STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395568	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Julia Pound Care Center	1155 Indian Springs Road Indiana, PA 15701

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 - Few	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. 48941 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to address and document the opportunity to formulate advance directives and failed to document in the resident's clinical record the resident's decision to accept or decline assistance to formulate advance directives for one of 37 residents reviewed (Resident 70). Findings include: The facility's policy regarding advance directives (instructions regarding the provision of health care and life sustaining measures when the resident is incapacitated), dated March 13, 2024, indicated that if the resident does not have an advance directive, facility staff must inform the resident or resident representative of their right to establish one as set forth in the laws of the state and provide assistance if the resident wishes to execute one or more directive(s). Facility staff must document in the resident's medical record these discussions and any advance directive(s) that the resident executes. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 70, dated May 10, 2024, revealed that the resident was cognitively intact, was understood and able to understand others, and required assistance with care needs. An admission checklist for Resident 70, dated September 25, 2023, indicated that the resident did not have advance directives and that information on advance directives were given to the resident. However, there was no documented evidence in the resident's clinical record that assistance was offered to formulate advance directives, and there was no documented evidence as to the resident's decision to accept or decline assistance to formulate advance directives. Interview with the Nursing Home Administrator on July 10, 2024, at 11:03 a.m. confirmed that there was no documented evidence in Resident 70's clinical record that assistance was offered to formulate advance directives, and there was no documented evidence as to the resident's decision to accept or decline assistance to formulate advance directives. 28 Pa. Code 201.29(a)(d) Resident Rights.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 41233 Based on observations and staff interviews, it was determined that the facility failed to provide a clean, homelike environment for one of 37 residents reviewed (Resident 27). Findings include: The facility's policy titled housekeeping department operations, dated March 13, 2024, revealed that the policy objective was to provide a safe, clean environment for residents. A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 27, dated July 3, 2024, revealed that the resident was cognitively intact, required assistance with most daily care needs, and had diagnoses that included heart failure and osteoarthritis (a type of arthritis that effects the bone). Observations of Resident 27 sitting in his wheelchair on July 8, 2024, at 11:42 a.m. and July 9, 2024, at 12:18 p.m. revealed that there was a moderate accumulation of removable dust/debris on the wheels and the metal supports under the chair. Interview with Housekeeper 1 on July 9, 2024, at 2:05 p.m. confirmed that Resident 27's wheelchair was cleaned in June as per their documented cleaning process. However, she also confirmed that the wheelchairs are also cleaned as needed and that Resident 27's wheelchair had a heavy layer of dirt and debris and should have been clean. Interview with the Licensed Practical Nurse 2 on July 9, 2024, at 2:08 p.m. confirmed that Resident 27's wheelchair had an accumulation of removable dust/debris on the wheels and the metal supports under the chair. Interview with the Nursing Home Administrator on July 9, 2024, at 3:00 p.m. confirmed that the removable dust, dirt and debris on Resident 27's wheelchair should not have been there, and it should have been cleaned. 28 Pa. Code 201.29(j) Resident Rights. 28 Pa. Code 207.2(a) Administrator's Responsibility.

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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. 46994 Based on review of facility policies, clinical records, and investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from abuse from a resident who wanders for one of 37 residents reviewed (Resident 64). Findings include: The facility's policy for abuse, dated March 13, 2024, indicated each resident is provided with a safe environment where they are not subject to mental, physical, verbal, and sexual abuse. Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies, serving the resident, family members, or legal guardians, friends, or other individuals. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Willful meant the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 64, dated March 26, 2024, indicated that the resident was understood and could understand others, had no behaviors, required assistance with daily care needs, and had diagnoses that included dementia and bipolar disease (a mental health condition that causes extreme mood swings). An annual MDS assessment for Resident 78, dated June 24, 2024, indicated that the resident was usually understood and could usually understand others, had no behaviors, required partial to maximum assistance with daily care needs, and had diagnoses that included dementia. A review of the clinical record for Resident 78 revealed that he had episodes of being loud and verbally aggressive, wandered in and out of other residents' rooms, and wore a wanderguard (a device that allows caregivers to monitor the activity of high risk or wandering residents who are cognitively impaired). A nurse's note for Resident 78, dated July 4, 2024, at 4:15 a.m. revealed that he was in Resident 64's room. He was witnessed to be almost on top of Resident 64, threatening to kill him. A nurse's note for Resident 64, dated July 4, 2024, at 4:49 a.m., revealed that staff heard Resident 64 screaming. A nurse witnessed Resident 64 in bed with Resident 78 standing over him, yelling at him, and Resident 64 reported that Resident 78 was hitting him and put his hands around his neck. A nurse's note for Resident 64, dated July 4, 2024, at 4:59 a.m., revealed that at 3:50 a.m. staff performed a physical assessment on Resident 64 after Resident 78 was near him, and that Resident 64 was observed to have reddened areas around his neck and chest. Resident 64 was reported stating, I don't want to see that man near me, I don't want to see him ever again. A statement from Registered Nurse 3 regarding the incident on July 4, 2024, revealed that Resident 64 reported to her that Resident 78 jumped on me and hit me all over my body, my legs, trunk, and face. He had his hands around my neck. I was asleep and then I was being attacked. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing on July 11, 2024, at 1:45 p.m. confirmed that they did not have a plan in place for Resident 78's wandering other than the wanderguard because it is a behavior that you cannot stop. The Director of Nursing also confirmed that Resident 78 did hit and threatened to kill Resident 64. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 201.29(j) Resident Rights.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 19102 Based on clinical record reviews and staff interviews, it was determined that the facility failed to notify the resident and legal guardian in writing regarding the reason for hospitalization for four of 37 residents reviewed (Residents 23, 36, 46, 67). Findings include: A significant Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 23, dated June 24, 2024, indicated that the resident was cognitively impaired, required assistance from staff for her daily care needs, and had diagnoses that included dementia. Nursing notes for Resident 23, dated June 16, 2024, at 10:30 a.m. and 4:56 p.m., revealed that the resident was unresponsive, then vomited bright red blood and clots. She was transferred to the hospital and admitted with GI (gastro-intestinal) bleeding. There was no documented evidence that a written notice of Resident 23's transfer to the hospital was provided to the resident's responsible party regarding the reason for transfer. A quarterly MDS assessment for Resident 36, dated April 24, 2024, indicated that the resident was cognitively intact, usually understood and was usually able to understand others, and required assistance from staff for her daily care needs. She had diagnoses listed in her clinical record that included muscular dystrophy and non-Alzheimer's dementia. Nursing notes for Resident 36, dated June 4, 2024, at 6:04 p.m., revealed that the resident complained of chest pain and difficulty breathing and was transferred to the hospital emergency room . There was no documented evidence that a written notice of Resident 36's transfer to the hospital was provided to the resident's responsible party regarding the reason for transfer. Interview with the Nursing Home Administrator on July 10, 2024, at 2:07 p.m. confirmed that the facility did not provide a written notice to Resident 36's responsible party when the resident was transferred to the hospital with the reason for transfer. A significant MDS assessment for Resident 46, dated May 23, 2024, indicated that the resident was cognitively impaired, usually understood and was usually able to understand others, and required assistance from staff for her daily care needs. She had diagnoses listed in her clinical record that included anxiety, depression, schizoaffective disorder, and dementia. Nursing notes for Resident 46, dated April 29, 2024, at 1:15 p.m., revealed that the resident had an increase in behaviors and resistance to care and was transferred to the hospital to behavioral health. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence that a written notice of Resident 46's transfer to the hospital was provided to the resident's responsible party regarding the reason for transfer. Interview with the Nursing Home Administrator on July 10, 2024, at 8:56 a.m. confirmed that the facility did not provide a written notice to Resident 46's responsible party when the resident was transferred to the hospital with the reason for transfer. A quarterly MDS assessment for Resident 67, dated May 11, 2024, indicated that the resident was cognitively intact, was dependent on staff for her daily care needs, and had diagnoses that included urinary tract infection and paraplegia (paralysis that occurs in the lower half of the body). Nursing note for Resident 67, dated April 25, 2024, at 11:24 a.m., revealed that the resident had increased swelling in her legs. The physician was notified, and the resident was transferred to the hospital for evaluation. Nursing note for Resident 67, dated May 1, 2024, at 7:45 a.m., revealed that the resident was complaining of severe abdominal pain. The physician examined the resident at her bedside and gave orders to send her to the hospital for evaluation and treatment. There was no documented evidence that a written notice of Resident 67's transfer to the hospital was provided to the resident's responsible party regarding the reason for transfer. Interview with the Nursing Home Administrator on July 10, 2024, at 12:32 p.m. confirmed that the facility did not provide a written notice to the resident or the resident's responsible party when a resident was transferred to the hospital. 28 Pa. Code 201.25 Discharge Policy. 28 Pa. Code 201.29(f)(g) Resident Rights.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 19102 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the resident and/or the responsible party was notified about the facility's bed-hold policy upon transfer to the hospital for four of 37 residents reviewed (Residents 23, 36, 46, 67). Findings include: The facility's policy for Bed Holds, dated March 13, 2024, indicated that all residents and/or their representatives shall be notified of the bed-hold policy, in writing through the admission agreement, on or before admission and upon transfer to the hospital. A significant Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 23, dated June 24, 2024, indicated that the resident was cognitively impaired, required assistance from staff for her daily care needs, and had diagnoses that included dementia. Nursing notes for Resident 23, dated June 16, 2024, at 10:30 a.m. and 4:56 p.m., revealed that the resident was unresponsive, then vomited bright red blood and clots. She was transferred to the hospital and admitted with GI (gastro-intestinal) bleeding. There was no documented evidence that the resident and/or the responsible party was notified about the facility's bed-hold policy at the time of the above transfers to the hospital for Resident 23. A quarterly MDS assessment for Resident 36, dated April 24, 2024, indicated that the resident was cognitively intact, usually understood and was usually able to understand others, and required assistance from staff for her daily care needs. She had diagnoses listed in her clinical record that included muscular dystrophy and non-Alzheimer's dementia. Nursing notes for Resident 36, dated June 4, 2024, at 6:04 p.m., revealed that the resident complained of chest pain and difficulty breathing and was transferred to the hospital emergency room . There was no documented evidence that Resident 36's responsible party was notified of the facility's bed hold policy at the time of the above transfer to the hospital. Interview with the Nursing Home Administrator on July 10, 2024, at 2:07 p.m. confirmed that there was no documented evidence that Resident 36's responsible party was notified about the facility's bed-hold policy at the time of the above transfer to the hospital. A significant MDS assessment for Resident 46, dated May 23, 2024, indicated that the resident was cognitively impaired, usually understood and was usually able to understand others, and required assistance from staff for her daily care needs. She had diagnoses listed in her clinical record that included anxiety, depression, schizoaffective disorder, and dementia. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing notes for Resident 46, dated April 29, 2024, at 1:15 p.m. revealed that the resident had an increase in behaviors and resistance to care and was transferred to the hospital to behavioral health. There was no documented evidence that Resident 46's responsible party was notified about the facility's bed-hold policy at the time of the above transfer to the hospital. Interview with the Nursing Home Administrator on July 10, 2024, at 8:56 a.m. confirmed that there was no documented evidence that Resident 46's responsible party was notified about the facility's bed-hold policy at the time of the above transfer to the hospital. A quarterly MDS assessment for Resident 67, dated May 11, 2024, indicated that the resident was cognitively intact, was dependent on staff for her daily care needs, and had diagnoses that included urinary tract infection and paraplegia (paralysis that occurs in the lower half of the body). Nursing note for Resident 67, dated April 25, 2024, at 11:24 a.m., revealed that the resident had increased swelling in her legs. The physician was notified, and the resident was transferred to the hospital for evaluation. Nursing note for Resident 67, dated May 1, 2024, at 7:45 a.m., revealed that the resident was complaining of severe abdominal pain. The physician examined the resident at her bedside and gave orders to send her to the hospital for evaluation and treatment. There was no documented evidence that the resident and/or the responsible party was notified about the facility's bed-hold policy at the time of the above transfers to the hospital for Resident 67. Interview with the Nursing Home Administrator on July 10, 2024, at 12:32 p.m. confirmed that there was no documented evidence that a bed-hold notice was provided to residents or their responsible party at the time of a transfer to the hospital. 28 Pa. Code 201.29(d) Resident Rights. 28 Pa. Code 211.5(f) Clinical Records.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19102 Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that comprehensive admission Minimum Data Set assessments were completed in the required time frame for three of 37 residents reviewed (Residents 103, 104, 105). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, indicated that an admission MDS assessment was to be completed no later than 14 days following admission. An admission MDS assessment for Resident 103, dated March 31, 2024, revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on April 8, 2024, which was 15 days after admission. An admission MDS assessment for Resident 104, dated May 7, 2024, revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on May 20, 2024, which was 20 days after admission. An admission MDS assessment for Resident 105, dated May 29, 2024, revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on June 7, 2024, which was 16 days after admission. An interview with Registered Nurse Assessment Coordinator (RNAC - a registered nurse who is responsible for the completion of MDS assessments) on July 11, 2024, at 2:14 p.m. confirmed that Resident 103, 104 and 105's admission MDS assessments were completed late. 28 Pa. Code 211.5(f) Clinical Records.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 46994 Based on a review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for two of 37 residents reviewed (Residents 60, 64). Findings include: The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, revealed that Section N0415F (Antibiotic Medications - medications used to treat infections) was to be coded if the resident took the medication during the seven-day look-back period. Physician's orders for Resident 60, dated June 8, 2024, included an order for the resident to receive one gram of Ceftazidime (antibiotic medication) intravenously (administration of fluids and/or medications directly into a person's vein) every eight hours for seven days for a urinary tract infection (infection involving any part of the urinary system including the kidney, ureters, bladder and urethra). Resident 60's Medication Administration Record for June 2024 revealed that the resident was administered Ceftazidime during the seven-day look-back assessment period. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 60, dated June 14, 2024, revealed that N0415F was not coded, indicating she did not receive an antibiotic medication during the seven-day look-back assessment period. The RAI User's Manual, dated October 2023, indicated that Section B0700 (make self-understood) should be coded with either clearly understood, usually understood, sometimes understood, or rarely/never understood. Section C0100 (should brief interview for mental status be conducted) should be completed if the resident is at least sometimes understood verbally, in writing, or using another method. Section C0100 was to be coded No (0) or Yes (1) to determine whether a Brief Interview for Mental Status (BIMS) (an assessment to determine a resident's cognitive status) should be attempted with the resident. The instructions for determining if a BIMS interview should be attempted indicated that if the resident was at least sometimes understood (verbally or in writing) then the BIMS interview was to be attempted with the resident and coded in Sections C0200 through C0500. If the resident was rarely/never understood, then the BIMS interview was not to be attempted, and a Staff Assessment of Mental Status was to be completed instead and coded in Sections C0600 through C1000. A quarterly MDS assessment for Resident 64, dated March 26, 2024, revealed that Section B0700 was coded clearly understood and Section C0100 was coded (no) indicating that a BIMS interview was not to be attempted. An interview with the Registered Nurse Assessment Coordinator (RNAC- a registered nurse who is responsible for the completion of MDS assessments) confirmed on July 11, 2024, at 2:13 p.m. that the assessments for Residents 60 and 64 were coded incorrectly. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.5(f) Clinical Records.

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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. 19102 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that baseline care plans included the information and instructions needed to provide person-centered care for two of 37 residents reviewed (Residents 25, 35). Findings include: The facility's policy regarding care plans, dated March 13, 2024, indicated that a baseline care plan is person-centered care plan designed to include the resident's basic healthcare information needed to care for the resident. It must be completed within forty-eight hours of admission and include initial goals based on admission orders, physician orders, dietary orders, therapy services, social services, address resident health and safety concerns, and identify needs for supervision, behavioral interventions, and assistance with care as necessary. The comprehensive care plan, which is derived from the baseline care plan and is triggered by care area assessments, will be entered into the electronic health record system. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 25, dated June 9, 2024, revealed that the resident was moderately cognitively impaired and received a diuretic (water pill). Physician's orders for Resident 25, dated June 7, 2024, included an order to administer 40 milligrams (mg) of Furosemide water pill) daily. A review of the resident's Medication Administration Record (MAR) for July 2024 revealed she received Furosemide from July 1 through July 11, 2024. There was no documented evidence that a care plan was developed to address Resident 25's individual care needs related to receiving a diuretic. An interview with the Director of Nursing on July 10, 2024, at 1:00 p.m. confirmed that a care plan to address Resident 25's use of a diuretic was not developed. An admission MDS assessment for Resident 35, dated June 30, 2024, revealed that the resident was cognitively intact, experienced hallucinations, required assistance from staff for care needs, had diagnoses that included dementia, and was receiving supplemental oxygen. Physician's orders for Resident 35, dated June 24, 2023, included that the resident receive 3 milliliters (ml) of ipratropium albuterol (medication to treat wheezing and shortness of breath) every six hours as needed for shortness of breath. Physician's orders for Resident 35, dated June 30, 2023, included that the resident receive four liters of supplemental oxygen as needed for shortness of breath at bedtime and while sleeping during the day. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Julia Pound Care Center	1155 Indian Springs Road Indiana, PA 15701

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse's note for Resident 35, dated June 24, 2024, at 9:31 p.m., revealed that the resident was admitted to the facility at 1:00 p.m. with a diagnosis of dementia with behavior disturbance, has intermittent confusion, and was reporting that a mouse was in her pants. She was heard to have upper airway wheezes (high-pitched whistling sound made while breathing) and shortness of breath when lying flat. Nurse's note for Resident 35, dated July 1, 2024, revealed that the resident was using supplemental oxygen, was short of breath with exertion, and was yelling out that rats were in her bed. There was no documented evidence that a care plan was developed to address Resident 35's individual care and treatment needs related to her dementia with hallucinations or her altered respiratory status with the use of supplemental oxygen. Interview with the Director of Nursing on July 11, 2024, at 1:40 p.m. confirmed that a care plan to address the care needs related to Resident 35's dementia with hallucinations or her altered respiratory status with the use of supplemental oxygen was not developed and should have been. 28 Pa. Code 211.12(d)(1) Nursing Services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48941 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that care plans were updated to reflect changes in care needs for one of 37 residents reviewed (Resident 60). Findings include: A significant Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 60, dated June 14, 2024, revealed that the resident was cognitively intact, was clearly understood and able to understand others, required assistance with care needs, had a foley catheter (a thin, flexible tube inserted into the bladder to drain urine from the bladder), had a urinary tract infection (infection involving any part of the urinary system including the kidney, ureters, bladder and urethra) in the last 30 days, and had a diagnosis that included neurogenic bladder (bladder lacks control due to nerve or muscle problems). Physician's orders for Resident 60, dated February 24, 2024, indicated that the resident was ordered 50 milligrams of Nitrofurantoin daily every Monday, Wednesday, and Friday for history of recurrent urinary tract infections. Clinical record review for Resident 60 revealed that she had a care plan, dated June 11, 2024, for recurrent urinary tract infections related to neurogenic bladder. There was no documented evidence that the care plan was revised to reflect Resident 60's need for a long-term antibiotic related to her history of recurrent urinary tract infections. Interview with the Director of Nursing on July 11, 2024, at 2:13 p.m. confirmed that Resident 60's care plan was not revised to reflect the need for long-term antibiotic related to her history of recurrent urinary tract infections and it should have been. 28 Pa. Code 211.12(d)(5) Nursing Services.

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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. 19102 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders for medications were followed for two of 37 residents reviewed (Residents 62, 80). Findings include: The facility's policy regarding medication administration, dated March 13, 2024, revealed that medications are administered as prescribed in accordance with good nursing principles and only by persons legally authorized to do so. Right resident, right drug, right dose, right route, and right time are applied for each medication being administered. Medications are administered in accordance with written orders of the prescriber. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 62, dated May 2, 2024, indicated that the resident was cognitively intact, required assistance from staff for her daily care needs, and had diagnoses that included atrial fibrillation (irregular heart beat) and dementia. Physician's orders for Resident 62, dated December 2, 2023, included an order for the resident to receive 75-50 milligrams (mg) of Triamterene-hydrochlorothiazide (a blood pressure medication) daily, and to hold the medication if the resident's systolic blood pressure (top number of a blood pressure reading) was below 110 millimeters of mercury (mmHg). Resident 62's Medication Administration Record (MAR) for May and June 2023 indicated that Triamterene-hydrochlorothiazide was administered on May 5 when the resident's blood systolic blood pressure was 94 mmHg, May 7 when the resident's blood systolic blood pressure was 100 mmHg, May 10 when the resident's blood systolic blood pressure was 105 mmHg, June 12 when the resident's blood systolic blood pressure was 102 mmHg, June 14 when the resident's blood systolic blood pressure was 86 mmHg, June 16 when the resident's blood systolic blood pressure was 94 mmHg, June 25 when the resident's blood systolic blood pressure was 80 mmHg, and June 28 when the resident's blood systolic blood pressure was 90 mmHg. Interview with the Director of Nursing on July 10, 2024, at 1:00 p.m. confirmed that staff did not follow the physician-ordered parameters for Resident 62's Triamterene-hydrochlorothiazide on the above dates and times. An admission MDS assessment for Resident 80, dated June 21, 2024, indicated that the resident was sometimes understood and could sometimes understand others, required substantial to moderate assistance with daily care needs, and had diagnoses that included dementia. Physician's orders for Resident 80, dated June 21, 2024, included for the resident to receive 0.25 milliliters (ml) of Lorazepam (antianxiety medication) 2 milligram (mg)/ml oral concentrate as needed for anxiety. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the controlled drug record (a form that accounts for each tablet/pill/dose of a controlled drug) for Resident 80, dated June 21, 2024, indicated that 0.5 ml of Lorazepam was administered on July 22, 2024, at 7:30 a.m. and at 1:30 p.m. Interview with the Director of Nursing on July 9, 2024, at 3:30 p.m. confirmed that the Resident 80 was not administered that correct dose of Lorazepam as ordered by the physician on the above-mentioned dates and times. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 46994 Based on facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain accountability for controlled medications (drugs with the potential to be abused) for two of 37 residents reviewed (Residents 67, 80). Findings include: A facility policy for medication administration, dated January 11, 2023, indicated that the individual that administers the medication dose records the administration on the resident's MAR directly after the medication is given. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 67, dated May 11, 2024, indicated that the resident was cognitively intact, was dependent on staff for her daily care needs, and had diagnoses that included urinary tract infection and paraplegia (paralysis that occurs in the lower half of the body). Physician's orders for Resident 67, dated November 22, 2023, included an order for the resident to receive 5 milligrams (mg)/325 mg of Hydrocodone-Acetaminophen (a narcotic pain medication) every eight hours as needed for pain. Review of the controlled drug record (a form that accounts for each tablet/pill/dose of a controlled drug) for Resident 67, dated April 2024 and May 2024, indicated that 5 mg/325 mg of hydrocodone-acetaminophen was signed out as administered on April 4 at 6:50 p.m., April 11 at 11:15 p.m., April 18 at 9:00 a.m., April 18 at 10:45 p.m., May 2 at 10:14 p.m., and May 22 at 2:00 a.m. Review of the Medication Administration Record (MAR) for Resident 67, dated April 2024, and May 2024, revealed no documented evidence that the signed-out doses of hydrocodone-acetaminophen were administered on the above-mentioned dates and times. Interview with the Director of Nursing on July 11, 2024, at 3:18 p.m. confirmed that there was no documented evidence that the signed-out doses of hydrocodone-acetaminophen were administered to Resident 67 on the above-mentioned dates and times. An admission MDS assessment for Resident 80, dated June 21, 2024, indicated that the resident was cognitively impaired, required substantial to maximum assist for daily care needs, and had diagnoses that included dementia. Physician's orders for Resident 80, dated June 21, 2024, included for the resident to receive 0.5 mg of Lorazepam (an anti-anxiety medication) oral concentrate every six hours as needed for anxiety or restlessness. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the controlled drug record for Resident 80, dated June 2024, revealed that on June 22 at 1:30 p. m. the amount of Lorazepam remaining in the resident's Lorazepam medication bottle was 29 ml. On June 22, 2023, at 5:30 p.m. after 0.25 ml of Lorazepam was administered, there was 14 ml of Lorazepam left in the resident's Lorazepam medication bottle. Review of the resident's MAR, dated June 2024, revealed no documented evidence that a dose of Lorazepam was administered on June 22, 2024, between 1:30 p.m. and 5:30 p.m. Review of a facility incident investigation related to missing narcotics, dated June 22, 2024, revealed that there was no documented evidence to account for the 14.75 ml of missing Lorazepam for Resident 80 identified on June 22 at 5:30 p.m. Review of the controlled drug record for Resident 80, dated June and July 2024, indicated that 0.5 mg of Lorazepam was signed out as administered on July 2 at 7:24 p.m., July 5 at 12:35 a.m., and July 5 at 6:35 a. m. Review of Resident 80's MAR, dated July 2024, revealed no documented evidence that 0.5 mg of Lorazepam was administered on that above-mentioned dates and times. Interview with the Director of Nursing on July 9, 2024, at 3:30 p.m. confirmed that an investigation was completed that revealed there was no accountability for the 14.75 ml of Lorazepam missing from Resident 80's Lorazepam medication bottle on June 22. An interview with the Director of Nursing on July 10, 2024, at 10:14 a.m. confirmed that there was no documented evidence that the signed-out doses of Lorazepam were administered to Resident 80 on July 2 at 7:24 p.m. and July 5 at 12:35 a.m. and 6:35 a.m. 28 Pa. Code 211.9(h) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41233 Based on review of policies, observations, and staff interviews, it was determined that the facility failed to ensure that nutritional drinks in the medication room and pantry were not expired (Crossroads). Findings include: The facility policy regarding food storage, dated [DATE], revealed that food is stored under safe and sanitary conditions to prevent injury and food-borne illness. Observations in the Crossroads medication room on [DATE], at 8:30 a.m. revealed that there were nine Nepro nutritional milkshakes (a protein drink generally used for dialysis residents) that expired in [DATE]. Observations in the Crossroads pantry refrigerator on [DATE], at 8:51 a.m. revealed that there were nine Nepro nutritional milkshakes that expired in [DATE]. Interview with the Dietary Manager on [DATE], at 8:58 a.m. confirmed that 18 expired Nepro nutritional milkshakes were in circulation on the Crossroads unit and should have been previously discarded. 28 Pa code 211.6(f) Dietary Services.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 48941 Based on review of clinical records, as well as resident and staff interviews, it was determined that the facility failed to maintain clinical records that were complete and accurately documented for one of 37 residents reviewed (Resident 60). Findings include: A significant Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 60, dated June 14, 2024, revealed that the resident was cognitively intact, was clearly understood and able to understand others, required assistance with care needs, had an indwelling catheter (a thin, flexible tube inserted into the bladder to drain urine from the bladder), had a urinary tract infection (infection involving any part of the urinary system including the kidney, ureters, bladder and urethra) in the last 30 days, and had a diagnosis that included neurogenic bladder (bladder lacks control due to nerve or muscle problems). Clinical record review for Resident 60 revealed that she had a care plan, dated February 12, 2024, for an indwelling catheter that included an intervention to provide catheter care every shift. Interview with Resident 60 on July 11, 2024, at 12:59 p.m. revealed that she was admitted to the hospital for a bad urinary tract infection and said the hospital stated it was because of bad catheter care. She stated that the nurse aides do good catheter care, but it is difficult because her legs are contracted, and they have to pull them apart to clean her. Review of the daily nurse aide charting for Resident 60 on day shift through the months of April, May, June and July of 2024 revealed that there was no documented evidence that catheter care was completed on April 3, April 4, April 5, April 6, April 11, April 14, April 24, April 28, April 29, April 30, May 1, May 3, May 7, May 25, May 28, May 30, May 31, June 1, June 3, June 24, June 25, June 27, June 28, June 30, July 7, and July 9, 2024. Review of the daily nurse aide charting for Resident 60 on evening shift through the months of April, May, June and July of 2024 revealed that there was no documented evidence that catheter care was completed on April 5, April 13, April 25, May 6, May 8, May 28, June 1, June 20, June 22, June 30, July 2, July 6, and July 7, 2024. Review of the daily nurse aide charting for Resident 60 on night shift through the months of April, May, June and July of 2024 revealed that there was no documented evidence that catheter care was completed on April 13, April 25, May 3, May 6, May 8, May 9, May 10, May 12, May 13, May 19, May 20, June 6, June 9, June 20, and June 21, 2024. Interview with the Director of Nursing on July 11, 2024, at 3:01 p.m. confirmed there was no documented evidence that catheter care was completed for Resident 60 on the above stated dates and shifts. 28 Pa. Code 211.5(f) Clinical Records. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 41233 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to obtain the required information from the contracted hospice provider for two of four hospice residents reviewed (Residents 8, 34). Findings include: The facility's policy regarding the hospice program, dated March 13, 2024, indicated that the resident acknowledges that he or she has been given a full explanation and understands the purpose of hospice care, with the focus on providing comfort and support to the resident. The hospice provider will have a contract with the facility and a modified plan of care. An quarterly MDS assessment for Resident 8, dated June 14, 2024, revealed that the resident was moderately cognitively intact, required assistance from staff for her daily care needs, and was receiving hospice services (end-of-life services). A hospice Election of Benefit document (a form signed to indicate that the individual waives all rights to traditional Medicare Part A payments for treatment related to the terminal illness) for Resident 8, dated August 23, 2023, revealed that the resident was receiving hospice services effective August 23, 2023. In the Election of Benefit document it states that the resident would be re-evaluated for continued hospice eligibility (recertification) at the end of each hospice benefit period in the order of two 90-day periods and every 60 days thereafter. As of July 9, 2024, there was no documented evidence in the resident's clinical record, or in the hospice provider's clinical record, that the facility obtained the hospice recertification of terminal illness from the hospice provider. Interview with the Nursing Home Administrator on July 9, 2024, at 3:25 p.m. confirmed that there was no documented evidence in Resident 8's clinical record, or in the hospice provider's clinical record, that the facility obtained the hospice recertification of terminal illness from the hospice provider. An annual MDS assessment for Resident 34, dated June 12, 2024, revealed that the resident was cognitively intact, required assistance from staff for his daily care needs, and was receiving hospice services (end-of-life services). A hospice Election of Benefit document (a form signed to indicate that the individual waives all rights to traditional Medicare Part A payments for treatment related to the terminal illness) for Resident 34, dated March 17, 2023, revealed that the resident was receiving hospice services effective March 17, 2023. In the Election of Benefit document it states that the resident would be re-evaluated for continued hospice eligibility (certification/recertification) at the end of each hospice benefit period in the order of two 90-day periods and every 60 days thereafter. As of July 9, 2024, there was no documented evidence in the resident's clinical record, or in the hospice provider's clinical record, that the facility obtained the hospice certification/recertification of terminal illness from the hospice provider. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Nursing Home Administrator on July 9, 2024, at 2:32 p.m. confirmed that there was no documented evidence in Resident 34's clinical record, or in the hospice provider's clinical record, that the facility obtained the hospice certification/recertification of terminal illness from the hospice provider. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 46994 Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plans of corrections for a State Survey and Certification (Department of Health) survey ending August 13, 2023, and a complaint investigation survey ending May 29, 2024, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility-maintained compliance with cited nursing home regulations. The results of the current survey, ending July 11, 2024, identified repeated deficiencies related to a failure to ensure the accuracy of Minimum Data Set (MDS) assessments, resident records being complete and accurate, and hospice services. The facility's plan of correction for a deficiency regarding the accuracy of assessment, cited during the survey ending August 13, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F641, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding accuracy of assessments. The facility's plan of correction for a deficiency regarding a failure ensure that the medical records were complete and accurate, cited during the survey ending on May 29, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F842, revealed that the QAPI committee was ineffective in maintaining compliance with the regulation regarding complete and accurate medical records. The facility's plan of correction for a deficiency regarding hospice records, cited during the survey ending August 13, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F849, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding hospice services and records. Refer to F641, F842, F849. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.