STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395572	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Manor	900 Manchester Road Fairview, PA 16415

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to ensure physician's orders and resident Pennsylvania Order for Life Sustaining Treatment (POLST- a legal document specifying the resident/responsible party choices regarding life-sustaining treatments) were consistent for one of 23 residents reviewed (Resident R29). Findings include: Facility policy entitled Pennsylvania Orders for Life-Sustaining Treatment policy (POLST) dated [DATE], indicated the purpose is to guide staff in providing care appropriate to the residents or surrogates wishes. It further stated that if a person is admitted with a POLST, it will be honored. If a person does not have one on admission, one will be completed with the person or surrogate. Resident R29's clinical record revealed an admitted [DATE], with diagnoses that included kidney failure (kidneys are no longer able to work therefore cannot filter waste and toxins from the blood), gastro-esophageal reflux disease (GERD - a condition where stomach acid flows back into the esophagus [tube that passes food from the mouth into the stomach]), and high blood pressure. Resident R29's clinical recorded revealed a physician's order dated [DATE], for Full Code (staff to implement Cardiopulmonary Resuscitation [CPR] -emergency life-saving procedure that is done when breathing or a heartbeat has stopped and when performed immediately can double or triple chances of survival after cardiac arrest). Resident R29's care plans revealed a care plan indicating Full Code. Resident R29's clinical record revealed a POLST dated [DATE], signed by both Resident R29 and his/her physician indicating DNR / Do Not Attempt Resuscitation (allow natural death). During an interview with the Director of Nursing on [DATE], at 11:50 a.m. he/she confirmed Resident R29's physician's orders, POLST, and care plan were not consistent with each other. He/she also confirmed that Resident R29's physician's orders, POLST and care plan should reflect Resident R29's Advance Directive wishes and be consistent with each other. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.18 (e)(1) Management (continued on next page)

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.5(f)(i) Medical records 28 Pa. Code 211.10(c) Resident care policies

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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** 40177 Based on review of Minimum Data Set (MDS - federally mandated standardized assessment conducted at specific intervals to plan resident care), clinical records and staff interviews, it was determined that the facility failed to ensure that the MDS assessment accurately reflected the status for one of 23 residents reviewed (Resident R29). Findings include: Review of MDS instructions for Section H Bladder and Bowel subsection H0300 Urinary Continence indicated that urinary continence is to be coded as not rated if during the seven day look-back period the resident had an indwelling bladder catheter (tubing from the bladder to drain urine into the bag), condom catheter, ostomy, or no urine output for the entire seven days. Resident R29's clinical record revealed an admitted [DATE], with diagnoses that included kidney failure (kidneys are no longer able to work therefore cannot filter waste and toxins from the blood), gastro-esophageal reflux disease (GERD - a condition where stomach acid flows back into the esophagus [tube that passes food from the mouth into the stomach]), and high blood pressure. Resident R29's clinical record revealed he/she had an Indwelling Catheter at the time of admission on 3/9/25. Resident R29's admission MDS with Assessment Reference Date (ARD) of 3/16/25, Subsection H0100 Appliances was coded as Indwelling Catheter and Subsection H0300 Urinary Continence was coded as Occasionally Incontinent, Medicare-5 day MDS with ARD of 3/16/25 Subsection H0100 Appliances was coded as Indwelling Catheter and Subsection H0300 Urinary Continence was coded as Always Incontinent, although Resident R29 had an indwelling catheter for the entire seven-day look-back period. During an interview on 4/10/25, at 2:00 p.m. Registered Nurse Assessment Coordinator confirmed that the 3/16/25 MDS's were coded inaccurately and urinary continence should have been coded as not rated for Resident R29. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.5(f)(ix) Medical Records

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of clinical records and staff interview, it was determined that the facility failed to obtain a physician's order for hospice services for one of four hospice residents reviewed (Resident R107). Findings include: Resident R107's clinical record revealed an admitted [DATE], with diagnoses that included Cerebral Infarction (a condition where a part of the brain is damaged or dies due to a lack of blood supply), Atrial Fibrillation (A-Fib - irregular and often rapid heartbeat that can lead to stroke, heart failure, and other complications), and constipation. Resident R107's clinical record revealed he/she was readmitted to the facility from the hospital on 3/28/25. Review of the hospital records revealed that Resident R107 was returning to the facility with hospice services provided by a hospice agency. Resident R107's clinical record contained documentation from the hospice agency that identified services were being provided while a resident at the facility. Further review revealed his/her clinical record lacked a physician's order for hospice services. During an interview on 4/09/25, at approximately 12:00 p.m. the Director of Nursing confirmed that there was no documented evidence of a physician's order for the hospice services that Resident R107 had been receiving from the hospice agency since his/her return to the facility on [DATE]. 28 Pa. Code 211.12(d)(1)(5) Nursing services 28 Pa. Code 211.5(f)(i) Medical records

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 17260 Based on resident interviews and review of resident council minutes, it was determined that the facility failed to provide sufficient nursing staff and services to promote the physical and mental well-being and meet the needs for five of 23 residents interviewed (Residents R2, R9, R35, R37, and R82). Findings include: Review of resident council minutes from the last three months from January, February, and March of 2025, revealed the following: March 2025 resident council minutes revealed there were complaints of halls being noisy at all times and staff were observed on their cell phones in the hallways. February 2025 resident council minutes revealed concerns with staff on their cell phones in the hallways during resident care, staff being very loud and yelling in the hallways having conversations, weekend staff not present when needed, and residents waiting to be served during meals for long periods of time. January 2025 resident council minutes revealed concerns with staff using foul language and yelling in the hallways during meal service and while performing care on all hallways, non-homelike environment during meals and care due to staff speaking loudly and inappropriately, call bells not being answered on third shift for long periods of time, showers not being completed on designated days and sheets not getting changed on beds. Interviews during the Resident Council meeting on 4/9/25, between 10:00 a.m. and 10:45 a.m., revealed five out of five alert and oriented residents in attendance with concerns related to staff not responding to their call bells timely. Resident R82 indicated that it could take 30-45 minutes for his/her call bell to be answered and staff are typically seen in the hallways talking or on their phones. Resident R9 indicated that he/she will wait for 30 minutes to 60 minutes to receive assistance to use the restroom after placing his/her call bell on. Resident R9 further indicated if he/she is not able to use the restroom in his/her room due to it being too small and required assistance to the hallway restroom with assistance of two people. Resident R9 indicated that it takes a 30 minutes or longer most of the time to have call lights answered to use the restroom. Resident R9 further indicated that he/she is supposed to be walked, and staff are always too busy and never have time to walk him/her as ordered. Residents R2, R35 and R37 indicated they wait 30 minutes or longer when their call bell is placed on to be responded to by staff. All residents agreed that they observe staff on their phones and standing talking to one another during their shifts. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 4/9/25, at 2:00 p.m. revealed that Resident R37 expressed concerns of poor call bell response times. Resident R37 revealed that on weekends and evenings he/she observes staff constantly watching tv, were on their phones, and talking in the back lounge area of B Hallway while call lights are on in the hallway. Resident R37 also indicated that he/she requires full assist with eating and there is not enough staff to assist everyone in a timely manner. By the time he/she gets someone to assist with his food it is cold and requires being heated up. Resident R37 stated this happens a lot. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(4)(5) Nursing services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on a review of facility policy and clinical records, observations, and staff interviews, it was determined that the facility failed to follow acceptable infection control practices regarding enhanced barrier precautions (EBP) during observations for one of eight residents reviewed (Resident R29). Findings include: Facility policy entitled Enhanced Barrier Precautions dated 12/4/24, indicated it is the intent of the facility to use Enhanced Barrier Precautions (EBP) in addition to Standard Precautions for residents to prevent transmission of MDRO's (Multidrug Resistant Organisms - a germ resistant to many antibiotics). The policy further stated that EBP may be considered for the following situations: indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator). The Center for Disease Control and Prevention (CDC) defines Enhanced Barrier Precautions as an infection control intervention designed to reduce transmission of MDRO's using an approach of isolation gown and gloves during high-contact resident care activities including catheter and central line care. CDC further indicates that facilities should post clear signage indicating EBP requirements, and ensure easy access to gowns, gloves, and alcohol-based hand rub. Resident R29's clinical record revealed an admitted [DATE], with diagnoses that included kidney failure (kidneys are no longer able to work therefore cannot filter waste and toxins from the blood), gastro-esophageal reflux disease (GERD - a condition where stomach acid flows back into the esophagus [tube that passes food from the mouth into the stomach]), and high blood pressure. Resident R29's clinical record revealed he/she had a PICC line (peripherally inserted central catheter - a long flexible thin tubing inserted into a vein in your upper arm then threaded to a central vein near your heart used to administer medications), and an indwelling catheter (tubing inserted into the bladder to drain urine) at time of admission on 3/9/25. Resident R29's physician's order failed to include an order for EBP. Observations on 4/08/25, at 2:00 p.m. and 4/09/25, at 1:00 p.m. revealed Resident R29 sitting in a chair in his/her room with a capped PICC Line to the right upper arm and an indwelling catheter that was covered and positioned below the bladder. Observation of Resident R29's room revealed that there was no signage alerting persons entering the room of EBP for infection control and no personal protective equipment (PPE) such as gloves and gowns available inside or outside of the room for use. During an interview on 4/09/25, at 2:15 p.m. the Director of Nursing confirmed that Resident 29's room lacked signage of EBP and appropriate PPE, such as gloves and gowns, when providing care for residents who have an indwelling urinary catheter and PICC line, and that signage should have been posted and PPE should be readily available. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services