STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395582	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Nursing & Rehabilitation Center	403 Hazle Township Boulevard Hazleton, PA 18202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on review clinical records, and resident and staff interview it was determined that the facility failed to provide care in a manner and environment, which promotes each resident's quality of life by failing to respond timely to residents' requests for assistance as reported by two residents out of 14 residents sampled (Residents 14 and Anonymous Resident 1). Findings include: During interview On May 31, 2024, at 11:40 AM with Anonymous Resident 1 (resident who preferred to remain anonymous for fear of retaliation), the cognitively intact resident stated that over the past weekend on the second shift he/she waited an hour for staff to answer the call bell to be answered and his/her brief to be changed. The resident stated that wait times seem to be longer when agency staff are working. Clinical record review revealed that Resident 14 was admitted to the facility on [DATE], with diagnoses which included diabetes and hypertension. The resident was cognitively intact. During interview on May 31, 2024, at 12:00 PM Resident 14 stated that in the evening after 6:00 PM it is not unusual to wait one hour or more for staff to answer the call bell and needed care such as toileting to be provided by staff Interview on May 31, 2024, at approximately 1:30 PM with the Nursing Home Administrator (NHA) confirmed that all residents are to be treated with dignity and respect, including timely response to their requests for assistance. The NHA confirmed that call bells were to be promptly answered and timely care and assistance provided to promote each residents' quality of life. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa Code 211.12 (d)(5) Nursing services

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on a review of clinical records and select incident reports, observation, and staff interview, it was determined that the facility failed to provide dependent residents with the necessary feeding assistance to promote safe swallowing for one of 14 residents sampled (Resident 196). Findings include: Review of Resident 196's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses to have included dysphagia (difficulty swallowing). Review of Resident 196's care plan initiated March 5, 2024, revealed the problem of self-care deficit with an intervention for staff assistance of one person for eating. The resident had a physician order dated March 27, 2024, for a pureed texture diet, nectar consistency liquids. Review of an incident revealed that the resident was coughing during the dinner meal on April 21, 2024, and the resident coughed up a small piece of shrimp. The incident report included employee witness statements, and none of the employees interviewed as witnesses stated that they had provided feeding assistance to the resident at this dinner meal as indicated in the resident's care plan. Review of the resident's clinical record, including nurse aide tasks, showed no evidence that he was assisted with his dinner meal on this date. During interview with the Nursing Home Administrator (NHA) and Director of Nursing on May 31, 2024, at 1:30 PM, they were unable to provide evidence that the facility provided necessary staff assistance with eating in accordance with Resident 196's care plan that indicated that the resident should have had staff supervision or assistance while eating to promote safe swallowing. Refer 805 28 Pa. Code 211.12 (d)(1)(5) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on review of clinical records and select facility policy, observations, and staff and resident interviews it was determined that the facility failed to provide necessary supervision and effective safety measures to monitor a resident's whereabouts and prevent an elopement by one resident (Resident 181) out of 14 sampled residents, placing the 65 residents out of 238 residents residing in the facility, identified at risk for elopement, including Resident 142, in immediate jeopardy to their health and safety. Findings include: Review of facility policy entitled Elopement/ Unauthorized absence, last revised by the facility February 6, 2024, revealed that elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so. The facility will identify residents with potential/or actual risk factors for elopement and protect the resident through development and implementation of safety interventions. In the event of a resident elopement the facility will implement its policies and procedures promptly to locate the resident in a timely manner. The corresponding procedures included: -all residents will be assessed for the risk of elopement -residents identified at risk will have interventions promptly implemented to reduce the risk of elopement -residents identified at risk will have their picture and face sheet form placed in the binder that is kept in an area accessible by staff. Upon determining that a resident cannot be located, a head count (of residents) will be conducted. If the resident is still missing, code green using the resident name, room number and unit name will be announced. The clinical supervisor or designee will notify the administrator, the Director of Nursing and the attending Physician. The highest-ranking staff member becomes the Team Leader and coordinates the search process. If the resident is not located on the premises, the team leader will direct staff to conduct an external search. A review of a facility policy Resident leave of absence revised April 25, 2024 revealed, that a leave of absence is defined as, time away from the facility, either on or off the property, where the resident is not under the direct care or supervision of facility staff, regardless of the amount of time, and someone other than facility stff has assumed responsibility for the resident during such time. Corresponding procedures were noted as: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-The resident/responsible party will be requested to sign-out of the facility, which indicates the resident's/responsible party's acceptance of responsibility for self/resident while participating in an LOA and reminded to sign back in and alert staff upon return. -prior to leaving the facility, the charge nurse will request the address and phone number of the location where the resident will be, if known and estimated date and time of return. A review of the clinical record revealed that Resident 181 was admitted to the facility on [DATE], with diagnoses, which included bipolar disorder (a mental health condition that causes extreme mood swings between depression and mania or hypomania) and difficulty walking. The resident was cognitively intact with a BIMS score of 13 (Brief Interview for Mental Status a score of 13-15 indicates intact cognition). He independently propelled on the nursing unit in the wheelchair. The resident was homeless prior to this recent admission to the facility. When reviewed at that time of the survey ending May 31, 2024, there was no evidence that an elopement risk assessment had been completed upon the resident's admission or at any time prior to his elopement from the facility. There was also no documented evidence at the time of the survey ending May 31, 2024, of a physician order permitting the resident to go out on a leave of absence. An anonymous facility employee reported a concern to the State Survey Agency reporting that on Saturday May 18, 2024, Resident 181, a resident residing on the second floor of the the Blue building (facility is comprised of two facilities on the same campus), left the facility unsupervised, without staff knowledge, and walked independently with his cane, traveling approximately 0.5 miles to a convience store. The nursing supervisor was called, found him brought him back to the building, but staff did not document the incident in the resident's clinical record. A review of Resident 181's clinical record, conducted during the survey on May 31, 2024, confirmed that there was no documentation in the resident's clinical record regarding the resident's elopement. Observation and interview conducted on May 31, 2024 at 10 AM revealed that Resident 181 was in his room on the second floor of the Blue building seated in his wheelchair. In the presence of the surveyor, Resident 181 wheeled to the nurses station and signed his name and the time in the resident sign out book. There was no nursing staff at the nurses desk or anywhere in the immediate vicinity at that time. The resident and the surveyor then entered the elevator, exited on the first floor, passed the front desk (which was also unattended at that time) and wheeled outside through front entrance into the parking lot area. An interview at that with Resident 181, revealed that he stated that on Saturday May 18, 2024, early in the morning he signed the Leave of Absence (LOA) sheet, in the binder on the nurses desk (on the second floor resident unit). He stated that there was no nursing staff in the area at the time he signed out. He also stated that he goes out of the building several times a day, unaccompanied, stating that he does not tell anyone he is leaving the floor. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident 181 stated that on Saturday May 18, 2024 he left the second floor in his wheelchair and had his cane with him. He took the elevator downstairs and left the building through the front entrance. When he got outside, he stood up from his wheelchair, and walked with his cane off the facility campus. He stated that it took him about an hour to walk from the facility to the convience store, stopping 4 to 5 times, sitting on the curb to rest. He stated that when he got to the store, he was shopping and he was approached by a gang of people from the facility. He stated that he was approached by a male nurse from the facility as well as 2 female nurse aides. These employees took him in a car and brought him back to the facility. He stated that the male nurse yelled at him and took his outside privledges away. Resident 181 stated that he is not steady on his feet and it was not easy to walk, and that he had to cross a busy street to get to the convenience store. Interview May 31, 2024 at 11:15 AM Employee 6, a nurse aide, stated that she worked 7 AM to 3 PM on Saturday May 18, 2024. She explained that residents who are independent can sign themselves out in a book that is at the nursing station, to go outside. Therapy and other services also use this book to sign residents off the unit. Employee 6 said, but if a resident leaves LOA (leave of Absence) there are papers to be signed in the resident's medical record. She stated sometimes people forget to sign in and/or out in this book, and staff have at times, needed to search for a resident because they didn't sign out. She stated she went on break with another aide sometime between 9:30 AM and 10:30 AM heading to a nearby convience store. While traveling in the car they noticed a resident sitting on the curb at the convience store. They returned to the facility and told the nursing supervisor that they saw the resident at the convience store. The nursing supervisor and two other staff members went to get the resident. Employee 6 stated she never saw any other employees with the resident or near the resident when they saw him sitting on the curb. She also stated that no facility staff member had asked her for a witness statement to give her account of the incident. An interview with Employee 7, a nurse aide, conducted at approximately 11:00 AM on May 31, 2024, revealed that she worked on Saturday May 18, 2024, during 7 AM to 3 PM shift. Employee 7 stated that she had not taken care of the resident who eloped, but recalled hearing the Code [NAME] (the facility's elopement code) sound and she participated in performing a head count and checked rooms for the missing resident, but were unable to find him. She stated that she heard the resident was found at the convience store and was returned to the facility. She stated no facility staff member had asked her for a witness statement as part of an investigation into incident. An interview with Employee 1, a nurse aide, on May 31, 2024, at 11:15 AM revealed the employee was working the dayshift on May 18, 2024. The employee stated the facility called a Code Green, the code called when a resident elopes from the facility. Employee 1 stated they began to look for the resident. Employee 1 stated she did not find him but heard he was found at the Turkey Hill down the street. Employee 1 stated that when residents are leaving the unit, they are supposed to sign out in the book that sits on the nursing station. She stated that the book is not supervised and at times, staff doesn't know who has signed themselves off the units. Employee 1 stated that if they are looking for a resident and cannot find them, they will check the book to see if they signed out. Employee 1 stated that there is no real procedure for ensuring the residents are signing the book or staff monitoring when residents are leaving the unit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with Employee 2, LPN, (license practical nurse) on May 31, 2024, at 11:25 AM revealed this nurse was working the dayshift on May 18, 2024. Employee 2 stated that Resident 181 went out for fresh air during the first cigarette break around 8:30 AM. Employee 2 stated that Employee 3, RN, called a Code [NAME] when the resident could not be found on the unit. Another employee who was on break saw the resident at the Turkey Hill down the street. Employee 2 stated that the resident was brought back to the facility at approximately 9:30 AM. Employee 2 stated that the resident was allowed to sign the book on the unit and go outsides on the facility grounds for fresh air independently. Employee 2 stated that staff don't monitor the book unless they need to check on a specific resident, and there is no procedure in place to ensure residents are signing the book and staff monitoring to ensure the residents return to the unit. An interview with Employee 4, nurse aide, on May 31, 2024, at 11:35 AM revealed the employee was working the dayshift on May 18, 2024. Employee 4 stated that while she was on her 15 minute break, she went to [NAME] Donuts to get a coffee. The employee stated when she was leaving [NAME] Donuts to return to the facility, she spotted the resident sitting on the curb at the Turkey Hill. The employee stated the resident was alone in the parking lot of the store, with no staff with him or nearby. Employee 4 stated that she did not see him outside in the facility parking lot prior to him leaving the facility and did not see him outside for the morning smoke break. Employee 4 stated that she came back to the facility and told Employee 3 (RN) and Employee 5 RN that the resident was at the Turkey hill. Employee 3 called a Code Green, and he drove his car down to the Turkey Hill to pick the resident up. Employee 4 stated that there is no procedure in place to supervise residents signing out to leave the unit and confirm their return. The employee stated the residents are not supervised and sign themselves out. Employee 4 stated that if they can't find a resident, they would look in the book to see if they signed themselves off the unit. Employee 4 stated there have been times when a resident was not on the unit but did not sign off in the book. There was no evidence that the facility had interviewed their staff to determine when staff had last seen the resident, or how he was able to exit the nursing unit and building without staff awareness of the resident's whereabouts. The facility failed to demonstrate that staff adequately monitored this resident's whereabouts and activities. Nursing staff outside the building on a break called the facility to inform the facility staff that the resident had left the building as facility staff were unaware and the duration of the resident's absence could not be determined due to the lack of investigation by the facility. At the time of the survey ending May 31, 2024, the facility had not investigated the incident to determine the circumstances and how long the resident was gone. Interview with the Director of Nursing on May 31, 2024, at approximately 2:00 PM, revealed that staff had informed her of the incident and she came into the facility on [DATE]. The DON confirmed that the facility failed to provide necessary supervision and implement effective safety measures for this resident. The DON also confirmed that the facility failed to investigate the resident's elopement to prevent recurrence and the incident was documented in the resident's clinical record or reported to the State Survey Agency. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the LOA binder located at the second floor nurses desk revealed on May 31, 2024, revealed the names of residents who signed out to leave the floor independently on multiple days. The residents' names were not listed on the list of residents approved to sign out and leave the floor independently provided during the survey by facility administration. This was confirmed during the survey by the DON and NHA on May 31, 2024, at 11:30 AM. Further, at the time of the survey of May 31, 2024, facility administration could not locate the sign-out sheet for May 18, 2024. Clinical record review revealed that Resident 142 was admitted to the facility on [DATE], with diagnoses to include schizophrenia, anxiety, major depression, bipolar disorder and difficulty walking and was moderately, cognitively impaired with a BIMS score of 10 (8012 indicates moderate cognitive impairment). A review of the LOA binder located on the second floor nurses station, revealed that May 29, 30 and 31, 2024, Resident 142 signed herself and left the floor. Review of the resident's clinical record revealed no evidence that the resident could leave the floor and the facility independently, which was confirmed by Director of Nursing during interview on May 31, 2024, at 1 PM. Immediate Jeopardy was called on May 31, 2024, due to the facility's failure to timely identify resident absences from the facility and prevent elopements. Lack of functioning operational procedures for monitoring residents who are signing out to leave the unit, building and facility grounds. The facility was notified of the Immediate Jeopardy on May 31, 2024, at 1:30 PM and the IJ template provided to the facility. An immediate plan of correction was requested and received on May 31, 2024. The plan included: - Identify residents who go outside independently and have the ability to be affected -policy and procedure reviewed with residents affected to ensure they know the process for leaving the unit -Therapy screen current residents affected to ensure they are able to leave safely -Residents with cognitive impairment will be reviewed to ensure the elopement assessments are accurate and interventions are in place to prevent elopement -review of current residents to ensure residents have an appropriate LOA order, if issues identified, call Physician for appropriate orders -Staff were made aware if a resident is not independent to go off the unit and outside and ensured they knew the policy for leaving the unit and/or LOA, Staff were educated that is a resident is not independently able to leave the unit, they must be stopped and supervision provided. -current staff educated on the LOA policy/procedure and the elopement policy and procedure (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-elopement drill completed on all shifts The Immediate Jeopardy was lifted on May 31, 2024, at 4:40 PM when the removal plan was verified as completed. 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 211.12 (c)(d)(5) Nursing services 28 Pa. Code 211.10 (a)(c)(d) Resident care policies

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F 0805 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on review of clinical records, the facility's diet manual and select facility incident reports, and staff interviews, it was determined that the facility failed to ensure that a resident identified with swallowing difficulties was consistently served food in a form to meet the resident's individual needs, which caused a choking incident and aspiration (when food, drink, or foreign objects are breathed into the lungs) requiring hospitalization of one of 14 residents reviewed (Resident 196). Findings Include: Review of Resident 196's clinical record revealed that the resident was admitted to the facility on [DATE], with a diagnosis of dysphagia (difficulty swallowing). Review of resident's current care plan dated March 5, 2024, and in effect on April 21, 2024, revealed the resident required the assistance of one staff person with eating. Resident 196's admission Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated March 9, 2024, indicated that the resident was provided a mechanically altered diet (a diet that required a change in texture of food) daily. Resident 196 had a current physician order for a regular Pureed texture diet with nectar thickened consistency liquids (liquids thickened to the consistency similar to apricot nectar) initially dated March 27, 2024 (pureed diet is a type of diet that consists of foods with a smooth pudding-like consistency). A review of a facility incident report dated April 21, 2024, at 5:45 p.m. indicated that Employee 7 (RN) was called to the unit to assist Resident 196, because he was coughing. Employee 7 arrived to find resident coughing mucous out, and eventually spits out a small piece of shrimp. Further stating that only a small amount of food was eaten from the top of the resident's meal plate. Review of employee witness statements for this incident revealed none of the nurse aide employees interviewed as witnesses indicated that they had provided feeding assistance to the resident during the dinner meal on April 24, 2024. Review of nurse aide tasks dated April 21, 2024, revealed Employee 6 (NA) provided resident 196's ADL (activities of daily living) care of toileting and other tasks associated with activities of daily living. Employee 6's witness statement indicated that she was not in the room with Resident 196 when he was eating his dinner meal on April 21, 2024. There was no documented evidence that any staff member was present when Resident 196 began eating his dinner meal on April 21, 2024. (continued on next page)

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F 0805 Level of Harm - Actual harm Residents Affected - Few	A review of facility planned menu for the evening meal on April 21, 2024, revealed that Shrimp Scampi over angel hair pasta was the dinner for residents receiving pureed diets. A review of the recipe for pureed shrimp scampi indicated that the shrimp and pasta servings should be separately put into the food processor, should be blended until smooth, served scoop of blended pureed shrimp over blended pureed pasta. Further review of resident's clinical record revealed that a stat chest x-ray was ordered by the physician at 5:45 p.m., on April 21, 2024. At approximately 10:00 p.m., the mobile x-ray company responded that they would not be able to make it to the facility until the next morning. Resident 196 was sent to the emergency room at approximately 10:19 p.m., on April 21, 2024, due to potential aspiration and drop in Spo2 (what percentage of your blood is saturated) registering in the 60's (normal range is 95-100%) requiring 2 liters of oxygen. Hospital documentation dated April 22, 2024, indicated that Resident 196 had acute respiratory failure requiring 4 liters of oxygen to maintain oxygen levels above 89%, had scattered rhonchi, moist respirations and an elevated temperature. The resident was started on Rocephin and Flagyl for likely aspiration pneumonia. Interviews with the director of nursing (DON) and nursing home administrator (NHA) on May 31, 2024, at approximately 3:00 p.m. the DON and NHA confirmed that the facility failed to serve food to Resident 196 that met the resident's individual needs for safe swallowing and consistent with the current prescribed pureed diet with nectar thick liquids resulting in a choking episode and aspiration pneumonia. Refer 677 28 Pa. Code 211.6 (a) Dietary Services 28 Pa. Code 211.12 (d)(3)(5) Nursing services

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on a review of clinical records and select facility policy, and resident and staff interview, it was determined that the facility failed to ensure the provision of a nourishing (satisfying to the resident) evening snack for one resident out of 14 sampled (Resident 14). Findings include: Review of the facility Nourishment and Supplement Policy last reviewed August 21, 2023, indicated that the facility will assure a supply of nourishments such as snacks between meals, and supplements that have been ordered are available. Clinical record review revealed that Resident 14 was admitted to the facility on [DATE], with diagnoses which included diabetes and hypertension. During an interview with Resident 14 on May 31, 2024, at 12:00 PM the resident stated that he has diabetes and feels that a bedtime snack would be beneficial to help control his blood sugars and to keep him from getting too hungry between supper and breakfast the next day. Resident 14 stated that he had requested a bedtime snack over the last four or five days but has not yet started receiving a snack at bedtime. Further review of the clinical record revealed no documented evidence that a bedtime snack was being provided to Resident 14. Interview with the director of nursing on May 31, 2024, at 1:30 PM confirmed that there was no documented evidence that a bedtime snack was being offered to Resident 14. 28 Pa. Code 211.12 (d)(3)(5) Nursing Services

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain City Nursing & Rehabilitation Center	403 Hazle Township Boulevard Hazleton, PA 18202

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 26142 Based on a review of clinical records, select facility policies, investigate reports, and employee job descriptions it was determined the facility's administration failed to effectively use its resources to promote resident safety by failing to implement established procedures to monitor resident whereabouts and prevent an elopement for one out of 16 sampled residents (Resident 181). Findings include: Based on review of clinical records and select facility policy, observations, and staff and resident interviews it was determined that the facility failed to provide necessary supervision and effective safety measures to monitor a resident's whereabouts and prevent an elopement by one resident (Resident 181) out of 14 sampled residents, placing the 65 residents out of 238 residents residing in the facility, identified at risk for elopement, including Resident 142, in immediate jeopardy to their health and safety. A review of the job description for the Administrator of the facility revealed that the Administrator leads and directs the overall operations of the facility in accordance with community policies and procedures, customer, and resident needs, and both state and federal guidelines. To maintain excellent care for the residents/patients and achieve the facility's business objective. The administrator is delegated the administrative authority, responsibility, and accountability for carrying out assigned duties. Responsible for carrying out the operational core responsibilities established by the company and the facility. Responsible for oversight of the resident care policies established by the facility. Essential functions, duties, and responsibilities include: monitoring each department's activities, ensuring that each department attains and maintains compliance with state and federal requirements, rounds frequently throughout the facility to monitor the delivery of nursing care, overall cleanliness and appearance of the facility, develops an environment where positive and creative thinking helps solve problems, and meets regularly with the residents of the facility to ensure they are satisfied with the delivery of care, ensures that company consultants and other support resources are appropriately utilized and a high level of interdepartmental teamwork is maintained, hold monthly all staff meetings, and meet at least quarterly with staff on evening and night shift. A review of the job description for the Director of Nursing (DON) indicated that under the supervision of the administrator, the DON is to organize, develop, and direct the overall operations of the Nursing Service Department in accordance with current federal, state, and local standards, guidelines and regulations that govern the facility. The DON is to work directly with the Administrator and Medical Director to ensure the highest degree of quality of care is maintained for each resident at all times. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395582	A. Building B. Wing	05/31/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON plans, develop, organize, implement, evaluate, and direct the nursing service department, as well as its programs and activities, in accordance with current rules, regulations, and guidelines that govern the nursing care facilities. Ensure nursing personnel have completed orientation, competencies, and perform annual and periodic evaluations. Responsible for the daily calculation of the direct nursing care personnel on duty each shift. Maintain a master schedule to enhance staffing and enable an accurate need for staffing at all times. Monitor nursing care to ensure all residents are treated fairly and with kindness, dignity, and respect. Participate in interviewing and selection of residents for admission. Responsible to complete daily rounds of the facility with the administrator. Responsible in developing a written comprehensive care plan to meet the nursing needs of each resident. Encourage the resident and his/her family to participate in the development and review of the resident's plan of care. Ensure all personnel are involved in providing care to the resident in accordance to the plan of care. Responsible for maintaining staffing levels to comply with the 5-Star review. The deficiency cited under the Code of Federal Regulatory Groups for Long Term Care, Quality of Care (F689) 483.25(d)(2) each resident receives adequate supervision and assistive devices to prevent accidents revealed that the Administrator and DON failed to fulfill the essential job duties for ensuring the health and safety of the residents and adherence to regulatory guidelines. Refer F689 28 Pa. Code: 201.12 (a) Responsibility of licensee 28 Pa. Code: 201.18 (b)(1)(e)(1) Management 28 Pa. Code:211.12 (c) Nursing Services