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	08/23/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31343 Based on review of facility policies, documents, clinical records and staff interviews, it was determined that the facility failed to make certain a resident was free from abuse and neglect for 20 of 24 residents reviewed (Resident R47, R58, R4, R23, R18, CR401, R104, R16, R12, R22, R89, R76, R96, R7, R51, CR402, R96, R37, R20 and R403). Findings include: The facility's policy Abuse Prohibition dated 1/3/24, with a previous review date of 1/24/23, indicated it is the facility's policy that it prohibits abuse, neglect, mistreatment, etc., for all residents. The facility implements a program through he screening of potential hires, training employees, prevention of occurrences, identification of possible incidents or allegations that need investigated, investigation of incidents and allegations, protection of residents during investigations and reporting of incidents, investigations and facility responses to the results of the investigations. Review of the clinical record indicated that Resident R47 was admitted to the facility on [DATE], with diagnoses which include morbid obesity, spinal stenosis (narrowing), chronic pain, adjustment disorder with anxiety and depression, and insomnia. Diagnoses added since admission include heart failure, irregular heart beat and skin and subcutaneous skin disorders. An MDS dated [DATE], indicated the diagnoses remained current. Review of facility provided documents indicated that Resident R47 submitted a grievance form indicating that on 4/5/24, Nurse Aide (NA) Employee E26 had punched and was yelling at Resident R47 when turning her to provide care and NA Employee E27 had to intervene and told NA Employee E26 to leave the room. Review of the investigation did not include interviews with any other residents to determine the if they had been physically and/or verbally abused by NA Employee E26. During an interview on 8/21/24, at 11:53 a.m., the Director of Nursing confirmed that the facility failed to fully investigate the abuse allegation from Resident R47 to prevent the potential for further abuse by NA Employee E26. Review of the clinical record indicated that Resident R58 was admitted to the faciliy on 1/19/24, with diagnoses which inlcuded lung disease, arthrodesis (surgery joining two bones), history of a deep vein clot of right leg, history of lung blood clots, dependence on oxygen, and anxiety. An MDS dated [DATE], indicated the diagnoses remained current. (continued on next page)

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

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a document provided by the facility indicated that on 8/13/24, the Social Worker Employee E28 had interviewed Resident R58 to determine if he had abuse concerns or problems with care givers. Resident R58 responded that on the previous Wednesday or Thursday she had issues with night shift staff Nurse Aide who had yanked her sheet off and touched her private area to check if she was wet even though Resident R58 had stated that she was dry. Additional documents dated the same date indicated that the Assistant Director of Nursing Employee E29 and Registered Nurse Employee E30 had again interviewed Resident R58 about the allegation. During an interview on 8/21/24, at 10:39 a.m., the Director of Nursing confirmed that the facility failed to make certain R58 was free from physical abuse. Review of the clinical record indicated that Resident R4 had been admitted to the facility on [DATE], with diagnoses which included epilepsy (abnormal brain activity causing seizures), high blood pressure, muscle weakness, and anxiety. A MDS dated [DATE], indicated the diagnoses remained current. Review of facility provided documents indicated that Resident R4 submitted a grievance form indicating that on 6/6/24, a Nurse Aide (NA) Employee E36 witnessed LPN Employee E34 yelling at Resident R4 for being in her room unsupervised and told the resident that she could not go to bed but had to stay in the dining room for another hour as a punishment. Again the NA Employee E36 heard the LPN Employee E34 deny Resident R4 a cookie because she [NAME] throwing up. Review of the investigation did not include interviews with any other residents to determine if they had been verbally abused by LPN Employee E34. During an interview on 8/21/24, at 10:49 a.m., the Director of Nursing confirmed that the facility failed to fully investigate the abuse allegation from Resident R4 and prevent the potential for further abuse by LPN Employee E34 to other residents. Review of the clinical record indicated that Resident R23 had been admitted to the facility on [DATE], with diagnoses which included high blood pressure, diabetes (high blood sugar), morbid obesity, reduced mobility, and history of falling. A MDS dated [DATE], indicated the diagnoses remained current. Review of facility provided documents indicated that Resident R23 reported during facility resident interviews that on multiple days, Nurse Aide (NA) Employee E35 attempted to kiss Resident R23 either on the lips or forehead after delivering her breakfast tray. Resident R23 would attempt to block the kisses by holding up a stuffed animal. Review of the investigation did not include interviews with any other residents to determine if they had been physically abused by NA Employee E35. During an interview on 8/21/24, at 10:46 a.m., the Director of Nursing confirmed that the facility failed to fully investigate the abuse allegation from Resident R23 and prevent the potential for further abuse by NA Employee E35 to other residents. Review of a facility provided document dated 8/10/23, indicated that Registered Nurse Employee E31 neglected to provide the 6:00 a.m. medications for 16 residents (R18, CR401, R104, R16, R12, R22, R89, R76, R96, R7, R51, CR402, R96, R37, R20, and R403). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/21/24, at 10:40 a.m., the Director of Nursing confirmed that the facility failed to protect Residents R4, R23, R18, CR401, R104, R16, R22, R89, R76, R96, R7, R51, CR402, R96, R37, R20 and R403. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 201.29(a)(c)(d)(j) Resident Rights 28 Pa. Code 211.10(c)(d) Resident Care Policies. 28 Pa. Code 211.12(d)(1)(3) Nursing services.

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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. 31343 Based on review of facility documents, and staff interview, it was determined that the facility failed to ensure that residents were free from misappropriation (the act of stealing something that you have been trusted to care for and using it for yourself) of medications for two of three residents reviewed (Residents R47 and R129). Findings include: Review of facility policy Abuse Prohibition dated 1/3/24, indicated the facility prohibits abuse, mistreatment, neglect and misappropriation of property. Review of a facility provided documents dated 11/12/24, indicated that the facility had identified a drug diversion and misappropriation of property when Pharmacist Employee E37 contacted the Director of Nursing about narcotics(drugs that affect mood or behaviors and is consumed for non medical purposes) of four tablets of Xanax (benzodiazepine- anti anxiety), five tablets of Oxycodone (opioid pain medication) and 3 tablets of Morphine IR (pain medication-severe) not being placed into the emergency medication machine (Omnicell) after Licensed Practical Nurse Employee E38 signed the form receiving them from delivery on 12/12/23. Review of a facility provided document dated 4/30/24, indicated that Licensed Practical Nurse Employee E39 had not provided two of three residents with their narcotic medications and had been acting as she was under the influence of a substance standing at her cart and falling asleep and was refusing a drug screen. Resident R47 was not provided her Ativan (Benzodiazepine-usually used for anxiety- slows brain function causes sleepiness) and Resident R129 was not provided Tramadol high risk for addiction- opiod). During an interview with the Director of Nursing on 8/21/24, at 9:14 a.m., confirmed that the facility failed to ensure that residents were free from misappropriation of medications for two of three residents (R47 and R129) and for any resident potentially requiring emergency narcotic medications of Oxycodone 5mg, Xanax 0,25mg, and Morphine IR 15 mg. 28 Pa Code 211.12(c)(d)(1)(2)(5) Nursing services 28 Pa. Code: 211.10 (c)(d) Resident Care Policies 28 Pa Code 201.14(a) Responsibility of licensee. 28 Pa Code 201.18(a)(b)(1)(e)(1) Management. 28 Pa Code 201.29(a)(j) Resident rights.

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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** 31343 Based on review of facility policy, review of resident council meeting minutes, facility concern/grievance log and clinical records, and resident and staff interviews, it was determined that the facility failed to identify and/or investigate potential abuse and/or neglect for five of eight residents(Resident R2, R47, R58, R4 and R23). Findings include: The facility's policy Abuse Prohibition dated 1/3/24, with a previous review date of 1/24/23, indicated it is the facility's policy that it prohibits abuse, neglect, mistreatment, etc., for all residents. The facility implements a program through he screening of potential hires, training employees, prevention of occurrences, identification of possible incidents or allegations that need investigated, investigation of incidents and allegations, protection of residents during investigations and reporting of incidents, investigations and facility responses to the results of the investigations. Review of clinical record indicated that Resident R2 was admitted to the facility on [DATE], with diagnoses which included psychosis, lung disease, diabetes, obstructive and reflux uropathy (disease when urine cannot flow through ureter, bladder or urethra due to some type of obstruction and can cause urine to flow backwards), urinary retention and history of beast cancer. A MDS (Minimum Data Set- a periodic review of resident care needs) dated 8/3/24, indicated the diagnoses remained current. Review of Resident R2's physician orders indicated change suprapubic catheter every night shift every 30 days for catheter care. The order start date identified as 3/26/24. Review of Resident R2's TAR's (Treatment Administration Record) dated from April 2024, through July 2024, did not include documentation that Resident R2's suprapubic catheter had been changed and nursing progress notes dated through the time identified included one statement that on June 25, 2024 Resident R2 had stated that she did not want the catheter changed as it had been done a couple days before, which had not been documented. Documentation did not indicate that staff had made an attempt to re-visit the change of the catheter with Resident R2 on any date since the placement of the suprapubic catheter in March 2024. During an interview on 8/23/24, at 9:41 a.m., the Director of Nursing confirmed that the facility failed to identify the non provision of catheter change with care as neglect. Review of the clinical record indicated that Resident R47 was admitted to the facility on [DATE], with diagnoses which include morbid obesity, spinal stenosis(narrowing), chronic pain, adjustment disorder with anxiety and depression, and insomnia. Diagnoses added since admission include heart failure, irregular heart beat and skin and subcutaneous skin disorders. A MDS dated [DATE], indicated the diagnoses remained current. (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 facility provided documents indicated that Resident R47 submitted a grievance form indicating that on 4/5/24, Nurse Aide (NA) Employee E26 had punched and was yelling at Resident R47 when turning her to provide care and NA Employee E27 had to intervene and told NA Employee E26 to leave the room. Review of the investigation did not include interviews with any other residents to determine the if they had been physically and/or verbally abused by NA Employee E26. During an interview on 8/21/24, at 11:53 a.m., the Director of Nursing confirmed that the facility failed to fully investigate the abuse allegation from Resident R47 and prevent the potential for further abuse by NA Employee E26 to other residents. Review of the clinical record indicated that Resident R58 was admitted to the faciliy on 1/19/24, with diagnoses which inlcuded lung disease, arthrodesis(surgery joining two bones), history of a deep vein clot of right leg, history of lung blood clots, dependence on oxygen, and anxiety. A MDS dated [DATE], indicated the diagnoses remained current. Review of a facility provided document indicated that on 8/13/24, the Social Worker Employee E28 had interviewed Resident R58 to determine if he had abuse concerns or problems with care givers. Resident R58 responded that on the previous Wednesday or Thursday she had issues with night shift staff Nurse Aide who had yanked her sheet off and touched her private area to check if she was wet even though Resident R58 had stated that she was dry. Additional documents dated the same date indicated that the Assistant Director of Nursing Employee E29 and Registered Nurse Employee E30 had again interviewed Resident R58 about the allegation. Review of the clinical record indicated that Resident R4 had been admitted to the facility on [DATE], with diagnoses which included epilepsy (abnormal brain activity causing seizures), high blood pressure, muscle weakness, and anxiety. A MDS dated [DATE], indicated the diagnoses remained current. Review of facility provided documents indicated that Resident R4 submitted a grievance form indicating that on 6/6/24, a Nurse Aide (NA) Employee E36 witnessed LPN Employee E34 yelling at Resident R4 for being in her room unsupervised and told the resident that she could not go to bed but had to stay in the dining room for another hour as a punishment. Again the NA Employee E36 heard the LPN Employee E34 deny Resident R4 a cookie because she [NAME] throwing up. Review of the investigation did not include interviews with any other residents to determine if they had been verbally abused by LPN Employee E34. During an interview on 8/21/24, at 10:49 a.m., the Director of Nursing confirmed that the facility failed to fully investigate the abuse allegation from Resident R4 and prevent the potential for further abuse by LPN Employee E34 to other residents. Review of the clinical record indicated that Resident R23 had been admitted to the facility on [DATE], with diagnoses which included high blood pressure, diabetes (high blood sugar), morbid obesity, reduced mobility, and history of falling. A MDS dated [DATE], indicated the diagnoses remained current. (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 facility provided documents indicated that Resident R23 reported during facility resident interviews that on multiple days, Nurse Aide (NA) Employee E35 attempted to kiss Resident R23 either on the lips or forehead after delivering her breakfast tray. Resident R23 would attempt to block the kisses by holding up a stuffed animal. Review of the investigation did not include interviews with any other residents to determine if they had been physically abused by NA Employee E35. During an interview on 8/21/24, at 10:46 a.m., the Director of Nursing confirmed that the facility failed to fully investigate the abuse allegation from Resident R23 and prevent the potential for further abuse by NA Employee E35 to other residents. During an interview on 8/21/24, at 10:39 a.m., the Director of Nursing confirmed that the facility failed to identify and/or investigate the allegation as abuse, and prevent potential further abuse. 28 Pa Code: 201. 14(a) Responsibility of licensee. 28 Pa Code: 201. 18 (b)(1)(3) Management. 28 Pa Code: 211.10 (d) Resident care policies. 28 Pa Code: 211.12 (d)(3) Nursing services.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 39311 Based on review of the Resident Assessment Instrument User's Manual, clinical records, and staff interview, it was determined that the facility failed to make certain that comprehensive Minimum Data Set assessments were completed accurately for four of 15 residents (Resident R19, R69, R76, and R104). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set Assessments (MDS - periodic assessment of care needs) dated October 2023 indicated: -Section C, C0100, Brief Interview for Mental Status: Resident interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available. -Section D, D0100, Resident Mood Interview: Resident interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available. -Resident R19 had an MDS completion date of 6/2/24. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R19 is sometimes understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R19 is rarely understood, and the BIMS assessment was not completed. Review of Section D: Mood, Question D0100 indicated that Resident R19 is rarely understood, and the Resident Mood Interview was not completed. -Resident R69 had an MDS completion date of 8/4/24. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R69 is usually understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R69 is rarely understood, and the BIMS assessment was not completed. Review of Section D: Mood, Question D0100 indicated that Resident R69 is rarely understood, and the Resident Mood Interview was not completed. -Resident R76 had an MDS completion date of 8/8/24. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R76 is sometimes understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R76 is rarely understood, and the BIMS assessment was not completed. Review of Section D: Mood, Question D0100 indicated that Resident R76 is rarely understood, and the Resident Mood Interview was not completed. -Resident R105 had an MDS completion date of 5/29/24. Review of Section B: Hearing, Speech, and Vision, Question B0700 indicated that Resident R105 is sometimes understood. Review of Section C: Cognitive Patterns, Question C0100 indicated that Resident R105 is rarely understood, and the BIMS assessment was not completed. Review of Section D: Mood, Question D0100 indicated that Resident R105 is rarely understood, and the Resident Mood Interview was not completed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/23/24, at 12:45 p.m. the Social Worker Employee E10 and the Registered Nurse Assessment Coordinator (RNAC) Employee E11 confirmed that the facility failed to make certain that MDS assessments were completed accurately for four of 15 residents. 28 Pa. Code: 211.5(f) Clinical records.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311 Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to develop comprehensive care plans to meet resident care needs for three of eight residents (Resident R3, R12, and R45). Findings include: Review of facility policy Person-Centered Care Plan dated 1/3/24, previously reviewed 1/24/23, indicated the care plan must be customized to each individual patient's preferences and needs. Review of Resident R3's admission record indicated she was originally admitted to the facility on [DATE], and readmitted [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 8/9/24, included diagnoses of chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), high blood pressure, and history of falling. Review of a progress note dated 12/19/23, at 2:00 p.m. indicated, CNA (nurse aide) alerted staff that while doing care resident rolled out of bed and landed on her R (right) side. Resident c/o (complained of) R shoulder and R hip pain s/p (status post, after) fall. On assessment a hematoma (bruise) noted to R forehead. [Medical provider] notified immediately and recommended an ER (emergency room) evaluation. Resident transferred to [hospital] via EMS at approximately 1438 (2:38 p.m.) without incident. Review of the Resident R3's care plan since admission on 11/9/23, failed to include information on bed mobility (the ability to roll left and right while in bed) until 12/19/23, Implement assist x2 to roll resident in bed / ensure staff turns resident towards them during changes (brief changes during incontinence care). Review of Resident R12's admission record indicated she was initially admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior) and heart failure (a progressive heart disease that affects pumping action of the heart muscles). Review of Section N: Medications revealed that Resident R12 was taking an antipsychotic medication. Review of a physician's order dated 8/5/24, indicated Resident R12 to receive Zyprexa (an antipsychotic medication) 10 milligrams daily. Review of the Resident R12's care plan revised 7/11/24, failed to include goals and interventions related to the use and side-effects of antipsychotic medication use. Review of Resident R45's admission record indicated he was admitted to the facility on [DATE]. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS dated [DATE], included diagnoses of COPD and a leg fracture. Review of the facility provided list of residents who smoke included Resident R45. During an interview on 8/23/24, at 10:05 a.m. when Nurse Aide Employee E12 was asked if she knew where Resident R45 was, she stated, Probably out smoking. During an observation on 8/23/24, at 10:09 a.m. of the resident smoking area, Resident R45 was present smoking. Review of the Resident R45's care plan dated 6/30/24, failed to include goals and interventions related to tobacco use or smoking. During an interview on 8/23/24, at 10:40 a.m. the Director of Nursing confirmed the facility failed to develop and implement comprehensive care plans to meet resident care needs for three of eight residents. 28 Pa. Code 211.11(d) Resident care plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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 review of facility policies, clinical records, and staff interview, it was determined that the facility failed to provide adequate supervision during bed mobility and transfers for three of eight residents (Resident R5, R3, and R39). Findings include: Review of the facility policy Safe Resident Handling/Transfer Equipment dated 1/3/24, previously reviewed 1/24/23, indicated patients will be assessed upon admission and on an ongoing basis to determine the patient's ability to transfer and reposition and the need for safe resident handling equipment. The policy further stated that two trained persons are required to operate a total lift or sit to stand lift, regardless if manufacturer instructions state only one person is needed. Review of Resident R5's admission record indicated she was originally admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 8/9/24, included diagnoses of spastic quadriplegic cerebral palsy (group of disorders that affect a person's ability to move and maintain balance and posture that affects both arms, legs, and often torso and face) and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of the MDS assessment dated [DATE], Section GG: Functional Abilities and Goals all indicated Resident R5 was dependent on staff (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) for all types of transfers assessed. Review of Resident R5's care plan for risk of falls, initiated 8/6/22, indicated, Hoyer lift (patient lift) to motorized wheelchair/ASSIST X 2. Review of Resident R5'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) as of 8/4/23, indicated, Hoyer lift (patient lift) to motorized wheelchair/ASSIST X 2. Review of a family member complaint to the facility dated 8/11/23, indicated that on 8/5/23, on the evening shift Resident R5 requested to be put back in bed. It was stated that Nurse Aide (NA) Employee E24 told Resident R5 that she did not have another aide to ask for help and she proceeded to use the Hoyer lift alone. The aide was also talking on her cell phone while using the lift and Resident R5 was dangling and spinning around suspended in the air by the lift while the aide had the Hoyer control in her one hand and her cell phone in her other. Review of a facility completed Report Form for Investigation of Alleged Abuse, Neglect, Misappropriation of Property dated 8/14/23, confirmed NA Employee E24 transferred Resident R5 with a Hoyer Lift without a second trained person assisting. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/23/24, at 10:40 a.m. the Director of Nursing (DON) confirmed that NA Employee E24 used a Hoyer lift without a second trained person assisting. Review of Resident R3's admission record indicated she was originally admitted to the facility on [DATE], and readmitted [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), high blood pressure, and history of falling. Review of the Resident R3's care plan since admission on 11/9/23, through 12/19/23, failed to include information related to bed mobility (the ability to roll left and right while in bed). Review of Resident R3's Kardex dated 12/18/23, failed to include information related to bed mobility. Review of a progress note dated 12/19/23, at 2:00 p.m. indicated, CNA (nurse aide) alerted staff that while doing care resident rolled out of bed and landed on her R (right) side. Resident c/o (complained of) R shoulder and R hip pain s/p (status post, after) fall. On assessment a hematoma (bruise) noted to R forehead. [Medical provider] notified immediately and recommended an ER (emergency room) evaluation. Resident transferred to [hospital] via EMS at approximately 1438 (2:38 p.m.) without incident. Review of a facility incident report dated 12/19/23, indicated, Resident reports rolling to be changed and hitting the floor. Reports hitting her head and R side of her body off of the floor. C/O R shoulder pain and R hip pain. Review of an undated employee statement written by NA Employee E22, revealed After giving Resident R3 a shower [NA Employee E12] assisted with transferring resident to bed. I asked Resident R3 to roll onto her left side so I could put cream on her butt and put her brief under her. While putting the brief under her I had put my left hand to try and stabilize her on her hip but she started rolling more and I tried to stop her but she rolled out of bed on to the floor hitting her head on her dresser. I immediately hollered for [NA Employee E12] and for her to get the nurse while staying with Resident R3 to make sure she was okay. The nurses came and did vitals then had her sent to the hospital. Review of hospital transfer paperwork dated 12/19/23, at 11:53 p.m. indicated, Patient states she rolled out of bed and hit her head. She is endorsing pain in her right shoulder, right wrist, and her right forehead. She also states she has a little bit of hip pain on the right side. During an interview on 8/23/24, at 10:40 a.m. the Director of Nursing (DON) confirmed that NA Employee E22 inappropriately rolled Resident R3 away from her when providing care. Review of the clinical record indicated Resident R39 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of hemiplegia (paralysis on one side of the body), muscle weakness, and history of a stroke. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of MDS assessments dated 11/3/23, 12/20/23, 3/21/24, 4/19/24, and 5/8/24, Section GG: Functional Abilities and Goals all indicated Resident R39 was dependent on staff for a bed-to-chair transfer. Review of an active physician's order dated 10/3/22, indicated Resident R39 was an Assist of one for transfers. Review of Resident R39's plan of care current on 6/1/24, indicated Provide resident with assist of 1 for transfers. Review of Resident R39's Kardex dated 6/1/24 indicated, Provide resident with assist of 1 for transfers. Review of a progress note dated 6/1/24, at 5:42 a.m. indicated, Witnessed fall occurring while transferring Resident from her bed to the wheelchair during morning care. CNA (nurse aide) was standing Resident when the Resident went down on both knees. CNA lowered the Resident onto her buttocks. Resident remained alert and complained of pain to her left knee. Resident denied any discomfort to her right knee. Both knees were free of any bruising/redness/wounds at present. Continue to monitor for any developing abnormalities. Review of an employee statement dated 6/1/24, written by NA Employee E22, revealed, I was with the resident during the incident. She went down on her knees during the transfer from bed to her wheelchair. During an interview on 8/23/24, at approximately 1:00 p.m. the DON confirmed that Resident R39 was totally dependent on staff for assistance, which precluded her being placed in a standing position next to her bed, as she was not able to maintain that position herself. During an interview on 8/23/24, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide adequate supervision during bed mobility and transfers for three of eight residents. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(1) Management. 28 Pa. Code 201.20(b)(1) Staff Development. 28 Pa. Code 211.11(d) Resident care plan. 28 Pa Code 211.12(d)(1)(2)(5) Nursing services.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31343 Based on review of facility policy, clinical records and staff interviews, it was determined that the facility failed to make certain that residents with suprapubic urinary catheters received appropriate treatment and services consistent with professional standards during catheter care by monitoring placement and skin, changing the catheters and providing care, resulting in actual harm as evidenced by penile split and traumatic insertion and removal for one of three residents (Resident R64) and failure to change a urinary catheter every 30 days as ordered for one of three residents (Resident R2). Findings include: Review of facility policy, titled Catheter: Urinary -Justification for Use dated 1/3/24, with a previous review date of 1/24/23, indicated, If patients' situation meets any of the indwelling catheter criteria, obtain physician order, include in care plan and follow Catheter: Indwelling Urinary- Care of procedure. Review of facility Procedure titled Catheter: Indwelling Urinary - Insertion dated 1/3/24, with a previous review date of 1/24/23, indicated, Secure catheter tubing with catheter securement device. Review of the facility policy Catheter: Urinary Care Of, last reviewed on 1/3/24, with a previous review date of 1/24/23, indicated that catheters are to be inspected for leakage. Catheters are to be secured and kept below the level of the resident's bladder. Catheters are to be changed as ordered and the physician is to be notified of any abnormal findings. Review of the clinical record indicated Resident R64 was originally admitted to the facility on [DATE], and readmitted on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 8/15/24, included diagnoses of neurogenic bladder (bladder problems due to disease or injury of the nervous system involved in the control of urination), hemiplegia (paralysis on one side of the body), and achondroplasia (short-limbed dwarfism). Review of Section H: Bladder and Bowel indicated Resident R64 has an indwelling catheter. Review of Resident R64's plan of care initiated on 5/24/24, indicated for the facility to ensure Resident R64 has a foley catheter securement device in place. Review of Resident R64's plan of care revised on 7/25/24, indicated Resident R64 has a suprapubic catheter, with interventions for catheter care twice daily and to ensure catheter securement device is in place. Review of Resident R64's physician's order history revealed the following: -5/24/24 through 7/24/24: Ensure Foley catheter securement device is in place every shift. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	-6/16/23 through 7/24/24: Indwelling catheter 16FR (16 French, catheter tubing size) with 10cc (cubic centimeters, equal to milliliters) balloon; to bedside, straight drainage for obstructive uropathy. -6/16/23 through 7/24/24: Change indwelling catheter monthly, and/or when occluded or leaking as needed AND every night shift starting on the 23rd and ending on the 23rd every month. -7/24/24: Change suprapubic catheter monthly and/or when occluded or leaking as needed AND every night shift starting on the 23rd and ending on the 23rd every month. -7/24/24: Ensure Suprapubic Catheter Securement Device is in place. every shift. Review of Resident R64's Documentation Survey Report (monthly record of nurse aide care) for the task of ensure foley catheter securement device is in place for May 2024 revealed this task was not documented as being done on the following shifts and dates: -Day Shift (0900-1500) 5/2, 5/3, 5/6, 5/15, 5/26, 5/26, 5/31. -Evening Shift (1500-2300) 5/2, 5/8, 5/10, 5/11, 5/17, 5/18, 5/19/ 5/20, 5/21, 5/22, 5/23, 5/25, 5/28, 5/31. -Night Shift (2300-0700) 5/5, 5/9, 5/11, 5/13, 5/19/, 5/28, 5/29. Review of a progress note written by Registered Nurse (RN) Employee E32 dated 5/24/24, at 4:30 a.m. indicated, Foley catheter changed, 18&10 (18 French, 10 cc balloon), this AM by this RN without issue. No urine return on insertion, but staff to monitor to ensure placement. The resident had no complaints or pain during insertion or after. Review of a progress note written by Licensed Practical Nurse (LPN)dated 5/24/24, at 9:00 a.m. indicated, when doing AM care CNA (NA, nurse aide) noted resident has a split in his penis. Review of a progress note dated 5/24/24, at 6:36 p.m. indicated, penis is injured from his Foley, tubing secured with clasp to prevent further injury. Review of a progress note dated 5/31/24, at 3:42 a.m. indicated, resident returned from urology f/u (follow-up) with new recommendation for suprapubic catheter (SPC) related to penile tear from Foley. Review of a progress note dated 6/11/24, at 10:44 p.m. indicated, Foley replaced by this RN with a 16 and 30 (16 French, 30 cc balloon). The previous foley fell out while the resident was being turned and changed. No trauma, swelling, or pain noted. Insertion done without issue or any complaints, positive for urine return. Staff to monitor. Tubing was clipped in a secure position to prevent injury. Review of a progress note dated 7/11/24, at 3:38 p.m. indicated Resident R64 returned from having a suprapubic catheter placed. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Review of a progress note dated 7/15/24, at 3:50 p.m. indicated, urology called r/t urine leaking around spc. Review of a progress note dated 7/24/24, at 4:27 p.m. indicated, resident's urinary drainage bag noted to be empty, attempted to flush supra pubic catheter and could not. reinserted new supra pubic catheter and tip of catheter was coming out penis. Urology office called and said catheter was probably just being advanced too much, said to attempt to reinsert catheter and if could not be reinserted in facility resident would need to go to ER, reinserted catheter with no difficulty. when trying to flush catheter, flush was noted to be coming out the tip of penis and around supra pubic insertion site. Review of a urology consultation note dated 7/25/24, indicated, [Urologist] put in 20 fr (20 French) suprapubic tube 7/11/24. SNF (skilled nursing facility) took it upon themselves to change it earlier this week because of leakage and they put it through and through his urethra. Review of Resident R64's progress notes from 5/11/24, failed to include any progress notes that indicated bleeding, erosion, or trauma to Resident R64's penis until 5/24/24. During an interview on 8/19/24, at 11:30 a.m. Resident reported having an indwelling catheter for several years and that he has had issues with the catheter over the past few months. During an interview on 8/23/24, at 10:00 a.m. RN Employee E32 reviewed the progress note dated 5/24/24, at 04:30 a.m. and provided additional details of the care provided to Resident R64. RN Employee E32 reported that Resident R64 had been seen as the foley catheter had become dislodged. RN Employee E32 confirmed that foley catheter did not have a catheter securement device in place. RN Employee E32 noticed a small laceration to the penis of Resident R64. RN Employee E32 confirmed this was not observed during prior times when RN Employee E32 provided care to Resident R64. RN Employee E32 confirmed that she replaced the foley catheter with a size 18 French 10 cc balloon since the size 16 French dislodged, instead of the physician ordered 16 French with 10 cc balloon. RN Employee E32 stated supplies are not always available, and this may have influenced her decision in using the larger catheter size. During an interview on 8/23/24, at 10:15 a.m. LPN Employee E33 reviewed the progress note dated 5/24/24, at 09:00 a.m. and provided additional details of the care provided to Resident R64. LPN Employee E33 stated she was informed by the nurse aide that Resident R64 had a split in his penis. LPN Employee E33 documented the assessment of the resident and notified the doctor who gave a verbal order for follow up with urology and LPN Employee E33 noted Foley Securement Device placed on resident and that Resident R64 is scheduled with urology for 5/31/24. LPN Employee E33 stated during the interview the penis is split and that this patient's urinary catheter care, before and after the injury, has been a learning experience. During an interview on 8/23/24, at approximately 10:30 a.m. the Director of Nursing confirmed no progress notes indicated penile trauma prior to 5/24/24, confirmed that a larger size than ordered catheter was placed in Resident R64, documented as being placed less than five hours prior to the penile trauma being noted, confirmed that when Resident R64 was rolled, his catheter tubing was attached to the mattress/linen rather than Resident R64's legs causing the tubing to dislodge when Resident R64 was rolled, and confirmed that on 7/24/24, Resident R64's suprapubic catheter was advanced far enough to extend through Resident R64's penis. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Review of clinical record indicated that Resident R2 was admitted to the facility on [DATE], with diagnoses which included psychosis, lung disease, diabetes, obstructive and reflux uropathy (disease when urine cannot flow through ureter, bladder or urethra due to some type of obstruction and can cause urine to flow backwards), urinary retention and history of beast cancer. A MDS dated [DATE], indicated the diagnoses remained current. Review of Resident R2's physician orders indicated change suprapubic catheter every night shift every 30 days for catheter care. The order start date identified as 3/26/24. Review of Resident R2's TAR's (Treatment Administration Record) dated from April 2024, through July 2024, did not include documentation that Resident R2's suprapubic catheter had been changed and nursing progress notes dated through the time identified included one statement that on June 25, 2024 Resident R2 had stated that she did not want the catheter changed as it had been done a couple days before, which had not been documented. Documentation did not indicate that staff had made an attempt to re-visit the change of the catheter with Resident R2 on any date since the placement of the suprapubic catheter in March 2024. During an interview on 8/23/24, at approximately 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to make certain that residents with suprapubic urinary catheters received appropriate treatment and services consistent with professional standards during catheter care by monitoring placement and skin, changing the catheters and providing care, resulting in actual harm as evidenced by penile split and traumatic insertion and removal for one of three residents and failure to change a urinary catheter every 30 days as ordered for one of three residents. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 39311 Based on review of facility policy, personnel records, and staff interview it was determined that the facility failed to complete annual performance evaluations for five out of five nurse aides (NA Employee E1, E2, E3, E4, and E5). Findings include: Review of facility provided performance evaluations revealed the following: Nurse Aide (NA) Employee E1 had a hire date of 2/2/21, failed to have a performance evaluation between 2/2/23, and 2/2/24. A performance review dated 9/8/22, was provided. NA Employee E2 had a hire date of 1/4/22, failed to have a performance evaluation between 1/4/23, and 1/4/24. An undated performance review was provided. NA Employee E3 had a hire date of 4/20/21, failed to have a performance evaluation between 4/20/23, and 4/20/24. NA Employee E4 had a hire date of 3/22/22, failed to have a performance evaluation between 3/22/23, and 3/22/24. NA Employee E5 had a hire date of 3/30/17, failed to have a performance evaluation between 3/30/23, and 3/30/24. A performance review dated 7/8/22, was provided. During an interview on 8/23/24, at 10:40 a.m. the Director of Nursing confirmed that the facility failed to complete annual performance evaluations for five of five nurse aides as required. 28 Pa Code: 201.20 (a)(b)(c)(d) Staff development. 28 Pa Code: 201.14 (a) Responsibility of licensee.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311 Based on review of clinical records, and staff interview, it was determined that the facility failed to implement procedures to ensure availability of prescribed medications for two of five residents (Residents R104 and R59). Findings include: Review of the facility policy Provider Pharmacy Requirements dated 1/3/24, previously reviewed 1/24/23, indicated the facility will provide regular and reliable pharmaceutical services, to provide residents with prescription and non-prescription medications, services, and related equipment and supplies. Review of the clinical record indicated Resident R104 was admitted to the facility on [DATE]. Review of Resident R104's Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated 8/5/24, included diagnoses dementia (a group of symptoms that affects memory, thinking and interferes with daily life), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and Parkinson's disease (neuromuscular disorder causing tremors and difficulty walking). Review of a physician's order dated 6/8/24, indicated for Resident R104 to receive Cipro (an antibiotic medication) 500 milligrams (mg), twice daily for seven days, for a urinary tract infection. Review of a progress note dated 6/9/24, at 2:25 p.m. indicated, Unable to access medication Pyxis (electronic medication dispensing machine) today and new abx (antibiotics) med not up from pharmacy, called and spoke with them and medication is being sent out. Adjusted time of medication to ensure resident receives full treatment. Review of a progress note dated 6/9/24, at 10:12 p.m. indicated, Called pharmacy again regarding status of antibiotic, per agent, medication left the pharmacy at 5pm and would be delivered this evening, unable to give an exact time. Review of Resident R104's Medication Administration Record (MAR) for June 2024, indicated: 6/8/24 Cipro (9:00 p.m.) and 6/9/24 Cipro (9:00 a.m.) were documented as NN (NN is code for No / See Nurse Note. Review of an eMAR (electronic Medication Administration Record) progress note dated 6/8/24, at 10:22 p.m. indicated, Med on order. Asked supervisor [Registered Nurse Employee E18] to pull from Omnicell (electronic medication dispensing machine); supervisor said Omnicell not working at this time. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a physician's order dated 7/10/24, indicated for Resident R104 to receive Piperacillin Sod-Tazobactam Solution Reconstituted 3-0.375 GM (Zosyn, injectable antibiotic medication) intravenously every six hours for seven days. Review of a physician's order dated 7/11/24, indicated for Resident R104 to receive Piperacillin Sod-Tazobactam Solution Reconstituted 3-0.375 GM intravenously every six hours for 26 administrations. Review of a progress note dated 7/11/24, at 4:30 a.m. indicated, Called and spoke to [pharmacy representative] regarding IV (intravenous) antibiotics for resident that have not yet been delivered. Informed him that they were called earlier because medication had not been received and that nurse was told it was out for delivery. Delivery arrived and medication was not sent. [Representative] spoke to On Call Pharmacist and told me they Pharmacist is working on it and will Stat it out to facility. Unable to provide timeframe for delivery when asked. Review of Resident R104's Medication Administration Record (MAR) for July 2024, indicated: 7/11/24, Zosyn doses for 12:00 a.m., 6:00 a.m., and 12:00 p.m. were documented as NN. Resident R104's 7/11/24, 10:00 p.m. dose did not have any documentation provided to indicate if it was provided. Review of an eMAR progress note dated 7/11/24, at 5:18 a.m. indicated, On order. IV meds were supposed to come in. Called pharmacy at 0115 (1:15 a.m.); spoke with pharmacy tech. This nurse asked when the iv meds were going to arrive. Pharmacy tech said she saw order for Zosyn and normal saline from 12 hours ago, but didn't know when the iv meds were coming, but should be enroute from pharmacy from 9pm delivery. When meds arrived, iv meds were not included with delivery. Supervisor [RN Employee E19] notified. Will continue to monitor. Review of an eMAR progress note dated 7/11/24, at 2:14 p.m. indicated, awaiting delivery from the pharmacy. Spoke with [pharmacy representative] who stated medication would be leaving facility at 9 this morning for delivery, still awaiting delivery at this time. Review of the clinical record indicated Resident R59 was admitted to the facility on [DATE]. Review of Resident R59's MDS dated [DATE], included diagnoses dementia, polyneuropathy (condition where multiple nerves have been damaged, causing pain, decreased sensation, and weakness), and chronic pain. Review of Section J: Health Conditions, indicated Resident R59 is on a scheduled pain medication regimen. Review of a physician's order dated 6/27/24, discontinued 7/29/24, indicated for Resident R59 to receive 50 mg of Tramadol (a narcotic pain medication used to treat moderate to severe pain) twice daily, and additionally every eight hours as needed for pain. Review of a physician's order dated 6/27/24, discontinued 7/29/24, indicated for Resident R59 to receive 50 mg of Tramadol twice daily, and additionally every eight hours as needed for pain. Review of Resident R59's MAR for July 2024, indicated the 7/30/24, 9:00 a.m. dose of Tramadol documented as NN. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an eMAR progress note dated 7/11/24, at 5:18 a.m. indicated that the facility was awaiting delivery from the pharmacy. Review of the facility provided medication dispensing machine inventory list revealed that Tramadol 50 mg was available in the Omnicell. During an interview on 8/23/24, at 10:40 a.m. the Director of Nursing confirmed that the facility failed to implement procedures to ensure availability of prescribed medications for two of five residents. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 39311 Based on a review of resident and staff interviews and observations it was determined that the facility failed to provide sufficient portions of food products for seven of 16 residents (Resident R9, R11, R23, R46, R62, R64, and R65). Findings include: During an interview on 8/19/24, at approximately 10:40 a.m. Resident R65 stated that he felt that the portions were not enough and sometimes it has no taste. During an interview on 8/19/24, at approximately 10:55 a.m. Resident R9 stated that the food was cold, that it doesn't have good flavor, and the portions are not large enough. During an interview on 8/19/24, at approximately 11:07 a.m. Resident R46 stated that food is cold when it arrives and makes it less appealing to eat, portions are very small. During an interview on 8/19/24, at approximately 11:22 a.m. Resident R23 stated that the food arrives cold, there is not enough in the portion, and the food has no taste. During an interview on 8/21/24, at approximately 10:25 a.m. Resident R64 stated the meal portions are small. During an interview on 8/21/24, at approximately 11:00 a.m. Resident R11 stated that the food is not so good, the portions are small. During an interview on 8/21/24, at approximately 11:17 a.m. Resident R62 stated that he does not find the food appetizing with small portions. During a resident group interview on 8/21/24, at 1:30 p.m. the following was stated: - The mashed potatoes wouldn't feed a baby. - I got a hot dog with three French fries. Four additional residents verbalized agreement with this statement. During an observation of the breakfast meal on 8/21/24, the portion sizes of the eggs served appeared small. During an observation of the lunch meal on 8/21/24, at approximately 12:00 p.m. Resident R108 stated, Look at this salad. Look how big it is. I don't think I can eat all of this. Resident R108 laughed at this point, and confirmed she was being sarcastic. Observation of the salad the resident displayed revealed a clear plastic desert cup, tapered at the base, filled just less than halfway with cucumber salad. Observation of Resident R108's meal ticket indicated zesty cucumber salad - 1/2 cup. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/21/24, at approximately 12:03 p.m. Speech Therapy Employee E16 stated that the portion sizes always appear to be small. During a test tray observation on 8/21/24, at approximately 1:10 p.m. the cucumber salad was measured. On the underside of the clear plastic desert cup was imprinted with 4 oz (four ounces, equivalent to 1/2 cup). Regional Dietary Manager Employee E17 provided a 1/2 cup disher (commonly referred to as an ice cream scoop, which measures 1/2 cup when the portion is level with the scoop edges), and measured the cucumber salad. Regional Dietary Manager Employee E17 confirmed at this time that the cucumber salad did not fully fill the disher and was less than the 1/2 cup measurement. During an interview on 8/21/24, at 2:00 p.m., Regional Dietary Manager Employee E17 was made aware that the residents had complaints about portion sizes of foods. This had been identified with individual interviews, resident group, observations of scrambled eggs, and measured size of cucumber salad served on 8/21/24, for lunch. During an interview on 8/23/23, at approximately 1:00 pm the Nursing Home Administrator confirmed that the facility failed to provide sufficient portions of food products for seven of 16 residents. PA Code 211.6(a)(b) Dietary services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 31343 Based on a review of facility policies, observations and staff interviews it was determined that the facility failed to properly store food products, failed to verify the washing temperature of the dish machine, failed to maintain the air gap and drain pipe for the ice machine, and failed to to make certain dietary staff wear proper hair restraints in the Main Kitchen (Main Kitchen), which created the potential for foodborne illness. Findings Include: Review of the facility policy Machine Warewashing and Sanitation, dated 1/3/24, indicated that the facility high temperature machine wash cycle ranges between 150 degrees to 165 degrees, the final rinse temperature is a minimum of 180 degrees. Manufacturer's specifications are followed. Temperatures are recorded after each use/meal. If temperatures fall below the standard for either wash or rinse, the Director of Dining Services is notified. Review of the facility policy Ice Machine Cleaning/Inspection dated 1/3/24, indicated that all ice machines are cleaned and inspected quarterly. During the inspection, staff are to make certain the drain hose is secured and a air gap is maintained. Review of the facility policy Staff Attire dated 1/3/24, 44, indicated that all staff members will have their hair off their shoulders, confined in a hair net or cap, and facial hair properly restrained. During an observation of the kitchen on 8/19/24, from 9:29 a.m., through 9:48 a.m. the following was identified: Dish machine wash temperature was not functioning/indicated on valve. Deep freezer had ice build up over pipe off of cooling fans over boxed food items. Ice machine in kitchen had no air gap to drain, black slime-like substance was observed on the pipe sticking out to machine. During an interview on 8/19/24, at 9:48 a.m., the Dietary Manager Employee E40 confirmed that the facility failed to verify the wash temperature of the dish machine, failed to maintain the drain hose and air gap of the ice machine and failed to properly store food products creating the potential for food borne illness. During a second observation of the kitchen on 8/21/24, at 8:00 a.m., Dietary Aide Employee E41 was observed plating food on resident trays with no facial hair restraint. During an interview on 8/21/24, at 8:48 a.m., the Dietary Manager Employee E40 confirmed that he facility failed to make certain staff are properly restraining facial hair. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Pa. 28 Code: 211.6(c)(d)(f) Dietary services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 49646 Based on policy review, documentation and review of Centers for Disease Control (CDC) guidelines for Legionella (bacteria that causes disease found in contaminated water) control, and staff interviews it was determined that the facility failed to maintain a comprehensive program for water management to monitor the potential development and spread of Legionella and failed to implement control measures for Legionella within the facility for eleven of twelve months (September 2023 through July 2024). Findings Include: Review of the facility policy Water Management dated 1/3/24, previously dated 1/24/23, indicated the facility will utilize water management practices to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. Core Elements of the Water Management Plan are: 1. Establish Water Management Plan team. 2. Describe Center's water system using text and flow diagram. 3. Risk assessment with control methods and corrective actions. 4. Monitoring control measures. 5. Corrective actions. 6. Verification and validation. 7. Documentation and communication. Review of Department of Health and Human services, Centers for Medicare and Medicaid services (CMS) memo Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease (LD) dated 7/6/18, revealed, Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water. This policy memorandum applies to Hospitals, Critical Access Hospitals (CAHs) and Long-Term Care (LTC). However, this policy memorandum is also intended to provide general awareness for all healthcare organizations. Facilities must have water management plans and documentation that, at a minimum, ensure each facility: -Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g., Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system. -Develops and implements a water management program that considers the ASHRAE (American Society of Heating, Refrigerating, and Air Conditioning Engineers) industry standard and the CDC toolkit. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Specifies testing protocols and acceptable ranges for control measures and document the results of testing and corrective actions taken when control limits are not maintained. -Maintains compliance with other applicable Federal, State, and local requirements. Review of the ASHRAE guidance Managing the Risk of Legionellosis Associated with Building Water Systems dated December 2020, indicated the most commonly used supplemental disinfection methods are treatment with chlorine, chlorine dioxide, copper -silver ions, and monochloramine. The guidance further indicated the recommended levels of residual chlorine are 0.50 - 3.00 ppm (parts per million). Review of the facility provided water management information failed to include specific testing protocols and acceptable ranges for control measures along with a description of the facility's water system using a flow diagram. Review of the Water Management Program Control Measures did not contain a log for Point of Use Disinfectant (the level of chlorine concentration in the water) indicated to measure and record hot water and cold water chlorine concentration as point of use, and to note that chlorine concentration below 0.5 ppm and above 4.0 ppm as outside the control limits. During an interview on 8/22/24, at approximately 11:30 a.m. the Maintenance Director Employee E20 stated that he was unaware that he needed to be using a method to test chlorine levels or to treat with chlorine, chlorine dioxide, copper -silver ions, and monochloramine. During an interview on 8/22/24, at approximately 11:40 a.m. the Nursing Home Administrator confirmed that the facility failed to maintain a comprehensive program for water management to monitor the potential development and spread of Legionella and failed to implement control measures for Legionella within the facility. 28 Pa. code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b) (1) (e) (1) Management.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain education regarding the pneumococcal immunization and/or the opportunity to receive the immunization was offered to three of seven residents (Residents R19, R133, and R138). Findings include: Review of the facility policy Pneumococcal Vaccination dated 1/18/24, indicated the facility will provide the opportunity to receive the appropriate pneumococcal vaccine to all patients/ residents. Review of the Admission Record indicated that Resident R19 was admitted to the facility on [DATE]. Review of Resident R19's Pneumococcal Vaccine Informed Consent form, dated 3/23/24, revealed Resident R19's responsible party indicated, May give vaccine if recommended by attending (provider). Review of Resident R19's clinical record failed to reveal any documentation that the appropriateness of Resident R19 receiving the pneumococcal vaccine was ever evaluated by the provider. Review of the Admission Record indicated that Resident R133 was admitted to the facility on [DATE]. Review of Resident R133's clinical record failed to reveal documentation that Resident R133 was provided education on the pneumococcal vaccination and provided the opportunity to receive it. On 8/22/24, when Resident R133's Pneumococcal Vaccine Informed Consent form was requested of the facility, only information regarding the influenza vaccination was provided. Review of the Admission Record indicated that Resident R138 was admitted to the facility on [DATE]. Review of Resident R138's clinical record failed to reveal documentation that Resident R133 was provided education on the pneumococcal vaccination. On 8/22/24, when Resident R138's Pneumococcal Vaccine Informed Consent form was requested of the facility, an Immunization Audit Report was provided, which indicated Resident R138 refused the Pneumococcal vaccination. The report question, Education Provided /By/Date was answered No. During an interview on 8/23/24, at 12:29 p.m. the Director of Nursing confirmed that the facility failed to make certain education regarding the pneumococcal immunization and/or the opportunity to receive the immunization was offered to three of seven residents. 28 Pa. Code 211.5(f) Clinical records.

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F 0941 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 39311 Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on effective communication for four of nine staff members (Employee E1, E2, E5, and E7). Findings include: Review of the facility policy, In-service Training dated 1/3/24, previously reviewed 1/24/23, indicated the facility will provide in-service training for all personnel on a regularly scheduled basis. All mandatory in-service training requirements must be completed annually as a condition of employment. Review of facility provided documents and training records revealed the following staff members did not have documented training on effective communication. Nurse Aide (NA) Employee E1 had a hire date of 2/2/21, failed to have effective communication in-service education between 2/2/23, and 2/2/24. NA Employee E2 had a hire date of 1/4/22, failed to have effective communication in-service education between 1/4/23, and 1/4/24. NA Employee E5 had a hire date of 3/30/17, failed to have effective communication in-service education between 3/30/23, and 3/30/24. Social Work Employee E7 had a hire date of 6/1/21, failed to have effective communication in-service education between 6/1/23, and 6/1/24. During an interview on 8/23/24, at approximately 10:40 a.m. the Director of Nursing confirmed that the facility failed to provide training on effective communication for four of nine staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.

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F 0942 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 39311 Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on resident rights for three of ten staff members (Employee E5, E7, and E8). Findings include: Review of the facility policy, In-service Training dated 1/3/24, previously reviewed 1/24/23, indicated the facility will provide in-service training for all personnel on a regularly scheduled basis. All mandatory in-service training requirements must be completed annually as a condition of employment. Review of facility provided documents and training records revealed the following staff members did not have documented training on resident rights. Nurse Aide (NA) E5 had a hire date of 3/30/17, failed to have resident rights in-service education between 3/30/23, and 3/30/24. Social Work Employee E7 had a hire date of 6/1/21, failed to have resident rights in-service education between 6/1/23, and 6/1/24. Registered Nurse Employee E8 had a hire date of 3/13/16, failed to have resident rights in-service education between 3/13/23, and 3/13/24. During an interview on 8/23/24, at approximately 10:40 a.m. the Director of Nursing confirmed that the facility failed to provide training on resident rights for three of ten staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 39311 Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on the prevention of abuse, neglect, and misappropriation for three of ten staff members (Employee E5, E7, and E8). Findings include: Review of the facility policy, In-service Training dated 1/3/24, previously reviewed 1/24/23, indicated the facility will provide in-service training for all personnel on a regularly scheduled basis. All mandatory in-service training requirements must be completed annually as a condition of employment. Review of facility provided documents and training records revealed the following staff members did not have documented training on the prevention of abuse, neglect, and misappropriation. Nurse Aide (NA) E5 had a hire date of 3/30/17, failed to have the prevention of abuse, neglect, and misappropriation in-service education between 3/30/23, and 3/30/24. Social Work Employee E7 had a hire date of 6/1/21, failed to have the prevention of abuse, neglect, and misappropriation in-service education between 6/1/23, and 6/1/24. Registered Nurse Employee E8 had a hire date of 3/13/16, failed to have the prevention of abuse, neglect, and misappropriation in-service education between 3/13/23, and 3/13/24. During an interview on 8/23/24, at approximately 10:40 a.m. the Director of Nursing confirmed that the facility failed to provide training on the prevention of abuse, neglect, and misappropriation for three of ten staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.

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F 0944 Level of Harm - Potential for minimal harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 39311 Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on Quality Assurance and Performance Improvement (QAPI) for six of ten staff members (Employee E1, E2, E5, E7, E8, and E9). Findings include: Review of the facility policy, In-service Training dated 1/3/24, previously reviewed 1/24/23, indicated the facility will provide in-service training for all personnel on a regularly scheduled basis. All mandatory in-service training requirements must be completed annually as a condition of employment. Review of facility provided documents and training records revealed the following staff members did not have documented training on effective communication. Nurse Aide (NA) Employee E1 had a hire date of 2/2/21, failed to have QAPI in-service education between 2/2/23, and 2/2/24. NA Employee E2 had a hire date of 1/4/22, failed to have QAPI in-service education between 1/4/23, and 1/4/24. NA Employee E5 had a hire date of 3/30/17, failed to have QAPI in-service education between 3/30/23, and 3/30/24. Social Work Employee E7 had a hire date of 6/1/21, failed to have QAPI in-service education between 6/1/23, and 6/1/24. Registered Nurse Employee E8 had a hire date of 3/13/16, failed to have QAPI in-service education between 3/13/23, and 3/13/24. Licensed Practical Nurse Employee E9 had a hire date of 6/6/17, failed to have QAPI in-service education between 6/6/23, and 6/6/24. During an interview on 8/23/24, at approximately 10:40 a.m. the Director of Nursing confirmed that the facility failed to provide training on QAPI for six of ten staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.

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	08/23/2024

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

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 0946 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide training in compliance and ethics. 39311 Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on compliance and ethics for three of ten staff members (Employee E2, E6, and E7). Findings include: Review of the facility policy, In-service Training dated 1/3/24, previously reviewed 1/24/23, indicated the facility will provide in-service training for all personnel on a regularly scheduled basis. All mandatory in-service training requirements must be completed annually as a condition of employment. Review of facility provided documents and training records revealed the following staff members did not have documented training on compliance and ethics. Nurse Aide (NA) E2 had a hire date of 1/4/22, failed to have compliance and ethics in-service education between 1/4/23, and 1/4/24. Environmental Services Employee E6 had a hire date of 3/13/16, failed to have compliance and ethics in-service education between 3/13/23, and 3/13/24. Social Work Employee E7 had a hire date of 6/1/21, failed to have compliance and ethics in-service education between 6/1/23, and 6/1/24. During an interview on 8/23/24, at approximately 10:40 a.m. the Director of Nursing confirmed that the facility failed to provide training on compliance and ethics for three of ten staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 39311 Based on review of facility policy, staff education records, and staff interviews, it was determined that the facility failed to conduct at least 12 hours of in-service education, within 12 months of their hire date anniversary, for nurse aides as required for two of five nurse aides (Employees E2 and E5). Finding include: Review of the facility policy, In-service Training dated 1/3/24, previously reviewed 1/24/23, indicated the facility will provide in-service training for all personnel on a regularly scheduled basis. All mandatory in-service training requirements must be completed annually as a condition of employment. Review of Nurse Aide (NA) Employees E2 and E5's education records with hire date greater than 12 months revealed the following: NA Employee E2 had a hire date of 2/21/21, with approximately six hours, five minutes of in-service education between 2/21/23, and 2/21/24. NA Employee E5 had a hire date of 3/30/17, with approximately eight hours, 20 minutes of in-service education between 3/30/23, and 3/30/24. During an interview on 8/23/24, at 10:40 a.m. the Director of Nursing confirmed that the facility failed to provide the required 12 hours annual in-service education within 12 months of their hire date anniversary for two of five nurse aides. 28 Pa. Code: 201.14(a) Responsibility of Licensee. 28 Pa. Code: 201.20(c) Staff Development.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0949 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 39311 Based on review of facility policy, personnel in-service training records, and staff interview, it was determined that the facility failed to provide training on behavioral health for two of ten staff members (Employee E7 and E8). Findings include: Review of the facility policy, In-service Training dated 1/3/24, previously reviewed 1/24/23, indicated the facility will provide in-service training for all personnel on a regularly scheduled basis. All mandatory in-service training requirements must be completed annually as a condition of employment. Review of facility provided documents and training records revealed the following staff members did not have documented training on behavioral health. Social Work Employee E7 had a hire date of 6/1/21, failed to have behavioral health in-service education between 6/1/23, and 6/1/24. Registered Nurse Employee E8 had a hire date of 3/13/16, failed to have behavioral health in-service education between 3/13/23, and 3/13/24. During an interview on 8/23/24, at approximately 10:40 a.m. the Director of Nursing confirmed that the facility failed to provide training on behavioral health for two of ten staff members. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(c) Staff development.