STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395596	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgeville Rehabilitation & Care Center	3590 Washington Pike Bridgeville, PA 15017

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311 Based on a review of facility policy, clinical records, and incident investigations, it was determined that the facility failed to ensure that residents are free from misappropriation of property for 18 of 22 residents (Resident R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R16, R17, and R18). Findings include: Review of the facility policy Abuse Prohibition dated 10/24/24, defined misappropriation of resident property as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Review of the clinical record revealed that Resident R18 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of care needs) dated 2/10/25, included diagnoses of chronic kidney disease (gradual loss of kidney function), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and care needed after joint surgery. Review of Section C: Cognitive Patters revealed Resident R18 to be cognitively intact. Review of a physician's order dated 2/3/25, indicated Resident R18 received Oxycodone HCL 5 mg (milligrams) tablet (a narcotic pain medication), to Give 1 tablet by mouth every 4 hours as needed for mild-moderate pain AND Give 2 tablets by mouth every 4 hours as needed for severe pain. Review of facility submitted documentation on 2/7/25, indicated, On 2/6/25, This writer was notified that resident, [Resident R18], potentially had a discrepancy with oxycodone supply that had been delivered on 2/4/25, in the early morning hours. The potential discrepancy was noted at approx 9:30 p.m. on 2/7/25, by the primary nurse and evening supervisor. Local law enforcement was notified on the late evening of 2/6/25, by the RN (registered nurse) supervisor and report was taken with the responding Officer. Social Services to report to APS (Adult Protective Services). Update: 27 count of 10mg oxycodone pills are unaccounted for with no AP (alleged perpetrator) able to be identified. Review of a statement written by the Director of Nursing (DON) dated 2/8/25, indicated, A 27 count of oxy 10 mg has been found to be missing for resident [Resident R18]. Unable to account for card, pills, or narc sheet. No AP identified at this time. Education on narc counts for shift to shift handoff are being conducted, narc sheets are being audited for completion daily. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a statement dated 2/7/25, written by RN Employee E1 indicated, At 2130 (9:30 p.m.) I was informed by Licensed Practical Nurse (LPN) Employee E2 that patient [Resident R18] had no pain medication on med cart and patient had asked for it. LPN Employee E2 reported she called pharmacy to obtain pull code and pharmacy refused as 30 tabs oxycodone 10 mg and 30 tabs 5 mg were sent on 2/5/25. LPN Employee E2 reported count being correct at 7 pm for 9 cards of meds at 7 pm. Cart narcotics counted by myself and LPN Employee E2 and there were 9 but no narcotics for patient [Resident R18]. Medications not documented on Controlled Substance Inventory Sheet as being wasted. Meds were logged in when received from pharmacy. Neither individual patient narcotic record in cart logbook. Did find narcotic record for oxycodone 10 mg in patient record and it was marked as destroyed (27 tablets) because no order. Only able to find a destroyed med card for oxycodone 5 mg in shred box in unit managers office. Spoke with LPN Employee E3 at 130 a (1:30 a.m.) when she called in to report off ill. She reported the 10 mg oxycodone was wasted due to no order. When asked what happened to card of 5 mg oxycodone she did not know. Resident last medicated at 811 (8:11 a.m.) by LPN Employee E4 with oxycodone 5mg 2 tabs per documentation but administration record reflect patient given 1 10 mg tab. Review of an undated statement written by LPN Employee E3 indicated, On 2/6/25, around 6-6:30 p.m. LPN Employee E5 and I wasted 27 tablets of oxycodone 10 mg belonging to [Resident R18]. We destroyed them because the order in the computer stated oxycodone 5mg. I never knew there was a card of 5 mg as I never looked specifically for it. Review of a statement dated 2/6/25, written by LPN Employee E5, indicated, At approx. 1830 (6:30 p.m.) LPN Employee E3 and I wasted [Resident R18's] 10 mg oxy, 27 tabs. Review Resident R1's physician's order for oxycodone 20 mg dated 4/2/25, reordered 4/22/25, indicated to give 2 tablet by mouth every 4 hours as needed. Review of Resident R1's Medication Administration Record (MAR) for 4/16/25, through 4/23/25, revealed five of thirteen administrations signed out on the paper controlled drug record, without corresponding documentation of administration in the MAR: Unknown date: 20 mg at 8:00 a.m. 4/21/25: 40 mg at 5:50 p.m. 4/21/25: 40 mg at 9:50 p.m. 4/22/25: 40 mg at 1:45 p.m. 4/22/25: 40 mg at 9:45 p.m. Review Resident R2's physician's order for oxycodone 10 mg dated 3/28/25, indicated to give 1 tablet by mouth every 4 hours as needed. Review of Resident R2's MAR on 4/23/25 revealed three of three administrations signed out on the paper controlled drug record, without corresponding documentation of administration in the MAR: 4/23/25: 10 mg at 2:50 a.m. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/23/25: 10 mg at 7:39 a.m. 4/23/25: 10 mg at 11:30 a.m. Review Resident R3's physician's order for oxycodone 5 mg dated 4/12/25, indicated to give 1 tablet by mouth every 4 hours as needed. Review of Resident R3's MAR on from 4/15/25, through 4/23/25 revealed four of 21 administrations signed out on the paper controlled drug record, without corresponding documentation of administration in the MAR: 4/20/25: 5 mg at 1:00 a.m. 4/20/25: 5 mg at 8:00 p.m. 4/21/25: 5 mg at 11:30 a.m. 4/22/25: 5 mg at 3:00 p.m. Review Resident R4's physician's order for oxycodone 5 mg dated 4/14/25, indicated to give 2 tablets by mouth every 4 hours as needed. Review of Resident R4's MAR on from 4/19/25, through 4/23/25 revealed six of 16 administrations signed out on the paper controlled drug record, without corresponding documentation of administration in the MAR: 4/19/25: 5 mg at 10:00 a.m. 4/19/25: 10 mg at 9:00 p.m. 4/20/25: 10 mg at 8:30 a.m. 4/20/25: 10 mg at unknown time. 4/20/25: 5 mg at 5:00 p.m. 4/20/25: 5 mg at 9:00 p.m. Review Resident R5's physician's order for tramadol (narcotic pain medication for moderate pain) 50 mg dated 3/3/25, indicated to give 1 tablet by mouth every 8 hours as needed. Review of Resident R5's MAR on from 4/19/25, through 4/23/25 revealed one of four administrations signed out on the paper controlled drug record, without corresponding documentation of administration in the MAR: 4/19/25: 50 mg at 8:00 p.m. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review Resident R6's physician's order for tramadol 50 mg dated 4/14/25, indicated to give 1 tablet by mouth every 8 hours as needed. Review of Resident R6's MAR on from 4/18/25, through 4/20/25 revealed two of three administrations signed out on the paper controlled drug record, without corresponding documentation of administration in the MAR: 4/18/25: 50 mg at 6:00 p.m. 4/20/25: 50 mg at 8:00 a.m. Review of Resident R7's MAR on from 4/22/25, through 4/23/25 revealed one of five administrations signed out on the paper controlled drug record, without corresponding documentation of administration in the MAR: 4/22/25: 5 mg at 6:00 p.m. Review of Resident R8's MAR on from 4/18/25, through 4/20/25 revealed three of seven administrations signed out on the paper controlled drug record, without corresponding documentation of administration in the MAR: 4/19/25: 5 mg at 10:00 (a.m. or p.m. not documented). 4/19/25: 5 mg at 5:00 (a.m. or p.m. not documented). 4/20/25: 5 mg at 5:00 p.m. Review of Resident R9's MAR on from 4/16/25, through 4/23/25 revealed two of seven administrations signed out on the paper controlled drug record, without corresponding documentation of administration in the MAR: 4/16/25: 10 mg at 5:30 p.m. 4/17/25: 5 mg at 6:00 p.m. Review of Resident R10's MAR on from 4/9/25, through 4/14/25 revealed two of eight administrations signed out on the paper controlled drug record, without corresponding documentation of administration in the MAR: 4/9/25: 5 mg at 8:00 a.m. 4/9/25: 5 mg at 1:300 p.m. Review of Resident R11's MAR on from 3/20/25, through 4/18/25 revealed three of eleven administrations signed out on the paper controlled drug record, without corresponding documentation of administration in the MAR: 3/20/25: 5 mg at 9:15 p.m. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/9/25: 5 mg at 10:00 a.m. 4/18/25: 5 mg at 12:00 p.m. Review of Resident R12's MAR on from 3/23/25, through 4/23/25 revealed three of twelve administrations signed out on the paper controlled drug record, without corresponding documentation of administration in the MAR: 3/31/25: 50 mg at 12:11 a.m. 4/4/25: 25 mg at 2:42 p.m. 4/8/25: 25 mg at 5:41 a.m. Review of Resident R13's MAR on from 10/2/24, through 4/20/25 revealed five of 21 administrations signed out on the paper controlled drug record, without corresponding documentation of administration in the MAR: Undated, untimed administration (between 10/2/24-10/3/24). Undated, untimed administration (between 10/2/24-10/3/24). 11/7/2425: 50 mg at 12:00 p.m. 12/14/25: 50 mg at 9:00 a.m. Undated, untimed administration (between 3/21/25-4/20/25). Review of Resident R14's MAR on from 4/4/25, through 4/22/25 revealed two of 18 administrations signed out on the paper controlled drug record, without corresponding documentation of administration in the MAR: 4/5/25: 25 mg at 9:00 p.m. 4/6/25: 25 mg at 9:00 p.m. Review of Resident R15's MAR on from 4/14/25, through 4/23/25 revealed five of ten administrations signed out on the paper controlled drug record, without corresponding documentation of administration in the MAR: 4/21/25: 5 mg at 8:00 p.m. 4/22/25: 5 mg at 8:00 a.m. 4/22/25: 5 mg at 2:00 p.m. 4/23/25: 5 mg at 8:00 a.m. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/23/25: 5 mg at 2:00 p.m. Review of Resident R16's MAR on from 4/16/25, through 4/20/25 revealed three of eight administrations of tramadol signed out on the paper controlled drug record, without corresponding documentation of administration in the MAR: 4/16/25: 50 mg at 12:41 a.m. 4/18/25: 50 mg at 11:00 a.m. 4/20/25: 50 mg at 8:00 a.m. Review of Resident R16's MAR on from 4/13/25, through 4/14/25 revealed three of five administrations of oxycodone signed out on the paper controlled drug record, without corresponding documentation of administration in the MAR: 4/14/25: 5 mg at 10:30 a.m. 4/14/25: 5 mg at 4:00 p.m. 4/14/25: 5 mg at 10:00 p.m. Review of Resident R17's MAR on from 4/21/25, through 4/23/25 revealed two of five administrations signed out on the paper controlled drug record, without corresponding documentation of administration in the MAR: 4/21/25: 5 mg at 9:00 a.m. 4/22/25: 5 mg at 8:30 a.m. During an interview on 4/24/25, at approximately 1:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to ensure that residents are free from misappropriation of property for 18 of 22 residents. 28 Pa. Code: 201.14(a)(b) Responsibility of licensee. 28 Pa. Code: 201 18(b)(1)(2)(3) Management. 28 Pa. Code: 201.29(a) Resident rights.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311 Based on review of state laws, facility policies, clinical records, and staff interviews, it was determined that the facility failed to implement policies and procedures to report allegations of neglect for two of four residents (Resident R2 and R28). Findings include: Review of the Older Adult Protective Services Act of 11/6/87, amended by Act 1997-13, Chapter 7, Section 701, requires any employee or administrator of a facility who suspects abuse is mandated to report the abuse. All reports of abuse should be reported to the local area agency on aging and licensing agencies. Review of the facility policy, Abuse Prohibition dated 10/24/24, indicated that immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the facility will perform the following. -Report allegations to the appropriate state and local authority(s) involving neglect, exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of patient property not later than two (2) hours after the allegation is made if the event results in serious bodily injury. -Report allegations to the appropriate state and local authority(s) involving neglect, exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of patient property within 24 hours if the event does not result in serious bodily injury. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2024, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 3/10/25, included diagnoses of spinal stenosis (a narrowing of the spaces within the spine, which causes pain and weakness), heart failure (a progressive heart disease that affects pumping action of the heart muscles), and osteoarthritis (degeneration of the joint causing pain and stiffness). Review of Section G: indicated that Resident R2 required substantial/maximal assistance chair/bed-to-chair transfer. Review of Section C indicated a BIMS score of 15. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a physician order dated 9/12/24, indicated Resident R2 transfers with two person assist with Hoyer (mechanical patient lift). Review of Resident R2's plan of care for Activities of Daily Living (ADLs) updated 9/12/24, indicated an intervention of transfer assist of two people with a Hoyer lift. Review of Resident R2's Kardex (document that outlines the patients' ADLs, continence levels, and behaviors, as well as physician, advanced directives, diet, and allergies) utilized by nurse aide staff dated as of 2/14/25, indicated Transfers: assist x 2 with hoyer lift. Review of a progress note dated 2/17/25, at 6:23 p.m. indicated, Reddened and purplish discoloration noted on left lower leg. Skin intact at the site. Dorsalis pedis pulse (heart rate felt on the top of the foot) is palpable and expected. Pt (patient) denies pain at the site. The patient stated, It happened Saturday evening when my left got trapped between the lift's leg and the bed, I kept yelling that it hurts, my leg hurts, get my nurse so that he can help you but they refused to get the nurse and did not report the incident to the nurse or the supervisor. Review of a statement given by Resident R2 on 2/18/25, to the Director of Nursing stated, When I was in Hoyer pulled me over to line me up. I kept telling them to look under bed. Kept misaligning the Hoyer and cause your leg to hit off of Hoyer bar. LLE bruise and toe got hit. I yelled stop. When putting me in bed I needed to put bed down CNA (nurse aide) said, We know how to get people in bed we are experts. Explained bar under bed needing to be considered with Hoyer. I know what I need to get in bed. They didn't want to take direction. I said it would go smoother if we work together. She got frustrated and that was the end of it. I got in bed. Review of an (undated) employee statement written by the Director of Nursing (DON) stated, This was recently brought to the DON's attention. Upon second interview, the resident recounted the event of being transferred via Hoyer with two aides into bed around dinner time on Saturday night, 2/15/25. The resident denies ever having leg trapped but rather that her leg had inadvertently struck the side of the Hoyer lift during transfer. The resident denies yelling stop repeatedly but substantiates that she told the aides if they all worked together and listened to the resident it would be a better experience. The resident denies asking for a nurse when asked specifically. Resident was placed in bed as preferred with the only concern being the bumping of her LLL (left lower leg) which is at baseline edematous (swollen) and erythema (redness of skin). No pain verbalized by resident when asked. No incident to report to nurse or supervisor after second interview with resident, as the initial risk management system states. No further investigation or reporting required at this time. Resident voiced no concerns of abuse or neglect. Review of reports submitted to the local state field office did not include a report of possible neglect for Resident R2. Review of the clinical record indicated Resident R28 was originally admitted to the facility on [DATE], and readmitted on [DATE]. Review of the MDS dated [DATE], included diagnoses of chronic obstructive pulmonary disease (COPD - a group of progressive lung disorders characterized by increasing breathlessness), muscle weakness, and history of falling. Review of Section G: indicated that Resident R28 required substantial/maximal assistance chair/bed-to-chair transfer. Review of Section C indicated a BIMS score of 15. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a physician order dated 9/12/24, indicated Resident R28 is a transfer assist of two people. Review of Resident R28's plan of care for Activities of Daily Living (ADLs) updated 11/13/24, indicated an intervention of transfer assist of two people. Review of Resident R28's Kardex dated as of 3/27/25, indicated Transfer Assist x2. Review of a facility incident report dated 3/28/25, indicated that on 3/28/25, at 10:00 p.m. CNA (nurse aide) was attempting to transfer the resident from her bed to her chair and the resident was unable to complete the transfer without being lowered to the floor. A small skin tear to the right outer forearm occurred while the resident was lowered. During an interview on 4/23/25, at approximately 1:30 p.m. the DON confirmed that the nurse aide involved in the incident was agency staff that utilized the incorrect level of assistance. Review of reports submitted to the local state field office did not include a report of possible neglect for Resident R28. During an interview on 4/24/25, at approximately 1:00 p.m. the Nursing Home Administrator and the DON confirmed that facility failed to implement policies and procedures to report allegations of abuse and neglect for two of four residents. 28 Pa. Code 201.14(a)(c)(e) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) (e)(1) Management.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311 Based on review of state laws, facility policies, clinical records, and staff interviews, it was determined that it was determined that the facility failed to implement policies and procedures to investigate possible abuse and/or neglect for three of six residents (Resident R2, R28 and R29). Findings include: Review of the facility policy, Abuse Prohibition dated 10/24/24, The Center will identify possible incidents or allegations which need investigation. Injuries of unknown origin will be investigated to determine if abuse or neglect is suspected. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2024, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 3/10/25, included diagnoses of spinal stenosis (a narrowing of the spaces within the spine, which causes pain and weakness), heart failure (a progressive heart disease that affects pumping action of the heart muscles), and osteoarthritis (degeneration of the joint causing pain and stiffness). Review of Section G: indicated that Resident R2 required substantial/maximal assistance chair/bed-to-chair transfer. Review of Section C indicated a BIMS score of 15. Review of a physician order dated 9/12/24, indicated Resident R2 transfers with two person assist with Hoyer (mechanical patient lift). Review of Resident R2's plan of care for Activities of Daily Living (ADLs) updated 9/12/24, indicated an intervention of transfer assist of two people with a Hoyer lift. Review of Resident R2's Kardex (document that outlines the patients' ADLs, continence levels, and behaviors, as well as physician, advanced directives, diet, and allergies) utilized by nurse aide staff dated as of 2/14/25, indicated Transfers: assist x 2 with hoyer lift. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a progress note dated 2/17/25, at 6:23 p.m. indicated, Reddened and purplish discoloration noted on left lower leg. Skin intact at the site. Dorsalis pedis Pulse (heart rate felt on the top of the foot) is palpable and expected. Pt (patient) denies pain at the site. The patient stated, It happened Saturday evening when my left let trapped between the lift's leg and the bed, I kept yelling that it hurts, my leg hurts, get my nurse so that he can help you but they refused to get the nurse and did not report the incident to the nurse or the supervisor. Review of a statement given by Resident R2 on 2/18/25, to the Director of Nursing stated, When I was in Hoyer pulled me over to line me up. I kept telling them to look under bed. Kept misaligning the Hoyer and cause your leg to hit off of Hoyer bar. LLE bruise and toe got hit. I yelled stop. When putting me in bed I needed to put bed down CNA (nurse aide) said, We know how to get people in bed we are experts. Explained bar under bed needing to be considered with Hoyer. I know what I need to get in bed. The didn't want to take direction. I said it would go smother if we work together. She got frustrated and that was the end of it. I got in bed. Review of an (undated) employee statement written by the Director of Nursing (DON) stated, This was recently brought to the DON's attention. Upon second interview, the resident recounted the event of being transferred via Hoyer with two aides into bed around dinner time on Saturday night, 2/15/25. The resident denies ever having leg trapped but rather that her leg had inadvertently struck the side of the Hoyer lift during transfer. The resident denies yelling stop repeatedly but substantiates that she told the aides if they all worked together and listened to the resident it would be a better experience. The resident denies asking for a nurse when asked specifically. Resident was placed in bed as preferred with the only concern being the bumping of her LLL (left lower leg) which is at baseline edematous (swollen) and erythema (redness of skin). No pain verbalized by resident when asked. No incident to report to nurse or supervisor after second interview with resident, as the initial risk management system states. No further investigation or reporting required at this time. Resident voiced no concerns of abuse or neglect. On 4/23/25, the investigation into possible was requested from the facility, which was unable to provide any further information. Review of the clinical record indicated Resident R28 was originally admitted to the facility on [DATE], and readmitted on [DATE]. Review of the MDS dated [DATE], included diagnoses of chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), muscle weakness, and history of falling. Review of Section G: indicated that Resident R28 required substantial/maximal assistance chair/bed-to-chair transfer. Review of Section C indicated a BIMS score of 15. Review of a physician order dated 9/12/24, indicated Resident R28 a transfer assist of two people. Review of Resident R28's plan of care for Activities of Daily Living (ADLs) updated 11/13/24, indicated an intervention of transfer assist of two people. Review of Resident R28's Kardex dated as of 3/27/25, indicated Transfer Assist x2. (continued on next page)

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	395596	A. Building B. Wing	05/02/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility incident report dated 3/28/25, indicated that on 3/28/25, at 10:00 p.m. CNA was attempting to transfer the resident from her bed to her chair and the resident was unable to complete the transfer without being lowered to the floor. A small skin tear to the right outer forearm occurred while the resident was lowered. During an interview on 4/23/25, at approximately 1:30 p.m. the Director of Nursing confirmed that the nurse aide involved in the incident was agency staff that utilized the incorrect level of assistance and no further investigation was completed to determine if all staff knew and understood how to appropriately transfer residents. Review of the clinical record indicated Resident R29 was admitted to the facility on ,d+[DATE]. Review of the MDS dated [DATE], included diagnoses of syncope (fainting or passing out), history of wandering, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of Section C indicated a BIMS score of 03. Review of a progress note dated 2/22/25, at 9:09 p.m. indicated, This nurse was notified by CNA that the residents left arm has two large bruises of unknown origin. This nurse assessed residents left arm and observed two bruises to her lateral upper arm. The first bruise measures 12.5cmX5.5cm, while the second bruise measures 5cm x 3.5cm. Resident is denying any pain and is able to move extremity as normal. Review of a facility incident report dated 2/22/25, indicated that Resident R29 stated she did not know how the bruises occurred. Review of the facility provided investigation indicated that statements were obtained from the staff that care for the resident in the previous three days prior to the incident. Review of Resident R29's care record indicated the following staff were documented as having provided care to the resident in the 72 hours prior to the incident: NA Employee E7 NA Employee E8 NA Employee E9 NA Employee E10 NA Employee E11 NA Employee E12 LPN Employee E4 LPN Employee E13 LPN Employee E14 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN Employee E15 RN Employee E16 RN Employee E17 RN Employee E18 Review of the statement provided as part of the investigation revealed four statements obtained: -RN Employee E19, the nurse that provided care when injury was found, not part of the prior 72 hours. -NA Employee E7, provided care for evening shift on 2/19/25. -NA Employee E20, was not assigned to resident for previous 72 hours, I did not provide care for the resident, nor was I assigned to them. -NA Employee E21, was not assigned to resident for previous 72 hours, Did not have that assignment. Did not witness anything. During an interview on 4/24/25, at approximately 1:00 p.m. the Director of Nursing confirmed that the facility failed to complete a thorough investigation by not interviewing staff who were assigned to provide care to Resident R29 and interviewing staff who were not assigned to provide care to Resident R29. During an interview on 4/24/25, at approximately 1:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that facility failed to implement policies and procedures to investigate possible abuse and/or neglect for three of six residents. 28 Pa. Code 201.14(a)(c)(e) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) (e)(1) Management.

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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** 39311 Based on facility policy review, clinical and facility record review, facility submitted documents, and staff interviews, it was determined that the facility failed to provide adequate supervision to prevent elopement for one of twelve residents (Resident R19). This failure created an immediate jeopardy situation for 12 of 12 residents (Residents R19, R4, R17, R20, R21, R22, R23, R24, R25, R26, R27, and R28). This was identified as past non-compliance. 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 2024, indicated that a BIMS (Brief Interview of Mental Status) is a brief screening test that aids in detecting cognitive impairment. Scores from a BIMS assessment suggests the following distributions: 13 - 15: cognitively intact 8 - 12: moderately impaired 0 - 7: severe impairment Review of the facility policy Elopement of Patient dated 10/24/24, indicated that patients identified as at risk, an interdisciplinary elopement prevention patient-centered care plan will be developed with patient participation and patient representative when applicable. Review of facility provided documentation indicated that on 4/4/25, an Appointment Escort Protocol was developed. Within that protocol it stated, Any resident with a BIMS lower than 13 will require an appointment escort. Review of medical records on 4/24/25, 12 of 49 residents with physicians' orders that indicated they may leave the facility unaccompanied; the following residents were noted: Resident R4, BIMS score of 7 on 3/11/25. Resident R17, BIMS score of 7 on 4/21/25. Resident R20, BIMS score of 7 on 4/22/25. Resident R21, BIMS score of 5 on 4/14/25. Resident R22, BIMS score of 0 on 2/19/25. Resident R23, BIMS score of 4 on 4/22/25. Resident R24, BIMS score of 7 on 2/6/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident R25, BIMS score of 6 on 3/23/25. Resident R26, BIMS score of 3 on 4/11/25. Resident R27, BIMS score of 5 on 2/22/25. Resident R28, BIMS score of 4 on 4/19/25. None of these residents made attempts to leave the facility. During an interview on 4/24/25, at 11:47 a.m. Nurse Practitioner Employee E6 confirmed that residents with severe cognitive impairment should not leave the facility unaccompanied and confirmed that new residents who have not yet been seen by the provider should not have orders to leave the facility unaccompanied until after the provider has seen them. Review of the clinical record revealed Resident R29 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), heart failure (a progressive heart disease that affects pumping action of the heart muscles), anemia (too little iron in the body causing fatigue). Review of Section C: Cognitive Patterns revealed a BIMS score of 6. Review of an Elopement Evaluation completed on 2/28/25, indicated Resident R19 was not at risk for elopement. Review of the physician's order dated 2/28/25, indicated Resident R19 Patient may leave Center unaccompanied when arranged by the facility. Review of Resident R19's plan of care for initiated 2/28/25, did not include goals and interventions related to elopement. Review of a progress note dated 4/3/25, at 4:11 p.m. indicated Notified by driver that resident was not able to be found from his doctor's appt today. Unable to locate resident. County 911 called at 1607 (4:07 p.m.) full description of resident and clothing given. Missing persons report filed. Provider notified, Daughter unable to be reached via phone, office has no idea of whereabouts. Review of a progress note dated 4/3/25, at 6:14 p.m. indicated resident was found by local police at his residence. Resident R19 informed police, he called an Uber from his appointment and went home. Review of a progress note dated 4/3/25, at 8:24 p.m. indicated that Resident R19 located in community at his listed place of residence by transport driver and NHA (nursing home administrator) with police escort. Resident refused to return to facility and signed AMA (against medical advice) documentation after being educated on risks of not returning in an earlier conversation by this writer (Director of Nursing) and [local police department] officer. Resident verbalized understanding of risks. 911 was called to take resident to the hospital for RUA PICC (right upper arm, peripherally inserted central catheter) removal. Social Services to notify APS (Adult Protective Services) of AMA. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of facility submitted information dated 4/4/25, indicated that on 4/3/25, at 3:30 p.m. Resident R19 went by [facility] transport van to his physician. follow up appointment. After the appointment the physician's office was to call for Resident R19 to be picked up by the facility. When no call was received the driver went back to the physician's office after calling and being told they took Resident R19 to the lobby. The driver was unable to locate Resident R19, he searched the building, talked to the staff at the office and called the facility to notify them that resident was unable to be located at the office. Resident was not exit seeking while in the facility. Review of a phone interview completed on 5/1/25, by the NHA with Transportation Employee E22 indicated, Resident was alert enough to speak to me while heading to his appointment on 4-3-2025 and seemed fine to go to his appointment. Throughout the whole day [Resident R19] seemed fine and was able to have a fluent conversation with me about his life, sports, and his housing situation. He did not seem confused at all and was very with it the entire day as we interacted. Review of an employee statement dated 5/1/25, written by LPN Employee E23 indicated, I was the primary nurse on 4/3/25 for [Resident R19]. There was no concern or confusion noted with the patient. He was able to participate in care and make decisions appropriately. Review of an electronic communication from Nurse Practitioner Employee E6 dated 5/1/25, at 1:19 p.m. indicated, On 4/3/25, patient [Resident R19] was appropriate for making his own medical decisions and there was no concern for him going to appointments without an escort. During a phone interview on 5/1/25, at approximately 1:30 p.m., Resident R19 stated he 'hated it there and left when he had the opportunity. The NHA and the DON were made aware that an Immediate Jeopardy situation existed for Residents R19, R4, R17, R20, R21, R22, R23, R24, R25, R26, R27, and R 28 on 5/1/25, at 4:42 p.m. and a corrective action plan was requested. The Immediate Jeopardy template was provided to the facility administration at this time. On 5/1/25, at 4:42 p.m. an acceptable Corrective Action Plan was reviewed which included the following interventions: -Complete AMA (against medical advice) discharge at residence. -Emergency services called for hospital transfer for PICC removal. -Notification of Adult Protective Services. -Notification of Ombudsman. -Review of escort protocol. -Education to staff on sending residents to appointments with escorts. -Elopement book update. -Wellness check on resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Elopement drills every shift. -Validation of appointment returns for three months. -Developed protocol of offices calling building/driver for return and not putting residents in the lobby. -Daily review in morning meeting of upcoming appointments and if escorts are needed. -Update care plans. This plan was implemented on 4/4/25 and completed by 4/22/25. Based on previous review of facility plan of correction actions, the Immediate Jeopardy was removed on 5/1/25, at 4:43 p.m. when the action plan implementation was verified. During an interview on 5/1/25, at approximately 5:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to provide adequate supervision during resident transfers that resulted in the actual harm of a skin tear for one of three residents, failed to ensure residents with severe cognitive impairment are not provided orders to leave the facility unaccompanied for 13 of 66 residents, and failed to provide adequate supervision to prevent elopement for one of twelve residents. This failure created an immediate jeopardy situation for one of twelve residents. This was identified as past non-compliance. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(e)(1) Management. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa Code 211.12(d)(1)(2)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39311 Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to make certain that medications were properly secured in one of three medication carts (First-floor medication cart for rooms 100-117) Findings include: Review of the facility policy Security of Medication Cart dated 11/1/24, indicated medication carts must be securely locked at all times when out of the nurse's view. During an observation on 2/8/24, at 2:18 p.m. of the First-floor medication room, the 100-117 medication cart was observed unlocked. The surveyor remained with the medication cart. At approximately 2:22 p.m. the surveyor opened and the medication cart drawers, and observed that the narcotic drawer was not secured. The surveyor reviewed the narcotic book, and narcotic cards. At 2:30 p.m. First Floor Unit Manager was requested to confirm that the medication cart and the narcotic drawer were both unsecured. During an interview on 2/11/25, at approximately 3:00 p.m., the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to make certain that medications were properly secured in one of three medication carts. 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1)(e)(1) Management. 28 Pa. Code: 211.9 (a)(1) Pharmacy services. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.