four liters per minute via nasal cannula, continuous every shift related to SOB. (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 observation on May 7, 2024, at approximately 8:49 AM revealed the resident sitting in his wheelchair in his room sleeping wearing nasal cannula with the oxygen concentrator turned off. Employee 2 Registered Nurse (RN) confirmed this observation and stated that the resident will continuously turn the oxygen concentrator off. During an observation on May 8, 2024, at approximately 12:40 PM the resident was seated in a wheelchair in the dayroom sleeping. The resident was wearing a nasal cannula, but the oxygen concentrator was turned off. Staff were present in this area, but were not observed to attempt to turn the concentrator back on to deliver continuous O2 as ordered. Employee 3, Licensed Practical Nurse (LPN), confirmed this observation. During an interview May 10, 2024, at 12:30 PM, the Director of Nursing (DON) and Nursing Home Administration (NHA) confirmed that the resident's care plan failed to include planned measures for monitoring the resident's respiratory status and continuous oxygen usage. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on a review of clinical records, select facility policy and investigative reports and staff interviews it was determined that the facility failed to assess and implement individualized measures planned to meet the toileting needs of one resident out of three residents sampled with a decline in continence (Resident 27). Findings included: A review of a facility policy entitled Urinary Incontinence - Clinical Protocol that was last reviewed by the facility on November 27, 2023, indicated that as part of the initial assessment, the physician will help identify individuals with impaired urinary continence. The staff and physician will review the progress of individuals with impaired continence until continence is restored or improved as much as possible, or if it is identified that further improvement is unlikely. This should include documentation of a resident's response to attempt interventions such as scheduled toileting, prompted voiding, or medications used to treat incontinence. A review of Resident 27's clinical record revealed that the resident was admitted to the facility on [DATE], and readmitted following a hospitalization on [DATE], with diagnoses that included congestive heart failure [is a progressive heart disease that affects pumping action of the heart muscles that causes fatigue, shortness of breath], abnormal gait (changes in walking patterns) and mobility, and dysphasia (difficulty swallowing). The resident's plan of care, dated February 5, 2024, identified that the resident was incontinent of bowel and bladder and was at risk for impaired skin integrity related to impaired mobility and incontinence with planned interventions to periodically evaluate the resident's pattern of urination and episodes of incontinence, apply barrier cream post incontinent episodes, and assist of two-person with toileting. A 5-day Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident was moderately cognitive impaired with a BIMS (brief interview for mental status - a tool to assess cognitive status) of 12, was occasionally incontinent of bladder and frequently incontinent of bowel and was not on a bladder or bowel retraining program. Resident 27's readmission MDS assessment dated [DATE], revealed that the resident had a decline in bladder continence from occasionally incontinent to frequently incontinent with no bladder or bowel retraining program in place. A review of the resident's clinical record revealed that a wound care consultant progress note was completed by the Nurse Practitioner dated March 20, 2024, noting that Resident 27 had developed a small stage 2 pressure ulcer [partial-thickness skin loss into but no deeper than the dermis and includes intact or ruptured blisters] to the right buttocks. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the resident's Survey Documentation Reports (a summary report of staff's task/intervention completion) dated for the months of February 2024, March 2024, and April 2024 revealed no evidence that the facility had developed and implemented interventions to address the resident's decline in urinary incontinence in an attempt to restore normal bladder function to the extent possible for this resident, which would also prevent incontinence related complications, such as skin breakdown. During an interview with the Director of Nursing (DON) on May 9, 2024, at 9:45 a.m., confirmed that the facility was unable to provide evidence of the facility's response to the decline in urinary continence and the implementation of measures designed to decrease urinary incontinency and prevent incontinence related complications. 28 Pa. Code 211.12 (d)(5) Nursing services 28 Pa. Code 211.10 (a)(d) Resident care policies

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49782 Based on observation, clinical record review and staff interview it was determined that the facility failed to consistently administer oxygen (O2) as ordered for one out of 23 sampled residents (Resident 7). Findings included: According to the American Thoracic Society, O2 is a medication that requires a prescription from a healthcare provider. The provider will prescribe your O2 at a specific flow rate and a specific number of hours per day. It is very important that O2 is used as prescribed. Using too little O2 may put a strain on the heart and brain, causing heart failure, fatigue, or memory loss. Using too much O2 can also be a problem. For some patients, using too much O2 can cause them to slow their breathing to dangerously low levels. It is important to wear O2 as your provider ordered it. If the patient starts to experience headaches, confusion, or increased sleepiness after using supplemental O2, the patient may be getting too much. A review of the clinical record of Resident 7 revealed admission to the facility on [DATE], with diagnoses that include a history of falling, hemiplegia/paresis (severe or complete loss of strength or paralysis on one side of the body) following a cerebral infarction (stroke) affecting the left non-dominant side. The resident had a current physician order dated October 14, 2021, at 5:31 PM for O2 therapy at 2 liters per minute (L/min) via nasal cannula as needed for shortness of breath. A modified annual Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated February 7, 2024, revealed that the resident was severely cognitively impaired, requiring extensive assistance with activities of daily living (ADL). An observation on May 7, 2024, at 10:00 AM revealed Resident 7's O2 concentrator (machine delivering oxygen therapy) was turned on and running at 3 L/min which was not consistent with physician's orders. An observation on May 9, 2024, at 11:46 AM revealed Resident 7's O2 concentrator was turned on and again running at 3 L/min failing to follow physician's orders. Employee 2 Licensed Practical Nurse (LPN) confirmed this observation. Interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on May 10, 2024, at approximately 12:45 PM, confirmed that the physician's order for supplemental O2 was not followed for Resident 7. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on review of clinical records and select facility policy, observations, and staff interviews it was determined that the facility failed to provide person-centered care and coordination of individualized resident services for one of one residents sampled receiving hemodialysis (Resident 51). Findings include: A review of a facility policy entitled Care of a Resident with End-Stage Renal Disease that was last reviewed by the facility on November 27, 2023, indicated that a resident's compressive care plan would reflect the resident's needs related to end stage renal disease [(ESRD) is a condition where the kidney reaches advanced state of loss of function. This causes changes in urination, fatigue, swelling of feet, high blood pressure, and loss of appetite]. A review of Resident 51's clinical record revealed that he was most recently admitted to the facility on [DATE], with diagnoses that included end stage renal disease with hemodialysis [is a procedure where a dialysis machine and a special filter called an artificial kidney, or a dialyzer, are used to clean blood] and dementia [is the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities]. A review of Resident 51's plan of care dated April 10, 2024, indicated that the resident has an impaired genitourinary status related to end-stage renal disease (ESRD) and planned interventions included to coordinate resident's care in collaboration with the dialysis center Monday, Wednesday, and Friday at 4:30 AM, monitor dialysis access site and report to physician of signs or symptoms of bleeding or signs of infection: redness, swelling, local warmth, tenderness. A physician order dated April 10, 2024, indicated that the resident's scheduled dialysis time is 4:00 a.m., on Monday, Wednesday, and Friday, and the resident's wife may transport the resident. However, the resident's care plan did not include the resident's specific schedule preferences and provisions to meet Resident 51's care needs related to transportation plans and meal schedule related to dialysis schedule. During an interview with the facility's Director of Nursing (DON) on May 9, 2024, at 10:00 a.m., confirmed that Resident 51's care plan of care failed to include preferred transportation and meal accommodations required for dialysis schedule and daily routine on dialysis days. 28 Pa. Code 211.12 (d)(3)(5) Nursing Services

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on review of clinical records and resident and staff interview it was determined that the facility failed to ensure each resident was provided with the necessary behavioral health care and services to meet the needs of two residents out of 23 sampled (Residents 90 and 28) to maintain the residents' highest practicable physical, mental, and psychosocial well-being). Findings include: A review of clinical record revealed that Resident 90 was admitted to the facility on [DATE], with diagnoses that include adjustment disorder (a short-term condition arising due to difficulty in managing stressful changes that can lead to significant impairment in functioning) with mixed anxiety, depression (mood disorder with experiences of persistent symptoms of sadness), major depressive disorder (mental health disorder having episodes of depression that can be dangerous or life threatening if untreated), and acute stress reaction (occurs after an unexpected life crisis or traumatic event). A quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated March 13, 2024, revealed that the resident was cognitively intact, requiring extensive assistance with activities of daily living (ADL). A review of Resident 90's Psychological Services Supportive Care progress note dated February 20, 2024, revealed that the resident reported she has been struggling for a while with health issues. The resident stated that a few months ago she was receiving rehab therapy to strengthen her legs and was unable to stand, called an ambulance and when they arrived she endured a traumatizing experience that led to her braking two bones in her leg requiring surgery. She stated that she is struggling in therapy now at this facility due to this experience and grows very anxious when the therapists are helping her to stand. The progress note indicated that the Clinician will continue to work with the patient to develop a rapport and learn patients' history, recommend follow-up as needed. During an interview with Resident 90 on May 7, 2024, at 10:10 AM the resident stated that she has not seen psychiatric services since approximately February 2024 and has not been given any explanation as to why. The resident continued to explain that when she was provided these services, they were tele-health (over the phone) and she did not feel as though the psychologist was listening to her as evidenced by their child making loud noises in the background causing distractions and being agreeable by saying yeah, sure after everything the resident said. She stated that she did not feel comfortable during these telephone consultations but really felt that she needed for services because she has been having nightmares of a recent traumatizing event that happened leading her to this facility with the inability to walk. She stated that she is sad all the time and wonders if this is how she will have to spend the rest of her retirement, laying in a bed for the rest of her life. She feels as though she would benefit from therapy and would prefer it to be in person. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence that Resident 90 was provided follow-up psych services treatment between February 20, 2024, through the time of the survey ending May 10, 2024, and that the facility had evaluated the appropriateness and effectiveness of the telehealth services provided to support this resident's mental health needs. Review of the clinical record revealed that Resident 28 was admitted to the facility on [DATE], and had diagnoses, which included schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania). Review of Resident 28's clinical record revealed she was deemed a PASRR (Pennsylvania preadmission screening resident review) level II, with specialized mental health services to be provided by the facility. Review of a Psychological evaluation dated October 19, 2023, indicated that Resident 28 had increased anxiety symptoms. Recommendations included individual psychotherapy follow up in four weeks to monitor residents symptoms. Further review of the resident's clinical record conducted during survey ending May 10, 2024, revealed the resident was not seen by psychological services until March 25, 2024. During an interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA), on May 10, 2024, at approximately 12:40 PM the NHA confirmed that Resident 90 had not received psychological/psychiatric services as recommended for follow-up during the period of February 20, 2024 and May 10, 2024 and Resident 28 had not received services between October 19, 2023 and March 25, 2024. 28 Pa. Code 201.29 (a) Resident rights

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on clinical record review and staff interviews, it was determined that the facility failed to attempt a gradual dose reduction of psychoactive medications for two residents out of 23 sampled (Resident 52 and 77). Findings include: A review of Resident 52's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include dementia. The resident had a physician order initially dated April 25, 2018, for Trazadone 100 mg (antidepressant) by mouth at hour of sleep (HS) for insomnia. The resident also had a physician order dated dated April 28, 2018, for Lexapro 10 mg (antidepressant) one time a day for depression . A review of a pharmacist consult to the physician dated December 1, 2023 reveled a request for a gradual dose reduction (GDR) for the Lexapro and Trazadone. There was no physician documentation of the clinical necessity of the duplicate antidepressant drug therapy. The physician's response was solely to disagree with the recommendation with no explanation of the individualized clinical rationale. The facility was unable to provide documented evidence to support the continued use of the current dose of Lexapro and Trazadone or evidence that a gradual dose reduction attempt of the psychoactive medications conducted in the past year. A review of Resident 77's clinical record revealed admission to the facility on [DATE], with diagnoses to include dementia with unspecified severity without behavioral, psychotic, mood disturbance and anxiety, and bipolar disorder. A physician order dated March 3, 2023, at 1:47 PM for Depakote Extended Release (ER) 250 milligrams (mg) (medication used to treat seizures and some psychiatric disorders) by mouth at bedtime for bipolar disorder and an additional order for Depakote ER 500 mg by mouth at bedtime to equal 750 mg for bipolar disorder. The resident also had a physician order dated July 18, 2023, at 6:01 PM for Olanzapine 2.5 mg (antipsychotic drug) by mouth daily for bipolar disorder. A physician order dated October 23, 2023, at 8:24 AM was also noted for Escitalopram Oxalate 10 mg (antidepressant) by mouth daily for major depressive disorder, recurrent severe with psychotic symptoms. A review of Consultant Pharmacist Recommendation to Prescriber dated February 28, 2024, revealed that the pharmacist recommended that the physician consider a dose reduction of the resident's Olanzapine to determine the minimal effective dose. The physician's response was no gradual dose reduction (GDR) at this time (elaborate) clinical deterioration, no behaviors noted. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Consultant Pharmacist Recommendation to Prescriber dated February 28, 2024, revealed a recommendation for the physician to consider a dose reduction of the resident's Depakote to determine the minimal effective dose. The physician's response was the same, noting no GDR at this time (elaborate) stable clinical deterioration possible no behaviors noted. A review of Consultant Pharmacist Recommendation to Prescriber dated April 16, 2024, revealed a recommendation for the physician to consider a dose reduction of the resident's Escitalopram Oxalate to determine the minimal effective dose. The physician's response was to disagree with the recommendation, indicating that this dose works well for this patient. A review of the resident's clinical record, including progress notes dated from January 2024 through May 2024, revealed no documented evidence of behaviors. The facility was unable to provide documented evidence to support the continued use of the current dosages of Olanzapine, Escitalopram Oxalate, and Depakote, or evidence that a GDR of the psychoactive medication's for Resident 77 was conducted in the past year. During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on May 10, 2024, at approximately 12:45 PM, confirmed the lack of GDR attempts for the psychoactive drugs prescribed for Resident 52 and 77. 28 Pa. Code 211.9 (a)(1)(k) Pharmacy Services 28 Pa. Code 211.2 (d)(3)(9) Medical Director 28 Pa. Code 211.5 (f) Clinical records

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49782 Based on a review of select facility policy and manufacturer's directions for use, observations, and staff interview, it was determined that the facility failed to ensure adherence to pharmacy supplies expiration/use by dates on two of three resident units (First and Second Floor). Findings include: A review of facility policy entitled Storage of Medications with a review date of [DATE], revealed that medications and biologicals are stored in the packaging and nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. If the facility has discontinued, outdated, or deteriorated medications or biologicals the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. Medication refrigeration are stored in a refrigerator located in the medication room at the nurse's station or other secured location separately from food with temperature ranges 36 degrees Fahrenheit to 46 degrees Fahrenheit. Multi-dose vials that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. A review of facility policy entitled Irrigation Solutions with a review date of [DATE], revealed irrigation solutions are labeled with a date and time immediately upon opening. Observations on [DATE], at 9:00 AM of the facility's second floor medication room revealed the following: Snap secure Foley catheter securement device that expired on [DATE]. There was no resident name or instructions on an opened tube of Santyl Collagenase 30 grams (gm) observed in the treatment cart. A box of 27 povidone/iodine swab stick antiseptic expired on [DATE]. An opened 100 milliliter (ml) and 250 ml bottle of Normal Saline Irrigation Solution 0.9% (NSS) without a date when it was opened. An opened 16 fluid ounce bottle of alcohol 70% without a date. An opened 16 fluid ounce bottle of hydrogen peroxide 3% without a date. Two 16 fluid ounce bottles of hydrogen peroxide 3% that expired [DATE]. There were 17 BD Eclipse Needle 25-gauge by one inch that expired on [DATE]. There were 14 needleless sterile (germ free) connectors that expired on the following dates: [DATE], [DATE], [DATE], [DATE]. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Two bottles of 100 count Assure Platinum Blood Glucose testing strips that expired on February 23, 2024. There were five 24-gauge by 0.55-inch safety needle that expired on [DATE]. One central line tray with chloro-prep that included two masks, gloves, towel, tape, antiseptic skin prep, film dressing, two gauze, measuring device, and forceps that expired on [DATE]. Three Opti foam heel wound dressing that expired [DATE]. Ten urostomy pouches 2.5 inches expired [DATE]. An opened sterile foley catheter insertion tray. Urine BD vacutainer culture and sensitivity transfer straw kit preservative 4.0 ml expired February 2024. Sterile urine cups expired February 2023 and [DATE]. Comfort foam Ag wound dressing with soft silicone adhesive and silver four inches by five inches expired [DATE]. 20 Bisacodyl medicated laxative suppositories expired [DATE]. An opened multi-vial bottle of Apisol injection (intradermal solution used to diagnose tuberculosis) 5 units/0.1 ml without a date of when it was opened failing to follow facility policy for multidose medications. The medication refrigerator was observed to have a thick layer of ice in the freezer area with scattered dark colored substances and a pile of frozen paper towels. This medication refrigerator held medications and vaccines. There was no evidence of documented temperatures monitoring as noted in facility policy. Employee 1 Licensed Practical Nurse (LPN) confirmed the observed findings above. During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on [DATE], at approximately 12:30 PM confirmed expired pharmacy products should have been removed from the storage room and discarded, the Apisol solution and Bisacodyl medication should have been sent back to the pharmacy and the medication refrigerator should have been defrosted and cleaned with temperatures being monitored and documented. 28 Pa. Code 211.9 (a)(1)(k) Pharmacy Services 28 Pa. Code 211.12 (d)(3)(5) Nursing services

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 39929 Based on observation, review of facility scheduled meal times and select facility policy, and resident and staff interviews the facility failed to ensure the provision of a nourishing (satisfying to the resident) evening snack when greater than 14 hours elapsed from the supper meal to breakfast the next day for residents including four residents of 23 sampled (Residents 72, 5, 64, and 41). Findings include: Review of the facility's Snacks Policy last reviewed by the facility February 2024, indicated that it is the facility policy to provide the resident with adequate nutrition. Review of the facility's scheduled (not exact times may fluctuate +/- 15 minutes) meal times revealed 15 hours between the evening meal and the next day's breakfast meal. During a group interview with six alert and oriented residents on May 8, 2024, at 10:00 AM, all four residents (Residents 72, 5, 64, and 41) in attendance stated that snacks are not routinely offered to them in the evenings. The residents stated they would like to receive an evening/bedtime snack. Residents reported that when they have requested a snack, one is provided for them but if they do not ask, then none is offered or received. Residents residing on the Dementia unit also have a 15 hour time gap between dinner and breakfast, but there was no evidence that these residents are offered a nourishing snack at bedtime. During an interview on May 9, 2024, at approximately 11:00 AM the administrator failed to provide documented evidence that residents were routinely offered and provided with a bedtime/evening snack. 28 Pa. Code 211.12 (d)(3)(5) Nursing Services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43944 Based on a review of select facility policy, observation, and staff interview, it was determined that the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness, in the dietary department and the second floor and Memory Care Unit resident food storage areas. Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). A review of a facility policy entitled Food Storage and was last reviewed by the facility on November 27, 2023, indicated that items shall be stored by using appropriate methods to ensure the highest level of food safety. Pantry or kitchenette areas will be cleaned and sanitized daily by dining service staff. Dining services staff will discard outdated items. The initial tour of the dietary department was conducted with the facility's food services manager on May 7, 2024, at 9:40 a.m., revealed the following unsanitary practices with the potential to introduce contaminants into food and increase the potential for food-borne illness, were identified: An observation of the dietary department's beverage station revealed that the juice and thickened juice dispensing guns were dangling by their hoses and in contact with bulk juice boxes that were on metal wire shelves. Additionally, the juice dispensing guns had a buildup of a red, gel like substance inside of the nozzle. Observations of the dry storage room revealed that there was clean resident dishware, plastic bins, and beverage pitchers that were not covered. Observations of dietary staff performing dish room duties revealed that there were several racks of thermal bowls and cups, identified as cleaned by the CDM, that were placed directly next to carts of dirty dishes and pans. Observations inside of the dish room revealed that there was a large metal wire storage rack with cleaned cooking equipment and supplies placed directly next to dirty carts and dirty items. Several small black flies (three or more) were observed flying around the dish room and the CDM confirmed that drain flies were commonly observed in the area due to damp and wet conditions. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observations of the 2nd floor dining area on May 9, 2024, at 9:57 a.m., revealed food particles and debris on the floor underneath the dining tables. A accumulation of dirt was observed on the floor around perimeter of the room and in the corners and an accumulation of dust and debris on the windowsills. On entry to the dining room, on the right side there was a brown substance spilled down the wall and a dead large-winged bug on the floor under a wheelchair. Inside of the meal service area dried food was observed stuck to the side of the plate warmers and dirt and debris on the floor collected behind the equipment. Further observations of the 2nd floor dining area and resident food storage room revealed that inside of the refrigerator there were nine 4-ounce chocolate shakes that were not dated. Once defrosted, shakes should be used within 14-days as per the manufacturers' instructions and thaw dates could not be determined. Small black dead bugs were observed inside of the ceiling light cover. During observations of the Memory Care Unit's pantry/kitchenette area on May 9, 2024, at 10:50 a.m., a build-up of dirt and debris was observed on the floor under the cabinets and in the corners of the room. The outside of stainless-steel reach-in refrigeration door was splattered with food and felt sticky. Observations of the Memory Care dining area revealed that there was a tray of cleaned thermal mugs placed on a tray that was stained and visibly dirty. During an interview with the Nursing Home Administrator (NHA) on May 9, 2024, at 1:45 p.m., confirmed that the facility failed to ensure that the dietary department and resident pantry/kitchenette food storage were maintained in a sanitary manner and foods were to be labeled and dated to prevent the potential of food-borne illness. 28 Pa. Code 201.18 (e) (2.1) Management 28 Pa. Code 211.6 (f) Dietary Services

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 26142 Based on staff interviews and a review of documentation provided by the facility, it was determined that the facility failed to timely review and update its facility wide assessment in order to identify the specific personnel and resources presently available and/or required, which are necessary to care for its current resident population. Findings include: At the time of the survey ending May 10, 2024, the facility had reviewed its facility assessment on April 15, 2024, to determine the specific and unique needs of its resident population and the available and accessible resources to meet these needs on a daily basis and during emergent situations. The facility provided a facility assessment tool to the survey team on May 7, 2024. There was no documentation on the form that identified and addressed the needs of the locked third floor unit, Dementia/Memory care unit. The form did not include any focus on the care and needs of the 61 residents with documented diagnosis of Dementia/Alzheimers disease and 43 residents residing on the locked dementia unit. A review of the results of surveys completed by the state survey agency on January 25, 2024 and February 27, 2024, revealed deficient facility practice was identified related to the facility's failure to provide adequate dementia care and behavioral health care services for residents with dementia or behavioral symptoms to meet their psychosocial needs and maintain resident safety. Instances of resident to resident abuse were also cited during both surveys. During this current survey ending May 10, 2024, the facility was also cited for failing to provide behavioral health services to meet the mental health needs of a resident with a diagnosed mental disorder. There was no evidence that the facility updated its facility-wide assessment in a timely manner to address available, and necessary, resources for making staffing and operating budget decisions while managing the resident census to ensure that the facility had the necessary staff resources, with the necessary skills and competencies, to care for its current resident population in a manner that met minimum licensure and certification standards. The facility assessment presented to the survey team during the survey ending May 10, 2024, did not include updated comprehensive data with respect to its current resident population and updated resources necessary to competently and safely care for the residents in the facility with dementia, behaviors and mental health needs. Refer F740 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18 (b)(e)(1)(3) Management

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on review of clinical records, observation and staff interviews it was determined that the facility failed to maintain and accurate and complete clinical records for two out of 23 residents reviewed. Findings included: 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 judgement 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 the clinical record of Resident 7 revealed admission to the facility on [DATE], with diagnoses that included a history of falling, hemiplegia/paresis (severe or complete loss of strength or paralysis on one side of the body) following a cerebral infarction (stroke) affecting the left non-dominant side. A modified annual Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated February 7, 2024, revealed that the resident was severely cognitively impaired, requiring extensive assistance with activities of daily living (ADL). During an observation on May 7, 2024, at 10:30 AM the resident was observed sleeping in a wheelchair with her legs elevated. A scabbed area, was observed on the resident's left lower extremity, measuring approximately 5.0 x 0.5 centimeters (cm) without drainage, open to air. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's clinical record conducted during the survey ending May 10, 2024, revealed no documented evidence of this skin injury, a nursing assessment of the resident's injury or the cause of the injury. During an interview with the Director of Nursing (DON) on May 7, 2024, at 11:00 AM confirmed there was no evidence of any documentation of an assessment on Resident 102's injury on the left lower leg. A review of the clinical record of Resident 43 revealed admission to the facility on [DATE], with diagnoses that include type 2 diabetes mellitus ([T2DM] a condition resulting in insufficient production of insulin causing high blood sugar) and explosion and rupture of boil (red, swollen, painful and pus-filled area under the skin). A quarterly MDS dated [DATE], revealed that the resident was cognitively intact, requiring extensive assistance from staff with ADLs. A review of progress notes dated March 7, 2024, at 10:00 AM revealed that the resident stated that she has a history of boils, and was complaining of a boil to her left inner labia majora (the larger outer folds of the female external genitals). Upon staff inspection, of the area it was noted to be open and appeared to have burst. The physician was made aware with orders to clean the area with soap and water every shift and as needed with changes and peri-care. A physician's order dated March 8, 2024, at 10:51 AM indicated Ichthammol External Ointment (a topical salve medication) 20% apply to affected area topically two times a day related to explosion and rupture of boil. A review of the Treatment Administration Record (TAR) for the month of March 2024 revealed that that staff administered the prescribed treatment of Ichthammol Ointment prescribed from March 9, 2024, until March 19, 2024. A review of documents titled Skin Inspection dated March 18, 2024, at 9:39 AM revealed that there were no new observed skin issues. A review of the resident's clinical record conducted during the survey ending May 10, 2024, revealed no documented evidence of the healing progress, status or condition of the resident's boil, or the date it had resolved. There was no evidence of documentation provided that an ongoing assessment, wound tracking, or resolution of Resident 43's skin boil was performed. Interview with the DON and Nursing Home Administrator (NHA) on May 10, 2024, at approximately 12:45 PM confirmed there was no nursing documentation in the resident's clinical record tracking the healing and resolution of the resident's boil. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services 28 Pa. Code 211.5 (f) Medical records

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 26142 Based on review of facility documents and staff interviews, it was determined that the facility failed to ensure that the Medical Director or designee was in attendance at monthly Quality Assurance Process Improvement (QAPI) Committee meetings for four of four months (January 2024 through April 2024) Findings include: A review of QAPI Committee meeting sign-in sheets for the period of January 2024 through April 2024, revealed that the Medical Director or other physician was not in attendance, virtually or in-person, at the QA meetings held from January 2024 through April 2024, missing 4 monthly meetings (January 2024 through April 2024). Interview with the administrator on May 9, 2024, at 12:00 PM confirmed that the a physician failed to attend the facility's QAPI meetings on a monthly/quarterly basis. 28 Pa. Code 211.2(d)(5)(6)(7)(8)(10) Medical director 28 Pa. Code 201.18 (e)(2)(3)(4) Management.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on observation and staff interviews it was determined that the facility failed to ensure call bells were accessible to one of 23 residents sampled (Resident 52). Findings include: Observation on May 9, 2024, at 9 AM revealed that in resident room [ROOM NUMBER], in which Resident 52, a severely, cognitively impaired resident resided, but was not in the room at the time of the observation there was no call bell connected to the wall outlet or anywhere these in the room. There was no alternate method for use as a call bell, such as a tap bell noted in the resident's room. There were 2 plugs placed into the wall outlet call bell unit. The plugs were utilized to circumvent the alarm when the outlet is unplugged. Interview with Employee 4 (licensed practical nurse) on May 9, 2024, at 9:05 AM confirmed the observation that Resident 52 did not have access to a call bell to summon staff assistance while in bed and verified that call bells are to be placed within reach of the residents and each resident's bedside. Interview with the Nursing Home Administrator on May 9, 2024, at approximately 1 PM, verified that call bells are to be placed at each resident's bedside. 28 Pa. Code 205.67 (j) Electric Requirements for existing and new construction

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 43944 Based on observation, facility pest service records and resident and staff interview, it was determined that the facility failed to maintain an effective pest control program. Findings include: During the initial tour of the kitchen that was conducted on May 7, 2024, at 9:40 a.m., inside of the dish room several small black flies (three or more) were observed flying around a large metal wire storage rack of clean cooking equipment and supplies. The CDM confirmed the observations and stated that drain flies are frequently observed in the area due to the damp environment. Observations of the 2nd floor dining area on May 9, 2024, at 9:57 a.m., revealed small dead black bugs on floor, on the windowsills, and the air-conditioning units. The windowsill was loose and gaps to the outside were present. A dead, large-winged insect was observed on the floor below an unoccupied wheelchair. An interview with the facility's Director of Maintenance on May 9, 2024, at 10:40 a.m., revealed that pest treatments were performed to floor drains in the dietary department, but the employee was unable to provide documented evidence that regular treatments were performed to deter pest activity in the kitchen area. During an interview Resident 90, a cognitively intact resident, on May 9, 2024, at approximately 1:15 p.m., revealed that there were small dark insects flying around the resident. Resident 90 stated that it was a normal occurrence to see insects flying around the facility and that it bothered them when eating meals. A review of the facility's most recent monthly pest control report dated April 5, 2024, at 12:09 p.m., revealed that routine pest control was performed for rodent and insects. The pest control technician noted that door gap/damage to cafeteria double main doors leading out to courtyard need repair and that cracks or damage along the building's exterior allowed pest access and need to be secured, such as loose air conditioning covers. Further interview with the maintenance director on May 9, 2024, confirmed that the facility was not able to provide evidence that the facility acted upon the issues identified by the facility's pest control company and that the facility performed routine and preventative measures to deter entrance and reduce and eliminate the presence of the pests in the facility 28 Pa. Code 201.18 (e)(2.1) Management

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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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on observation, review of select facility policy and clinical records, and staff interview, it was determined that the facility failed to implement established procedures to assure safe smoking ability for one resident out of one resident identified as a current smoker (Resident 34). Findings include: During an onsite survey beginning May 7, 2024, a policy was observed on facility bulletin board indicating that the facility was a non-smoking facility that smoking is not permitted within the facility or on facility grounds. During entrance conference on May 7, 2024, at 9:30 a.m. the Nursing Home Administrator stated that one resident, Resident 34 was a current smoker. Review of Resident 34's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses to have included chronic obstructive pulmonary disease (COPD). Review of Resident 34's plan of care, reviewed during the survey ending May 10, 2024, revealed no care plan to address the resident's smoking until surveyor inquiry on May 8, 2024. The facility did not have a smoking policy to address the decision to allow Resident 34 to smoke at the non-smoking facility and grounds until brought to the facility's attention during survey ending May 10, 2024. Interview with the Nursing Home Administrator and Director of Nursing on May 09, 2024 at 9:15 a.m. were unable to provide evidence that Resident 34's smoking was addressed in a care plan and a revised smoking policy was created. 28 Pa. Code 209.3 (a)(c) Smoking.