STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395570	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milton Rehabilitation and Nursing Center	743 Mahoning Street Milton, PA 17847

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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. 18229 Based on observation and resident and staff interview, it was determined that the facility failed to ensure that care and services were provided in a manner that enhanced resident dignity for one of 24 residents sampled (Resident 57). Findings include: Observation on November 3, 2024, at 10:19 AM revealed Resident 57 was wheeling himself down the hallway with his uncovered catheter bag hanging full of urine under his wheelchair. Observation on November 3, 2024, at 11:52 AM revealed Resident 57 was participating in an activity in the activity room with his uncovered catheter bag hanging full of urine under his wheelchair. Observation on November 3, 2024, at 2:03 PM revealed Resident 57 was in the hallway outside of his room with his uncovered catheter bag full of urine under his wheelchair. Interview with Resident 57 on November 5, 2024, at 10:54 AM confirmed the facility placed the catheter bag covering on November 4, 2024, after the surveyor's discussion with Resident 57. The surveyor reviewed the above findings during a meeting with the Director of Nursing on November 5, 2024, at 2:35 PM. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.29(a) 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. 44738 Based on observations and staff interview, it was determined that the facility failed to provide a clean, comfortable, homelike environment on one of two nursing units (West Side Nursing Unit). Findings include: Observation on November 6, 2024, at 9:00 AM of the [NAME] Side Nursing Unit revealed the following: A white air unit on the ceiling in the resident hallway adjacent to the nurse's station had a significant build-up of a black-colored substance on the interior vents. Observation on November 6, 2024, at 9:15 AM of the [NAME] Side Nursing Unit shower room revealed the following: A resident lift in the shower room had a significant accumulation of debris on the standing pad of the unit. The canvas storage bag attached to the lift had an extensive build-up of debris in the bag that included the following: two large pill-like objects that were partially dissolved, an open and unrolled elastic bandage, an exam glove, a crushed plastic disposable cup, and various other unidentified dirt and debris in the bottom of the canvas bag. The resident shower stall contained black colored dot-like stains on the perimeter wall of the shower cove base where the wall met the floor. There were multiple dead winged insects on the exterior of the light in the shower stall. The shower curtain contained multiple black colored stains of various sizes on the interior/exterior of the shower curtain especially near the bottom of it. Employee 1, nurse aide, was advised of the findings for the [NAME] Side Nursing Unit shower room on November 6, 2024, at 9:20 AM and proceeded to start cleaning out the canvas storage bag. The above information was reviewed with the Director of Nursing on November 6, 2024, at 10:35 AM. 28 Pa. Code 201.18(b)(3)(e)(2.1) Management

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44738 Based on clinical record review and staff interview, it was determined that the facility failed to ensure assessments accurately reflected residents' status for four of 24 residents reviewed (Residents 63, 84, 113, and 115). Findings include: Clinical record review for Resident 84 revealed a quarterly MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated August 26, 2024, in which facility staff assessed the resident as receiving insulin during the last seven days in the assessment period. Further clinical record review revealed no evidence that Resident 84 received insulin during the assessment period for the MDS noted above. An interview with Employee 4, registered nurse assessment coordinator, on November 5, 2024, at 9:44 AM confirmed that Resident 84 did not receive insulin as indicated during the assessment period. Clinical record review for Resident 63 revealed that on July 9, 2024, at 12:30 PM facility staff identified that they had right mandible (jaw) swelling, with Resident 63 indicating a bad tooth concern. Staff visualized a molar with a large filling that broken away from the filling and notified their physician. Facility staff completed Resident 63's annual MDS on August 4, 2024, which indicated that the resident did not have any obvious or likely cavity or broken natural teeth. Closed clinical record review for Resident 115 revealed that the facility completed a discharge MDS on August 12, 2024, which indicated that the resident was discharged to an acute care hospital. Review of Resident 115's clinical record revealed social service documentation dated August 12, 2024, at 2:36 PM that they discharged to home with family. The surveyor reviewed the above findings during an interview with the Director of Nursing on November 5, 2024, at 2:33 PM and November 6, 2024, at 10:41 AM. Clinical record review for Resident 113 revealed a significant change MDS dated [DATE], in which facility staff assessed Resident 113 as receiving insulin during the assessment period. Further clinical record review revealed no evidence that Resident 113 received insulin during the assessment period for the MDS noted above. Interview with Employee 4 on November 5, 2024, at 9:46 AM confirmed Resident 113 did not receive insulin as indicted during the assessment period. 483.20(g) Accuracy of Assessments (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Previously cited 12/15/23 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 18229 Based on clinical record review and resident and staff interview, it was determined that the facility failed to provide bathing support for a resident requiring staff assistance for one of two residents sampled for activities of daily living (Resident 57). Findings include: Interview with Resident 57 on November 3, 2024, at 11:50 AM revealed that the facility admitted him on August 29, 2024. Resident 57 stated that he did not get a shower for his first month in the facility. Clinical record review for Resident 57 revealed his admission MDS (Minimum Data Set, an assessment completed at specific interval to determine care needs) dated September 5, 2024, noted staff assessed him as requiring partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for bathing. Further review of Resident 57's clinical record revealed diagnoses including spina bifida and paraplegia. Clinical record for Resident 57 revealed his preference for bathing is to receive a shower on Mondays and Thursdays. Review of Task documentation (electronic system of nurse aide documentation of activities of daily living care) revealed Resident 57 did not receive a shower from August 29 to October 6, 2024. There were no documented refusals. The facility failed to provide assistance for bathing for a Resident 57 dependent on staff assistance. These findings were reviewed during a meeting with the Director of Nursing on November 5, 2024, at 2:39 PM and she confirmed there was no further documentation that Resident 57 received showers per his preference. 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 44738 Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician ordered weights for three of nine residents reviewed (Residents 22, 51, and 84) and appropriate positioning for meals for one of nine residents reviewed for nutritional concerns (Resident 105). Findings include: Clinical record review for Resident 84 revealed a diagnoses list that included severe protein-calorie malnutrition. Review of the current care plan for Resident 84 revealed the resident has a potential nutrition problem for risk of malnutrition. The goal listed in the care plan for Resident 84 included maintaining adequate nutritional status as evidenced by maintaining weight, no signs/symptoms of malnutrition, consuming at least 60 percent of meals daily, and a target date listed as November 4, 2024. Review of the most recent weights for Resident 84 were documented as: September 7, 2024: 161 pounds (lbs) October 7, 2024: 149.3 lbs (an 11.69 pound weight loss) October 8, 2024: 153 lbs A weight change note for Resident 84 on October 9, 2024, at 8:44 AM revealed a weight warning and a weight loss was noted. The recommendations from Employee 5, nutritional and dietetic technician, were a sugar free shake at lunch for nutritional support and place on weekly weights for four weeks for monitoring. Facility documentation for Resident 84 titled, Physician's Call Report, and dated October 8, 2024, noted written communication to the physician of a 12-pound weight loss in one month. New orders placed on the sheet included: weekly weights for four weeks and a sugar free shake at lunch for nutritional support. The physician noted and signed the documentation on October 10, 2024. Further review of Resident 84's clinical record revealed no evidence that the weights recommended by the dietary staff and ordered by the physician were completed. An interview regarding the weights for Resident 84 on November 6, 2024, at 11:43 AM with Employee 5 revealed that the weights were not completed. The above information for Resident 84 was reviewed with the Director of Nursing on November 6, 2024, at 12:07 PM. Clinical record review for Resident 105 revealed a diagnoses list that included muscle weakness, dysphagia oropharyngeal and oral phase (difficulty swallowing), and muscle weakness. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further clinical record review for Resident 105 revealed a quarterly Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated August 27, 2024, that noted facility staff assessed the resident as having a BIMS (Brief Interview for Mental Status) of 7, which indicated cognitive impairment. The MDS also revealed that staff assessed the resident's transfer status of chair/bed-to-chair (the resident's ability to transfer to and from a bed to a chair or wheelchair) as dependent. Current physician orders for Resident 105 revealed the following orders: a diet order dated July 17, 2024, that instructed staff that the resident is to be OOB (out of bed) for all meals; an order dated July 2, 2024, that noted OOB (out of bed) for all meals every day and evening shift; and aspiration precautions (precautions taken to prevent food or fluids from entering the airway during eating) every shift for aspiration risk dated July 2, 2024. Review of the current task list for Resident 105 revealed that the resident is Dependent x2 assist with hoyer lift. Another task noted the resident is to be OOB for all meals. Review of the Treatment Administration Record (TAR) for Resident 105 for November 2024, revealed that staff were documenting the order for OOB for all meals with a check, which indicated it was completed. There were no documented refusals. Review of the Speech Therapy documentation for Resident 105 titled, Speech Therapy Recommendations, dated July 5, 2024, and July 17, 2024, revealed a recommendation on both documents that the resident be OOB for all meals. An interview with Employee 7, speech therapy, on November 5, 2024, at 12:58 PM revealed that the recommendations for Resident 105 to be out of bed during meals was to facilitate safe swallowing. Observation of Resident 105 revealed the following: November 4, 2024, at 12:25 PM: resident in bed eating lunch November 5, 2024, at 9:01 AM: resident in bed eating breakfast November 5, 2024, at 12:40 PM: resident in bed eating lunch There was no further evidence documented for Resident 105 that indicated the resident refused to be out of bed for the meals or a reason noted why the speech therapy recommendations or physician order was not followed. The above information for Resident 105 was reviewed with the Director of Nursing on November 5, 2024, at 2:18 PM. Clinical record review for Resident 22 revealed a physician's order dated March 21, 2024, for staff to complete a daily weight every morning for CHF (congestive heart failure). Staff were to notify the physician if there was a weight increase or decrease by three-pounds in a day or an increase or decrease of five-pounds in a week. Weigh Resident 22 when he gets out of bed and attempt prior to breakfast. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident 22's clinical documentation revealed that there was no physician notification regarding their weight increase or decrease of three-pounds in a day or five-pounds in a week on the following dates: April 5, 17, and 26, 2024 May 4 and 18, 2024 June 5, 12, 22, and 28, 2024 July 3, 5, 7, 17, 30, and 31, 2024 August 7, 2024 September 18, 22, and 28, 2024 October 9, 12, 23, and 26 2024 November 2, 2024 Clinical record review for Resident 51 revealed a physician's order dated July 3, 2024, for staff to complete a daily weight every morning for CHF. Staff were to notify the physician if there was a weight increase or decrease by three-pounds in a day or an increase or decrease of five-pounds in a week. Attempt to weigh Resident 51 prior to breakfast. Further review of Resident 51's clinical documentation revealed that there was no physician notification regarding their weight increase or decrease of three-pounds in a day or five-pounds in a week on the following dates: August 5, 2024 September 21, 25, and 26, 2024 October 2, 3, 7, 8, 14, 26, 27, and 28, 2024 The surveyor reviewed the above information during an interview on November 6, 2024, at 10:41 AM with the Director of Nursing. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 38839 Based on clinical record review and staff interview, it was determined that the facility failed to identify triggers related to a resident's diagnosis of Post-Traumatic Stress Disorder, to provide culturally, competent, trauma-informed care, and to eliminate or mitigate re-traumatization for one of two residents reviewed for mood/behavior (Resident 25). Findings include: Clinical record review revealed the facility admitted Resident 25 on August 24, 2024, with a diagnosis of chronic Post Traumatic Stress Disorder (PTSD, a mental and behavioral disorder that develops related to a terrifying event). A review of Resident 25's plan of care revealed a care plan was added addressing Resident 25's history of trauma until September 24, 2024, one month after the resident's admission, and only indicated the resident had the potential for ineffective coping related to stress from a traumatic event of complications during childbirth. Further review of Resident 25's clinical record contained no evidence the facility collaborated with the resident, and as appropriate, the resident's family, friends, and any other healthcare professionals (such as psychologists and mental health professionals) to identify triggers to develop and implement individualized interventions to prevent re-traumatization. The Director of Nursing was made aware on November 4, 2024, at 2:00 PM that Resident 25's plan of care failed to indicate potential triggers for Resident 25's trauma and how staff can prevent re-occurrence. A social service note dated November 5, 2024, at 4:05 PM revealed the social worker had met with Resident 25 to review triggers of the resident's trauma, which included seeing and speaking about very small children or babies had the ability to create increased frustration and sadness. Resident 25's plan of care was revised on November 4th and 5th, 2024, with events that trigger the resident's trauma and individualized interventions to prevent re-occurrence of the trauma, after it was brought to the facility staff's attention. 483.25(m) Trauma informed care Previously cited 12/15/24 28 Pa Code 211.12 (d)(3)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 44738 Based on observation and staff interview, it was determined that the facility failed to properly secure and account for resident medications and biologicals on one of two nursing units (West Side Nursing Unit). Findings include: Observation on November 6, 2024, at 8:45 AM during the resident medication pass with Employee 2, licensed practical nurse, revealed a clear medication cup in the top drawer of the medication cart. The cup contained three pills: two round, brown-colored pills and a smaller pink colored one. The medication cup contained no labels, and it was unclear on the identity of the pills. A concurrent interview with Employee 2 revealed that it was unknown how long the cup of pills was in the cart because they were there when the employee started the shift. Further observation of the medication cart revealed three unsecured pills in the bottom drawer of the cart. One pill was a half of a smaller round white colored pill, another was a pink colored oblong tablet, and the third was a round white colored pill. A concurrent interview with Employee 2 revealed it was unknown how long these pills were there or the identity of the pills. Further observation of the medication cart revealed the front left, top corner of the cart was taped with multiple pieces of adhesive white colored tape. Parts of the tape were peeling away, and the peeling parts were discolored and contained small debris. An interview with Employee 2 revealed it was unknown how long the tape was on the cart or how the taped area was cleaned or sanitized. The above information was reviewed with the Director of Nursing on November 6, 2024, at 10:35 AM. 28 Pa. Code 211.9(k) Pharmacy services 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. 29512 Based on clinical record review, and staff and resident interview, it was determined that the facility failed to provide dental services to meet the needs of residents for three of four residents reviewed (Residents 36, 46, and 63). Findings include: Clinical record review for Resident 63 revealed that the dentist saw them on June 14, 2023, and indicated that if Resident 63 experienced any intra-oral (inside mouth) pain or swelling, please refer to an oral surgeon for extractions as needed. On July 9, 2024, at 12:30 PM facility staff identified that they had right mandible (jaw) swelling. Resident 63 indicated a bad tooth concern. Staff visualized a molar with a large filling that was broken away from the filling and notified their physician. Resident 63's physician ordered Clindamycin (an antibiotic) 450 milligrams by mouth (PO) three times a day (TID) for one week for an infected tooth. Resident 63 saw the dentist again on July 18, 2024, who noted increased mouth pain and swelling. The dentist referred Resident 63 to an oral surgeon for x-rays and extraction of any teeth with less than favorable overall prognosis. Resident 63 saw the dentist again on September 19, 2024, who noted that the resident had not yet seen by oral surgeon. The dentist rewrote the oral surgeon referral. After extractions, will evaluate further for any necessary restorative and removable prothesis. Further review of Resident 63's clinical record revealed that the facility failed to refer the resident to an oral surgeon for follow-up as identified by the dentist on July 18, 2024, and September 19, 2024. Clinical record review for Resident 46 revealed they saw the dentist on July 18, 2024. The dentist referred Resident 46 to the oral surgeon for x-rays and extractions of any teeth with less than favorable overall prognosis. Resident 46 saw the dentist again on September 19, 2024. The dentist indicated that the resident had not yet seen the oral surgeon and re-wrote the referral to the oral surgeon. Further review of Resident 46's clinical record revealed that on October 26, 20244, at 7:22 PM they complained of a toothache. The facility notified the resident's provider. They saw Resident 46 on October 28, 2024, and ordered Orajel (for tooth pain). There was no facility documentation that Resident 46 was referred to the oral surgeon after seeing the dentist on July 18, 2024, or September 19, 2024, or after her complaint of tooth pain on October 26, 2024. The surveyor reviewed the above dental concerns during an interview with the Director of Nursing on November 6, 2024, at 10:41 AM. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Resident 36, on November 3, 2024, the resident stated she has teeth that are broken off to the gum, and the dentist in the facility told her, They should all be pulled out and a plate put in there. The resident stated she would need an oral surgeon but doesn't know how to go about getting one. A review of Resident 36's most recent dental visits revealed the resident was seen by the facility's dental service on May 22, 2024. The visit report indicated the resident was referred to an oral surgeon for extractions of all max teeth, tooth number 31, and any other teeth with a less than favorable prognosis. It was also suggested the resident use a high concentrate fluoride toothpaste such as Prevident 5000. Resident 36 was again seen by the facility dentist on September 19, 2024, in which the visit report noted the resident has not yet been seen by an oral surgeon for full radiographic examination and extractions. In an interview with Employee 6, transportation scheduler, on November 6, 2024, at 12:07 PM Employee 6 indicated Resident 36 required a medical facility oral surgeon due to having a pace maker and could not be seen in a non-medical facility based oral surgeons office and provided documentation of faxed referrals indicating attempts to schedule the resident have been unsuccessful on May 27, 2024, June 16, 2024, July 24, 2024, August 13, 2024, September, 23, 2024, and October 4, 2024. Employee 6 indicated there were no other medical facility oral surgeons to refer the resident to and the facility just finally got some other residents who were referred before Resident 36 in for an appointment. Although the facility was continuing to attempt to get the resident to the medical based oral surgeon, there was no evidence as of November 6, 2024, at 10:48 AM that the facility had implemented or addressed the suggested recommendation of the high concentrate fluoride toothpaste that was suggested back on May 22, 2024. The above information regarding Resident 36, was reviewed with the Director of Nursing on November 6, 2024, at 10:48 AM. 483.55(b) Dental services Previously cited 12/15/2023 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 211.15. Dental 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. 38839 Based on observation and staff interview, it was determined the facility failed to store food and maintain food service equipment in a safe and sanitary manner and prevent the potential for food borne illness in the facility's main kitchen. Findings include: Observation of the facility's main kitchen on November 3, 2024, at 8:52 AM revealed the following: The right side of the food steamer was covered in dried food splatter. The flooring under the steamer and the two-door cooler and stove area beside it contained a buildup of dirt, dried food, and debris. Several potholders lying on tables and the meal service area were blackened and stained. Dust and debris were observed on the shelves where food products were stored in the dry storage area. A set of plastic risers was observed on the floor in the dry storage area with a carboard box of plastic lids and a box of food thickener sitting on it. The risers had a buildup of crumbs and debris in the crevices of the riser. A small fabric cooler lunch bag was observed inverted lying on top of the cardboard box of plastic lids with the lid hanging over the edge of the box, with liquid dripping from it, which had caused a large wet area on the plastic riser. Concurrent interview with Employee 3, cook, revealed the lunch bag is used for residents going out for dialysis and it had been washed and placed over the box to dry. Peeling paint was in multiple areas of the dry storage area on the concrete block walls behind canned products. A ceiling light cover in the dry storage room was broken/cracked. Wire shelving units in the walk-in freezer contained dust build up. A clear plastic wrapped pork loin was observed on the floor in the corner of the walk-in freezer under the shelving units. Dust buildup was observed on condenser units in the front and back walk-in coolers. A wooden shelf that extends from the steam table used for meal services was observed with corners and edges broken off exposing porous particle board material. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395570	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milton Rehabilitation and Nursing Center	743 Mahoning Street Milton, PA 17847

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dishwasher temperatures to ensure optimal sanitization revealed a completed log for October 2024. Although staff had not yet washed any items in the machine on November 3, 2024, when observed, there was no evidence of any monitoring for November 1, or 2, 2024. Employee 3 obtained a new blank form from an office in the department for November 2024, and indicated staff had not placed a new form for the change to November and confirmed there was no evidence the machine temperatures were checked on November 1, or 2, 2024, when washing resident tray items and food service items occurred. The above information was reviewed with the Director of Nursing on November 4, 2024, at 2:05 PM. 483.60 (i)(2) Food store, distribute, maintain, sanitary Previously cited 12/15/23 28 Pa. Code 201.14 (a) Responsibility of licensee