STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395606	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John J Kane Regional Center-Ro	110 McIntyre Road Pittsburgh, PA 15237

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50075 Based on observations and staff interview, it was determined that the facility failed to provide a dignified dining experience for one of three units observed (Three East) and failed to protect and value residents' private space for one of three units observed (Three East). Findings include: Review of the facility policy Resident Rights and Responsibilities dated 1/2/25, indicated that each resident have the right to be treated with dignity and respect. During a dining observation of the Three East dining room on 4/7/25, at 11:54 a.m. revealed that Resident R21 was being assisted with lunch by a staff member. Nurse Assistant (NA) Employee E7 was standing beside Resident R21 while feeding him his lunch. During an interview on 4/7/25, at 12:07 p.m. NA Employee E7 stated, I know we are supposed to sit down. During an interview on 4/7/25, at 3:00 p.m. the Director of Nursing confirmed the facility failed to provide a dignified dining experience for Resident R21. During an observation on Three East Unit on 4/7/25, at 12:11 p.m. Housekeeping Employee E26 was seen entering Resident R92's room without knocking or requesting permission to enter. During an observation on Three East Unit on 4/7/25, at 12:12 p.m. Housekeeping Employee E26 was seen entering Resident R41's room without knocking or requesting permission to enter. During an interview on 4/7/25, at 12:12 p.m. Housekeeping Employee E26 confirmed that she failed to knock prior to entering Resident R92's, and R41's rooms which failed to protect and value the residents' private space. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 201.29(a)Resident Rights.

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of facility policy, observations and staff interviews it was determined that the facility failed to provide a clean, safe, comfortable, and homelike environment for one of three resident areas (room [ROOM NUMBER]). Findings include: Review of the facility policy Resident Rights and Responsibilities dated 1/2/25, indicated Resident Rights are posted on each floor. Review of The Resident's [NAME] of Rights, indicated the resident has the right to a safe, clean comfortable and homelike environment, including but not limited to ensuring that the physical layout of the facility maximizes resident independence and is sanitary, orderly and comfortable. Observation on 4/7/25, 11:22 a.m. of unoccupied Resident room [ROOM NUMBER] revealed a large maintenance cart in the room. There were no beds or furniture in the room. Cart noted with handheld drills, scraping tools, caulk gun supplies, screws, wires and other maintenance tools. The lights above where the beds should be removed on both sides and wires were visibly sticking out of the wall. A light bulb was observed on the floor by the closet. room [ROOM NUMBER] shares a bathroom with room [ROOM NUMBER] which was occupied at the time. Interview on 4/7/25, at 12:10 p.m. Environmental Services Director Employee E4 confirmed the above observation and that the room was unlocked and unattended which posed a safety risk to residents. Interview on 4/7/25, at 2:00 p.m. the Nursing Home Administrator confirmed the facility failed to provide a clean, safe, comfortable, and homelike environment for one of three resident areas (room [ROOM NUMBER]). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(e)(2.1) Management.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 48546 Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to ensure that residents were free from neglect for two of four residents reviewed (Residents R35 and R68). Findings include: Review of facility policy Abuse - Resident and Reasonable Suspicion of a Crime dated 1/2/25, indicated neglect is the failure of the facility, the staff, or service providers to provide goods and services to a resident that are necessary to avoid or may result in physical harm, pain, mental anguish, or emotional distress. Review of the clinical record indicated Resident R35 was admitted to the facility on [DATE]. Review of Resident R35's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/17/25, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). MDS Section K0520-Feeding tube was checked indicating resident received while a resident. Review of current physician orders indicated that Resident R35 was receiving nutrition through an enteral feeding tube (a tube inserted in the stomach through the abdomen) and was NPO (nothing by mouth). During an interview on 4/7/25, at 10:22 a.m. Resident R35 stated that he just ate a cookie a few minutes ago and an empty plate was observed on his bed side table. During an observation on 4/7/25, at 10:25 a.m. Activity Employee E8 was observed going through the hallway with a cart of cookies and drinks offering to residents. During an interview on 4/7/25, at 10:31 a.m. Activity Employee E8 confirmed that she gave Resident R35 a cookie this morning and asked the Speech Therapist who stated he would be ok to have a cookie prior to giving it to him. During an interview on 4/7/25, at 12:19 p.m. Speech Therapist (ST) Employee E9 denied giving permission to Employee E8 to serve Resident R35 a cookie before his evaluation was completed. ST Employee E9 stated, He went out to the hospital, and I have to review his hospital documentation while he was there to see if he had a change of condition during his stay and I have to evaluate him first before making any recommendations. During a review of ST documentation, a referral was made to see Resident R35 indicated reason for referral: Resident with hospital readmission. He was NPO at the hospital and upon return until he can be assessed by ST for recommendations. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 4/7/25, at 2:29 p.m. Nursing Home Administrator and Director of Nursing confirmed that the facility failed to ensure Resident R35 was free from neglect, as required. Review of the clinical record indicated Resident R68 was admitted to the facility on [DATE]. Review of Resident R68's MDS dated [DATE], indicated diagnoses of high blood pressure, weakness, and dependence on wheelchair. Review of a physician order dated 4/22/24, indicated the resident requires assist of two to complete bathing on shower day. Review of facility submitted documentation dated 3/29/25, stated, Resident R68 received a shower this afternoon, her aide Nurse Aide (NA) Employee E2, did not find a second person to assist her with it, proceeded to shower the resident alone in the shower room. Review of a witness statement dated 3/29/25, indicated NA Employee E2 stated, I was not aware of having two people in the shower. I took Resident R68 anyway no one came to help me. Review of a witness statement dated 3/29/25, indicated Registered Nurse (RN) Employee E27 stated, Around 12:45 p.m. I was standing by room [ROOM NUMBER] pulling meds for 263 and Resident R68 and NA Employee E2 came out of the room. The resident was sitting on a shower chair. She was covered in a bed sheet and part of the bed sheet was tangled on the chair's wheel so I assisted to pull out though I was unable so NA Employee E2 wheeled the resident backwards towards the shower room. As I headed down the hall NA Employee E2 asked you need 2 people? Then stated she is telling me we need 2 people, referring to the resident. I told her definitely it has to be two people during shower. I headed to 263 as I was holding her medications. Then I headed back to the cart after giving medication and readjusted 263D in her wheelchair. When the shower door was open the resident notified the nurse that she was given a shower by one NA. I asked NA Employee E2 and she stated I didn't know but I told her I notified her and also the resident notified her and I educated her that if someone is not available to spot her she should always wait than do what is against the facility's policy. The resident then went ahead and stated I told her and I will report this to the supervisor. I notified the supervisor on duty. During an interview on 4/10/25, at 1:58 p.m. the DON confirmed that the facility failed to ensure Resident R68 was free from neglect as required. 28. Pa Code 201.14(a) Responsibility of licensee. 28. Pa Code 201.18(b)(1)(e)(1) Management. 28. Pa. Code 211.12(d)(1)(5) Nursing services.

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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** 48546 Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to develop and implement a comprehensive care plan to meet care needs for four of four residents (Residents R7, R42, R66, and R219). Findings include: Review of facility policy Comprehensive Person-Centered Care Planning last reviewed on 1/2/25, indicated that the facility will comply with requirements related to comprehensive person-centered care planning. The services provided to or arrange for residents will meet professional standards of quality, are provided by qualified persons, and are culturally-competent and trauma-informed. Review of the clinical record indicated Resident R7 was admitted to the facility on [DATE]. Review of Resident R7's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/2/25, indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and muscle weakness. Review of a physician order dated 2/28/25, indicated FreeStyle Libre 2 Plus Sensor (a continuous glucose monitor) change every 14 days. Review of Resident R7's can plan failed to include care and management of the FreeStyle Libre 2 Sensor. Review of Resident R42's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R42's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes, and heart failure (a progressive heart disease that affects pumping action of the heart muscles). Review of Resident R42's physician order dated 11/12/24, indicated Free Style Libre Reader, changed every two weeks on Saturdays. Review of Resident R42's current care plan failed to include care and management of the FreeStyle Libre Reader. Review of the clinical record indicated Resident R66 was admitted to the facility on [DATE]. Review of Resident R66's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes, and muscle weakness. Review of a physician order dated 12/23/24, indicated FreeStyle Libre Sensor, change sensor every 2 weeks. (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 Resident R66's can plan failed to include care and management of the FreeStyle Libre 2 Sensor. Review of the admission record indicated Resident R219 admitted to the facility on [DATE]. Review of Resident R219's MDS dated [DATE], indicated the diagnoses of diabetes, arthritis, and high blood pressure. Review of Resident R219's physician order dated 3/31/25, indicated FreeStyle Libre 2 Reader special instructions, change every 14 days on the 12th and 26th of the month. Review of Resident R219's current care plan failed to include care and management of the FreeStyle Libre 2 Reader. During an interview on 4/11/25, at 9:42 a.m. Registered Nurse Assessment Coordinator (RNAC) Employee E3 confirmed the Resident R7, R42, R66, and R219's care plans did not reflect care and management of the FreeStyle Libre 2 Reader, and that the facility failed to develop and implement a comprehensive care plan to meet care needs for four of four residents as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing Services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to notify the physician of decreased Capillary Blood Glucose (CBG) levels per physician orders and failed to implement the facility's hypoglycemia protocol for two of four residents (Residents R65 and R66). Findings include: Review of facility policy Hypoglycemia Protocol dated 1/2/25, indicated a CBG reading of less than 70 milligrams per deciliter (mg/dL) and symptomatic or a CBG of less than 60 mg/dL regardless of symptoms, hold all diabetic mediations and insulin until reviewed with physician, provide treatment, recheck CBG in 15 minutes, treat according to protocol, and notify physician. May repeat such administrations of this medication up to 2 times within 30 minutes time period in the event of an acute hypoglycemic episode. The Centers for Disease Control defines diabetes as: Diabetes Mellitus is a chronic (long-lasting) health condition that affects how your body turns food into energy. Most of the food you eat is broken down into sugar (also called glucose) and released into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy. If you have diabetes, your body either doesn't make enough insulin or can't use the insulin it makes as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in your bloodstream. Over time, that can cause serious health problems, such as heart disease, vision loss, and kidney disease. Hypoglycemia is a condition that occurs when blood glucose is lower than normal, usually below 70 mg/dL. If left untreated, hypoglycemia may lead to weakness, confusion, unconsciousness, arrhythmias and even death. People with Diabetes Mellitus may be prescribed injectable insulin to assist in maintaining acceptable levels of CBG's. Review of the clinical records indicated Resident R65 was admitted to the facility on [DATE]. Review of Resident R65's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 2/5/25, indicated diagnoses of depression, coronary artery disease (damage or disease in the heart's major blood vessels), and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of a physician order dated 3/3/25, indicated to administer Humalog (a type of insulin) subcutaneously (beneath the skin into the fatty tissue layer) with meals, inject as per sliding scale: - If blood sugar is less than 70 call physician; - If 70 - 140 = 0 units; - 141 - 180 = 2 units; - 181 - 220 = 4 units; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 221 - 260 = 6 units; - 261 - 300 = 8 units; - 301 - 340 = 10 units; - If blood sugar is greater than 340, give 12 units and call physician. Special instructions: If MD called, please document the outcome of the call. Review of Resident R65's Blood Sugar records for March 2025, and April 2025, indicated the following blood glucose measurements: - 3/13/25, at 6:04 p.m. = 63 mg/dL - no progress note - 3/30/25, at 6:20 p.m. = 68 mg/dL - 3/31/25, at 6:30 p.m. = 53 mg/dL - 4/5/15, at 6:40 p.m. = 59 mg/dL During a review of Resident R65's progress notes failed to indicate that the physician was made aware of the above findings. Review of the clinical record indicated Resident R66 was admitted to the facility on [DATE]. Review of Resident R66's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes, and hyperlipidemia (high levels of fat in the blood). Review of a physician order dated 3/31/25, indicated to administer Humalog subcutaneously before meals, inject as per sliding scale: - If blood sugar is less than 70 call physician; - If 70 - 140 = 0 units; - 141 - 180 = 2 units; - 181 - 220 = 4 units; - 221 - 260 = 6 units; - 261 - 300 = 8 units; - 301 - 340 = 10 units; - If > 340, give 12 units and call physician (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R66's vitals records for March 2025, indicated the following blood glucose measurements: - 3/29/25 4:51 p.m. = 49 mg/dL - 3/29/25 5:15 p.m. = 61 mg/dL Review of a nursing progress note dated 3/29/25, stated, Residents blood sugar at 4:50 p.m. was 49 resident was alert and verbal, OJ (orange juice) was given along with graham crackers. Blood sugar was rechecked 15 minutes later, reading was 61. Resident was already eating her dinner tray at this time. Blood sugar rechecked around 5:30 p.m., reading was 144. Noted on MD (physician) book for follow up by in-house MD, will monitor the resident. During an interview on 4/9/25, at 10:37 a.m. the DON confirmed that the facility failed to notify the physician of decreased CBG levels per physician order and failed to implement the facility's hypoglycemia protocol for Resident R65 and R66. 28 Pa. Code: 201.14(a) Responsibility of licensee. 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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, clinical record review, observations, and staff interviews, it was determined that the facility failed to ensure a resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility for two of five residents (Residents R61 and R98). Findings include: Review of facility policy Contracture Management dated 1/2/25, indicated residents with limited ROM (range of motion) will receive appropriate treatment and services to increase and/or prevent further decrease in ROM. The nurse develops and coordinates an interdisciplinary person-centered plan of care that includes passive and/or active ROM exercises, splints, braces or other devices where applicable that will improve or maintain current ROM except where clinically contraindicated. Review of the admission record indicated Resident R61 was admitted to the facility on [DATE]. Review of Resident R61's Minimum Data Set (MDS- a periodic assessment of care needs) dated 2/27/25, indicated diagnoses of high blood pressure, hemiplegia (paralysis on one side of the body), and stroke (damage to the brain from an interruption of blood supply). Review of a physician order dated 4/4/25, indicated right palm guard (a brace used to prevent finger contractures and skin break down in the palm) to be worn at all times except hygiene. Review of Resident R61's care plan dated 2/26/25, failed to include care and management of the right palm guard. Interview on 4/11/25, at 9:42 a.m. with Registered Nurse Assessment Coordinator (RNAC) Employee E3 confirmed the Resident R61's care plan did not reflect care and management of the right palm guard. Review of the clinical record indicated Resident R98 was admitted to the facility on [DATE]. Review of Resident R98's MDS dated [DATE], indicated diagnoses of high blood pressure, hemiplegia, and anemia (too little iron in the blood). Review of a physician order dated 2/20/25, indicated bilateral (both sides) palm guards to be worn at all times except hygiene. Review of a physician order dated 2/13/25, indicated to clean the palms of both hands with soap and water, rinse, pat dry, re-apply hand braces daily at bedtime. Review of Resident R98's care plan dated 11/22/24, indicated bilateral palm guards to be worn at all times except for hygiene. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an observation on 4/7/25, at 10:11 a.m. Resident R98 was observed without her bilateral palm guards applied. During an observation on 4/8/25, at 9:49 a.m. Resident R98 was observed without her bilateral palm guards applied. During an interview on 4/8/25, at 9:51 a.m. Registered Nurse Employee E1 confirmed Resident R98 did not have her palm guards applied, and that the facility failed to ensure Resident 98 received appropriate services, equipment, and assistance to maintain or improve mobility. Interview on 4/11/25, at 2:30 p.m. the Director of Nursing confirmed the facility failed to ensure a resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility for two of five residents (Residents R61 and R98). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 211.10(a)(c)(d) Resident care policies. 28 Pa. Code: 211.12(c)(d)(1)(2)(3)(5) Nursing services.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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** 46336 Based on review of facility policy, clinical records, facility documents, and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision and person-centered care plan interventions that resulted in an elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) for two residents. This failure created an immediate jeopardy situation for two of 21 residents who were identified as at risk for elopement (Residents R6, and R111). Findings include: Review of the policy Accident Prevention dated 1/2/25, indicated the facility policy is to prevent resident accidents and injuries to the extent possible by maintaining, as much as possible, an environment free from accident hazards and by assuring residents receive adequate supervision and assistive devices to prevent accidents. Review of the policy Wanderguard and Elopement dated 1/2/25, indicated the facility implements safety measures for residents who wander and/or are at risk for elopement to attempt to prevent elopement. Nursing evaluates resident upon admission and when the resident exhibits an exit seeking behavior in the Electronic Health Record (EHR) - Elopement Observation. Implements person-centered interventions to attempt to prevent elopement. Review of the admission record indicated Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's Minimum Data Set (MDS- a periodic assessment of care needs) dated 1/15/25, indicated the diagnoses of metabolic encephalopathy (a brain disorder caused by metabolic disturbances in the body, leading to impaired brain function), repeated falls, and diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). Section C0500 indicated a Brief Interview for Mental Status (BIMS - a screening test that aides in detecting cognitive impairment) score of 12 - moderately impaired cognition. Review of Resident R6's Elopement Observation dated 10/24/24, indicated no elopement risk factors identified or verbalized. Review of Resident R6's Elopement Observation dated 10/30/24, indicated new admission who has made statements questioning the need to be here checked yes. Does the resident exhibit any additional elopement risk criteria? - Other -wanting to go outside was checked as yes. Elopement care plan initiated. Review of Resident R6's care plan dated 10/30/24, indicated behavioral symptoms - apply wanderguard (a bracelet that alerts staff if a resident has gone through an alarmed doorway to the outside of the facility) to resident. Check placement of wanderguard every shift. If not on resident, then replace as soon as possible. Check function every night. (continued on next page)

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	395606	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John J Kane Regional Center-Ro	110 McIntyre Road Pittsburgh, PA 15237

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident R6's care plan intervention dated 10/31/24, indicated resident needs supervision to go outside to the courtyard. Review of Resident R6's progress notes indicated 31 occasions of incidents of confusion, resisting care, agitation, self-propelling up and down hallways, being found on the basement level of the facility, seven falling episodes and ultimate elopement from 3West Unit on 3/14/25, as follows: -10/24/24, at 3:00 p.m. indicated resident is alert and oriented at baseline but brother states resident is having some short-term memory issues related to recent urinary tract infections. Resident had fallen at his personal care home and hurt his wrist. Resident enjoys being outside and sitting in the sun. Resident's brother states resident has been doing this for years. -10/25/24, at 2:02 p.m. care conference indicated resident requires this level of care as lesser levels of care were unsuccessful. -10/25/24, at 10:18 p.m. indicated resident transfers with assist of one and self-propels in wheelchair independently. -10/26/24, at 2:43 p.m. Indicated resident is alert, verbal, confused at times. Self-propels in wheelchair around room and unit. -10/27/24, 6:39 a.m. indicated resident gets in and out of bed unassisted and sits in wheelchair. Somewhat confused. -10/27/24, 2:24 p.m. indicated resident alert, verbal, confused at times. -10/28/24, 2:20 p.m. indicated resident presented as alert and oriented times three, with periods of forgetfulness. Resident has short term memory loss and is very social. -10/30/24, at 3:14 p.m. indicated resident verbalized wanting to go outside. Courtyard assessment completed and found resident to be unsafe to do so without supervision. Resident's cognition fluctuates. His confusion increases at different times of the day as well as when resident has a medical issue occurring. Resident's brother reported resident would stay outside for hours on end in extreme heat and not drink or use the restroom which had resulted in multiple infections and episodes of dehydration prior to placement. Resident does lack safety awareness. Residents gets irritated at times when resident is reminded of safety issues including going outside and verbalizing to staff, resident would go regardless of supervised request. A wander guard has also been ordered. -11/6/24, 12:34 p.m. indicated resident was refusing grip socks. Resident's brother indicated resident is impulsive and implored resident that it's easier to call for help to the chair than help off of the floor. Resident is non-compliant. -11/7/24, at 5:29 a.m. resident found in wheelchair dressing himself. Resident indicated he is able to do for himself without help and refused for staff's assistance. After resident dressed, he self-propelled up and down the corridor. Resident is non-compliant. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-11/7/24, at 12:47 p.m. indicated resident was seen by therapy, then within the hour was found to be walking around in the room, pants at his ankles and brief around his knees. Resident was very agitated. This has become regular practice that resident exhibits impulsiveness and sudden mood changes. -11/7/24, physician note indicated staff called earlier today because it seems like resident is having a little bit of an adjustment, where resident becomes quickly agitated with staff. Also seemed a little more confused than normal. The staff found resident urinating throughout his room, instead of in the bathroom where resident normally goes. -11/8/24, at 7:48 a.m. indicated resident alert to name only. Confused to time and place. Resident stated sometimes he does feel anxious, agitated, and depressed at times. Resident is often not asking staff for help when he needs help with transfers. Resident does have a history of encephalopathy. Staff noting that resident has periods of increased confusion as well as emotional lability. -11/20/24, physician note indicated staff noting that resident has periods of increased confusion as well as emotional lability. Resident said he likes to do outdoor activities and would previously kayak. IMPRESSION AND PLAN: 1. Normal pressure hydrocephalus (a rare condition that occurs when too much cerebrospinal fluid builds up in the brain) has caused chronic gait abnormality and imbalance. Mostly scoots around in the wheelchair. Also has led to some increased confusion and memory issues. Monitor closely. -12/15/24, at 2:25 a.m. indicated resident found on the floor. Registered Nurse (RN) in to initiate investigation. -12/17/24, at 12:11 p.m. indicated resident continues to transfer independently. -12/26/24, at 1:33 p.m. indicated resident continues to be non-compliant. -12/27/24, physician's note indicated resident incorrectly told me that when he fell , he went to the emergency room and had X-rays, but it was confirmed with the staff that this was simply not true. Resident does have baseline confusion. IMPRESSION AND PLAN: Fall. Again, this was 11 days ago. Resident did not complain of left arm pain initially to the staff. Staff does report that there are times they have discovered that resident has fallen and does not tell people. -1/26/25, at 10:59 a.m. resident with increasing agitation. Staff found stool on the floor and on resident and offered to help clean resident, but resident refused. -1/26/25, at 1:17 p.m. indicated while Nurse Aide (NA) was delivering lunch tray into residents' room, resident was seen in bathroom on the floor, in a sitting position underneath the sink. Resident explained he placed himself on the floor to do plumbing. Water was slowly coming out of the pipes underneath the sink. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-2/8/25, 12:33 p.m. indicated resident was found sitting on floor in front of toilet in his bathroom. -2/9/25, at 6:03 a.m. indicated resident observed sitting on the edge of low bed at approximately 4:45 a.m. Assisted into wheelchair per resident request. Resident easily agitated with staff intervention. Remains moderate fall risk with impaired safety awareness. -2/17/25, at 4:15 a.m. physician note indicated a note in the communication book said resident has had some confusion. The resident does admit that he had some confusion last week and starting maybe ten days ago. Resident had a urinary tract infection. -2/19/25, at 6:31 a.m. indicated resident with increased confusion this, and prior shift. Hard time accepting help. Attempting to exercise in the bathroom and refusing to let staff help transfer to wheelchair. -2/19/25, at 11:50 a.m. indicated NA reported resident refused care this morning. Refused to go to orthopedic appointment and refused again to be cleaned up by NA. -2/20/25, physician's note indicated staff reported resident is having increased pain and noted to be more confused. -3/10/25, at 8:12 p.m. indicated resident was moving around the facility at approximately 7:00-7:15 pm. Resident was seen on the first floor (basement) by NA Employee E15, who notified the supervisor. But then resident's nurse Licensed Practical Nurse (LPN) Employee E16 came by, re-oriented resident and took resident back to his unit. Resident was placed safely in resident's room. Wanderguard is on the left wrist. Resident will be monitored every hour until midnight. When supervisor asked resident why he was on the first floor, resident said he wanted to see the sunset. -3/11/25, at 10:20 p.m. indicated resident self-propels throughout facility. Every one-hour checks maintained. -3/12/25, at 4:37 p.m. indicated staff notified that resident can't leave unit without supervision. -3/14/25, at 7:53 p.m. indicated spoke with resident's brother regarding resident wanting to go outside and safety concerns. Resident has wanderguard and needs to be supervised when outside in the courtyard. Resident on every two-hour safety checks due to recent increase in leaving the unit and trying to go outside. Resident's brother explained that resident loves to be outside and will spend most of his time out there if he can. Resident's brother said that he would try to come visit as often as possible to take him outside. -3/14/25, at 9:57 p.m. indicated around 3:45 p.m. NA reported that Resident R6 had eloped to the second floor and that she brought him up in his wheelchair. Review of the clinical record failed to include an Elopement Observation on 3/10/25, when Resident R6 was found in the basement unsupervised. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident R6's care plan failed to include an update or revision after resident was found in the basement unsupervised on 3/10/25. Review of a submitted facility document dated 3/14/25, at 3:30 p.m. indicated Resident R6's whose orders for level of supervision indicated may not leave third floor without supervision, was found on the second floor of the facility. Resident was seen on closed caption television getting on the elevator alone at 3:29 p.m. Resident attempted to go into the courtyard and was unsuccessful because the wanderguard alarmed. Resident is not permitted in the courtyard unsupervised. At 12:30 p.m. resident heads towards security (who turned the wanderguard alarm off). At 3:33 p.m. resident was observed in the second-floor activity room where activities were doing an activity. Interview on 4/7/25, at 9:50 a.m. Unit Clerk Employee E17 indicated some residents have wanderguards, night shift checks placement and function. When asked if there was a book with high-risk residents who wander on the unit, she replied no. Security has one on the second floor at the facility's entrance. Interview on 4/7/25, at 9:55 a.m. LPN Employee E18 indicated the wanderguard alarm goes off to the outside doors. The wanderguard doesn't stop residents from getting on and using the elevator. Interview on 4/7/25, at 10:00 a.m. Registered Nurse (RN) Employee E6 indicated in the evenings and overnight they have the elevators set so you cannot go to the basement. Staff cannot go from second floor or third floor to the basement on the evening or night shifts. Staff use the stairs. When asked who is in charge of the wander management program, RN Employee E6 indicated she believed it was Security or Administration, and that there was a list of wanderguards but no photographs. There's also a graph in the back of the DEA (narcotic book) book, which she went into the locked medication room to retrieve and brought back to the nursing desk area. Interview on 4/7/25, at 10:15 a.m. NA Employee E19 indicated we try to keep an eye on the ones that wander around. Interview on 4/7/25, at 12:53 p.m. LPN Employee E16 indicated on 3/10/25, she recalled coming back from dinner, and saw Resident R6 on the basement level of the facility where the employee cafeteria is located. LPN Employee E16 indicated she saw Resident R6 with NA Employee E15 who indicated Resident R6's trying to leave. LPN Employee E16 said to Resident R6 You know you're not supposed to be down here. Resident R6 responded with a laugh. Interview on 4/8/25, at 11:00 a.m. with NA Employee E19 indicated she recalled working 3/14/25, when Resident R6 got off the 3rd floor, stated NA Employee E20 was pushing Resident R6 back to the unit as she was coming out of the shower room with the shower bed and another resident. Interview on 4/8/25, at 11:08 a.m. LPN Employee E21 indicated Resident R6 likes to go down to the snack shop in the basement. Interview on 4/8/25, at 12:30 p.m. Unit Clerk Employee E17 pulled a binder out from the nursing desk on 3 [NAME] that had a wander list dated 10/31/24, and was unsure how often it should be updated. When asked how agency staff would know who was at risk for elopement, she indicated the staff would tell them who to watch. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 4/8/25, at 2:30 p.m. NA Employee E22 indicated Resident R6's allowed to second floor but not outside by himself. Resident R6 goes to the vending machine in the basement, and he'll come back up. Interview on 4/8/25, at 10:30 a.m. Security Guard (SG) Employee E23 at the front lobby entrance, indicated security has a book of photographs. When asked if it was available for review SG Employee E23 indicated sure, I'll go get it. It's locked in the security office down the hall. Review of the admission record indicated Resident R111 was admitted to the facility on [DATE]. Review of Resident R111's MDS dated [DATE], indicated the diagnoses of dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), muscle weakness, and need for assistance with personal care. Section C0500 indicated a BIMS score of six - severely impaired cognition. Review of Resident R111's Elopement Observation dated 9/25/24, indicated no elopement risk factors identified or verbalized. Elopement care plan not needed at this time. Review of Resident R111's care plan dated 9/26/24 (the next day), indicated to monitor safety status on an ongoing basis and intervene immediately if found in an unsafe environment, position, or etc. Apply wanderguard to resident. Review of Resident R111's progress notes indicated the following: -11/24/24, at 3:38 p.m. resident is disoriented today. Resident called her daughter to notify her that she was in downtown Pittsburgh. Resident indicated I've been calling my family to tell them I am in downtown Pittsburgh, and they keep telling me to take a nap. -11/25/24, 9:30 a.m. physician's note indicated resident's daughter was concerned that she visited yesterday at the facility and her mother seemed to be more confused than her baseline. Concerned because resident refuses care at times and thinks she may not be clean and have a urinary tract infection. Informed daughter that Dementia does slowly progress. -11/26/24, at 9:24 p.m. indicated resident observed by staff and other residents as being aggressive and yelling at roommate. Resident did state she was upset with roommate and was yelling at her but would not hurt her. When questioned resident indicated I'm sick of everyone coming into my room to bully me. -12/3/24, at 5:17 a.m. practitioner's note indicated resident has dementia and was seen last week by physician for increased confusion. Behavior is thought likely due to advancing dementia. Resident has had some more behaviors in the last few days as well. -12/15/24, at 1:27 p.m. indicated Medical Records Employee E24 found Resident R111 in the 2 [NAME] breakroom (this unit was closed at the time and without supervision of staff. Employee E24 happened upon Resident R111 only by the need for employee to use the restroom). Resident was easily redirected. Informed the staff on 2 East (Resident R111's unit that is not a locked unit) and suggested resident be checked on regularly. Will inform Administrative staff. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-12/17/25, at 11:23 a.m. indicated nursing reports that resident Sundown's (a neurological phenomenon that causes increased confusion and restlessness in people with dementia typically starting in the late afternoon). Staff report that she can be nasty and difficult to redirect in the evenings. Review of the clinical record failed to include an Elopement Observation on 12/15/24, when Resident R111 was found in the closed 2 [NAME] unit's break room. Review of Resident R111's care plan failed to include an update or revision after documented increased confusion on 11/24/24, 11/25/25, 11/26/24, 12/3/24, and 12/17/25 showing concerns about mental status changes, sundowners and advancing Dementia prior to resident being found unsupervised on the closed 2 [NAME] unit's break room on 12/15/24. The care plan failed to be updated or revised after Resident R111 was found on the closed 2 [NAME] unit. The care plan did not reflect a resident centered approach until revisions on 4/9/25, nearly four months post event. Review of a submitted facility document dated 12/15/24, at 1:01 p.m. indicated Resident R111 was found in the staff breakroom on the closed and unsupervised 2 [NAME] unit. Resident wandered there from her unit of 2 East without staff's knowledge. Wander guard was in place; however, would not have alarmed unless Resident R111 wound have gotten to an exit door leading to the outside of the facility. Review of Medical Records Employee E24's witness statement dated 12/17/24, at 10:35 a.m. indicated, I witnessed a resident sitting in the 2 [NAME] bathroom area. I asked her if she was okay. She responded yes. After I used the bathroom, I asked again if she needed anything. I informed the nurse there was a resident sitting in the 2 [NAME] bathroom area. Review of facility provided timeline indicated the following on 12/15/24: (information on timeline was received post event from CCTV.) -12:56 p.m. Resident R111 walks past agency staff member on 2 East nursing station. -12:57 p.m. Resident R111 walks past security guard and dietary worker at the entrance of 2 East and proceeded to the 2 East dining hall. -12:58 p.m. Resident R111 exits dining hall and heads towards 2 West. -1:00 p.m. Resident R111 goes past orange cones on 2 [NAME] in front of nurses station toward the low hall and goes behind the nurses station entering the employee lounge. Interview on 4/9/25, at 9:44 a.m. the Director of Nursing confirmed that the facility failed to make certain each resident received adequate supervision and person-centered care plan interventions that resulted in an elopement for Residents R6 and R111. The Director of Nursing and the Nursing Home Administrator were made aware that an Immediate Jeopardy situation existed for residents on 4/9/25, at 11:05 a.m. and an immediate action plan was requested. On 4/9/25, at 11:05 a.m. the Immediate Jeopardy template was provided to the facility administration. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Immediate Jeopardy was lifted on 4/10/25, at 1:28 p.m. and the abatement plan was verified as follows: Both residents have been re-assessed, updated care plans, and physician orders for wandering with patient centered interventions added. 116 of 116 total residents were re-assessed, updated care plans, and physician orders for wandering with patient centered interventions as appropriate. 24 hours of every one-hour safety checks completed on all residents. Photo wander books located and verified 3 west, 3 east, 2 east, Security desk. 26 [NAME] staff are off and will receive education prior to the next shift worked. Total staff of facility is 108 the remaining 15 staff will be educated prior to the next shift worked. 55 agency staff have been trained and 93 regular staff have received education. 44 in person interviews verified education received 4/10/25, at 12:26 p.m. Addendum For [NAME] Ross Facility added to the policy and procedure for Wanderguard and Elopement for the [NAME] Community Living Centers. Next QAPI meeting will be held April 29, 2025. Exit interview on 4/11/25, at 2:30 p.m. information was disseminated to the Director of Nursing and Nursing Home Administrator that the facility failed to make certain each resident received adequate supervision and person-centered care plan interventions that resulted in an elopement for two residents. This failure created an immediate jeopardy situation for two of 21 residents who were identified as at risk for elopement (Residents R6, and R111). 28 Pa. Code: 201.14(a) Responsibility of Licensee. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12 (d)(5) Nursing Services.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on review of facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that residents with an enteral feeding tube (a tube inserted in the stomach through the abdomen) received appropriate treatment and services to prevent potential complications for three of four residents (Residents R35, R91, and R368). Findings include: Review of the facility policy Feeding: Feeding Tubes, dated 1/2/25, indicated that feeding and flush bags are labeled with the resident's name, date, time, and direction. The nurse confirms placement - G tubes - aspirate gastric contents using a 60 cc (cubic centimeter) piston syringe. Review of the facility policy Medication Administration through Gastrostomy Tube dated 1/2/25, indicated nurse pinches off the G tube by kinking and attaches the barrel of the piston syringe to tube. Checks for placement of the tube by following facility policy. Pours 30 milliliters of water into the syringe barrel to flush tube. Review of the clinical record indicated Resident R35 was admitted to the facility on [DATE]. Review of Resident R35's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/17/25, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). MDS Section K0520-Feeding tube was checked indicating resident received while a resident. Review of current physician orders indicated that Resident R35 was to receive Fiber source HN (a type of liquid feeding that will supply a person with nutrition) to be administered at 60 milliliters an hour for 21 hours per day. During an observation on 4/7/25, at 10:10 a.m. Resident R35's enteral feeding bag was observed to be infusing, however was dated for 4/5/25, and did not include the name of the ordered formula to ensure that the resident was receiving the correct formula. The water bag used for flushes failed to have a current date. During an interview on 4/7/25, at 10:13 a.m. Registered Nurse (RN) Employee stated that the enteral feeding and bags should be changed daily. During an interview on 4/7/25, at 10:22 a.m. RN Employee E6 confirmed that the facility failed to label Resident R35's enteral feeding, and that the formula and bags were outdated. Review of the admission record indicated Resident R91 admitted to the facility on [DATE]. Review of Resident R91's MDS dated [DATE], indicated the diagnoses of stroke (damage to the brain from an interruption of blood supply), difficulty swallowing, and high blood pressure. (continued on next page)

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	395606	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R91's current care plan indicated check placement and patency of feeding tube before flushes and medication administration. During observation of medication administration on 4/9/25, at 11:30 a.m. Licensed Practical Nurse (LPN) Employee E21 failed to check placement of Resident R91's G tube prior to administering his medication as required. Interview on 4/9/25, at 2:00 p.m. the Director of Nursing confirmed LPN Employee E21 failed to check Resident R91's G tube for placement prior to administering medications as required. Review of the clinical record indicated Resident R368 was admitted to the facility on [DATE], with diagnoses of Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior), difficulty swallowing, and muscle weakness. Review of current physician order indicated that Resident R368 was to receive Isosource 1.5 (a type of liquid feeding that will supply a person with nutrition) to be administered at 55 milliliters for 21 hours per day. During an observation on 4/7/25, at 10:36 a.m. Resident R368's enteral feeding bag was observed to be infusing, however it was not labeled to ensure that resident was receiving the ordered formula of Isosource 1. 5 at the prescribed rate. During an interview on 4/7/25, at 10:41 a.m. RN Employee E6 confirmed that the facility failed to label Resident R368's enteral feeding. During an interview on 4/11/25, at 2:30 p.m. the Director of Nursing confirmed the facility failed to ensure that residents with an enteral feeding tube received appropriate treatment and services to prevent potential complications for three of four residents (Residents R35, R91, and R368). 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, observations, staff interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care for three of seven residents (Residents R5, R102, and R368). Findings include: Review of facility policy Oxygen Guidelines dated 1/2/25, indicated oxygen is a medication and must be ordered by a practitioner. Set-ups (cannulas, face masks, respiratory delivery, humidification bottles) should be changed every 7 days and are labeled with date of change initialed by staff. Set-ups are stored in plastic bag when not in use to avoid contamination. Replace if contamination occurs. Review of Resident R5's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/27/25, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and muscle weakness. Review of a physician order dated 2/26/25, indicated to administer O2 (oxygen) at 2L via NC (two liters per minute via nasal cannula - a lightweight tube that delivers oxygen into the nostrils) - check pulse ox qs (check blood oxygen level every shift) begin to wean resident from O2, maintain O2 saturation above 92%. During an observation on 4/7/25, at 10:16 a.m. Resident R5 was observed receiving oxygen at 3 liters per minute via nasal cannula. The humidification bottle was observed to be empty. During an interview on 4/7/25, at 11:08 a.m. Registered Nurse (RN) Employee E1 confirmed Resident R5 was not receiving oxygen at the rate ordered by the physician and that the humidification bottle was empty. During this interview, RN Employee E1 confirmed that the facility failed to provide appropriate respiratory care for Resident R5. Review of the admission record indicated Resident R102 admitted to the facility on [DATE]. Review of Resident R102' MDS dated [DATE], indicated the diagnoses of chronic obstructive pulmonary disease (COPD - a group of diseases that block airflow and make it hard to breathe), anemia (the blood doesn't have enough healthy red blood cells), and obstructive sleep apnea (a chronic condition in which the throat muscles relax during sleep and the airway may become partially or fully blocked). Review of Resident R102's physician order dated 3/10/25, indicated to apply BiPAP (a positive airway pressure machine when breathing in and breathing out) at 10:00 p.m. settings programmed into machine, at bedtime. Review of Resident R102's care plan dated 3/10/25, indicated apply BiPAP at night. Observation on 4/8/25, at 11:00 a.m. Resident R102 was in bed with his BiPAP mask sitting on the top of his bed, not in a bag as required. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 4/8/25, at 11:02 a.m. with Licensed Practical Nurse (LPN) Employee E21 confirmed the BiPAP mask was not bagged as required. Observation on 4/10/25, at 9:00 a.m. Resident R102 was in bed with his BiPAP mask sitting on the top of his bed, not in a bag as required. Observation and interview on 4/10/25, at 9:05 a.m. LPN Employee E 18 confirmed the BiPAP mask was not bagged as required. Review of the clinical record indicated Resident R368 was admitted to the facility on [DATE], with diagnoses of Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior), difficulty swallowing, and muscle weakness. Review of Resident R368's clinical record revealed an order to receive two liters of oxygen via nasal cannula as needed to keep oxygen saturations greater than 92%. During an observation on 4/7/25, at 10:36 a.m. Resident R368 was observed receiving oxygen via nasal cannula. The nasal cannula was observed to have not been dated. During an interview on 4/7/25, at 10:41 a.m. Registered Nurse Employee E6 confirmed that the facility failed to date Resident R368's nasal cannula. Interview on 4/11/25, at 2:30 p.m. the Director of Nursing confirmed the facility failed to provide appropriate respiratory care for three of seven residents (Residents R5, R102, and R368). 28 Pa. Code: 201.14(a) Responsibility of licensee. 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075 Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to properly store medical supplies in one of three medication carts (Three East Med Cart), and one of three medication rooms (Three [NAME] medication room). Findings: Review of facility Medication Administration General Guidelines policy dated [DATE], indicated that facility will safely administer medications to residents as prescribed by the practitioner and in accordance with current standards of practice and regulatory requirements. The purpose is to provide direction to the licensed staff in the safe and effective administration of medication, including the storing and handling of medication. Check manufactures or pharmacy expiration dates, documentation of date open. During a medication cart review on [DATE], at 11:37 a.m. the following were observed: - Insulin Glargine Pen (used to treat diabetes - a metabolic disorder in which the body has high sugar levels for prolonged periods of time) failed to have an open date or expiration date on it. - Tresiba Insulin Pen (used to treat diabetes) failed to have an open date or expiration date on it. - Humalog Insulin Vial (used to treat diabetes) expired [DATE]. - Humalog Insulin Pen (used to treat diabetes) failed to have an open date or expiration date on it. During an interview on [DATE], at 11:48 a.m. Licensed Practical Nurse (LPN) Employee E10 confirmed that there were expired and undated insulin pens and vial on the mediation cart. During a medication room observation on [DATE], at 11:39 a.m. of the Three [NAME] unit with LPN Employee E18, revealed a tuberculin (a protein extract used to diagnose tuberculosis) multi-dose vial dated [DATE]. Interview on [DATE], at 11:39 a.m. LPN Employee E18 verified the multi-dose vial was past the 28 days permissible after opening. During an interview on [DATE], at 3:00 p.m. the Director of Nursing confirmed that the facility failed to properly store medical supplies in one of three medication carts (Three East Med Cart) and one of three medication rooms (Three [NAME] medication room). 28 Pa Code: 211.9 (a)(1) Pharmacy services. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa code: 211.12 (d)(1)(5) Nursing 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. 46167 Based on a review of facility policies, observations and staff interviews it was determined that the facility failed to properly store, label. and date food and failed to monitor expiration dates of food products in the Main Kitchen which created the potential for food borne illness. Findings Include: Review of the facility policy Storing: Food and Equipment last reviewed 1/2/25, indicated that team members must store food in a manner that ensures quality, freshness, and safeguards against foodborne illness. All team members must follow food and temperature guidelines, labeling, use-by-dates, food storage chart, freezing, and leftover guidelines to ensure food and equipment criteria are met. Label food with name of product, date by which product should be used, and date thawed or frozen if applicable. Food should be discarded or used by the use-by-date. During an observation in the Main Kitchen Walk-in Cooler number one, on 4/7/25, at 9:35 a.m. the following was noted: An opened bag of French fries, was not sealed, labeled, or dated. A plastic bag containing bologna was marked with a use-by-date of 3/31/25. A plastic bag of pepperoni was marked with a use-by-date of 3/16/25. A plastic bag of turkey was marked with a use-by-date of 3/31/25. A container of pureed egg salad was marked with a use-by-date of 4/6/25. During an interview completed on 4/7/25, at 9:54 a.m. Food Service Director Employee E25 confirmed the above observations, and that the facility failed to properly store, label, and date food, and failed to monitor expiration dates of food products in the Main Kitchen which created the potential for food borne illness. 28 Pa. Code: 201.14(a)Responsibility of licensee. 28 Pa. Code: 201.18(b)(1) Management.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 46336 Based on review of job descriptions, clinical records, and staff interviews, it was determined that the Nursing Home Administrator and Director of Nursing did not effectively manage the facility to make certain that necessary care and services were provided to residents requiring adequate supervision to prevent elopement. Findings include: Review of CFR S483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on the findings in this report that identified the facility failed to maintain necessary supervision and person-centered care plan interventions that resulted in an elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) for two residents. This failure created an immediate jeopardy situation for two of 21 residents who were identified as at risk for elopement (Residents R6, and R111). Facility failed to provide fundamental principal that applies to treatment and care provided to facility residents. The facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, facility policies, physician orders, and the comprehensive person-centered policy. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on the review of clinical records, and staff interviews, it was determined that the facility failed to maintain and complete accurate, and appropriate documentation for two of eight residents (Resident R20, and R41). Findings include: Review of Title 42 Code of Federal Regulations (CFR) S483.709(i) Medical records. In accordance with accepted professional standards and practice, the facility must maintain medical records that are complete, accurately documented, readily accessible, and systematically organized. Review of the clinical record indicated Resident R20 was admitted to the facility on [DATE]. Review of Resident R20's Minimum Data Set (MDS) (assessment of a resident's abilities and care needs) dated 2/23/25, indicated diagnoses of high blood pressure, cerebrovascular accident (when blood flow to the brain is disrupted), and muscle weakness. Review of Facility Wound Summary Report provided on 4/7/25, Indicated that Resident R20 had a Stage three pressure injury (an ulcer that has burrowed past the second layer of the skin and reached fat layers beneath) to her coccyx (a small triangular bone at the bottom of the spine), and an unstageable pressure injury (an ulcer that has full thickness tissue loss but is either covered by extensive necrotic tissue or a scab) to her left ankle. Review of Resident R20's clinical record revealed a Nutrition progress note dated 2/19/25, that stated Presents with Gr X area. Review of Resident R20's clinical record revealed a Nutrition progress note dated 2/28/25, that stated Recommend supplement two times per day bmf. Review of Resident R20's clinical record revealed a Nutrition progress note dated 4/8/25, that stated Gr 3 to coccyx. Review of the clinical record indicated Resident R41 was admitted to the facility on [DATE]. Review of Resident R41's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and difficulty swallowing. Review of Facility Wound Summary Report provided on 4/7/25, Indicated that Resident R41 had a Stage two pressure injury (an ulcer with partial thickness loss of skin presenting as a shallow open injury with a red/pink wound bed or an intact or open/ruptured serum filled blister) to her coccyx, and an unstageable pressure injury (an ulcer that has full thickness tissue loss but is either covered by extensive necrotic tissue or a scab) to her left coccyx. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R241s clinical record revealed a Nutrition progress note dated 3/14/25, that stated Continues with area to left coccyx now Gr2. During an interview on 4/11/25, at 11:17 a.m. Registered Dietitian (RD) Employee E11, stated that she uses the term Gr X to define an unstageable pressure injury, the term bmf to define between meal feedings, Gr 3 to define stage three pressure injury, and Gr 2 to define a stage two pressure injury. During an interview on 4/11/25, at 2:12 p.m. Assistant Director of Nursing Employee E28 confirmed that the above terminology is not recognized, or considered to meet acceptable standards of practice, and that the facility failed to use appropriate medical terminology in the medical record for Resident R20, and R41. 28 Pa. Code: 201.14(a)Responsibility of licensee.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to follow enhanced barrier precautions for one of four residents (Residents R91). Findings include: Review of the facility policy Precautions: Enhanced Barrier Precautions (EBP) dated 1/2/25, indicated EBP is an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Residents with EBP are indicated, use with the following high-contact resident care activities: Device care or use: central line, urinary catheter, feeding tube, and tracheostomy/ventilator care. Review of the admission record indicated Resident R91 admitted to the facility on [DATE]. Review of Resident R91's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/14/25, indicated the diagnoses of stroke (damage to the brain from an interruption of blood supply), difficulty swallowing, and high blood pressure. Review of Resident R91's physician order 2/24/25, indicated EBP for G tube (a tube inserted in the stomach through the abdomen). Review of Resident R91's care plan dated 3/20/25, indicated EBP for G tube. Observation of Resident R91's doorway on 4/9/25, at 11:29 a.m. indicated enhanced barrier precautions. During observation of medication administration on 4/9/25, at 11:30 a.m. Licensed Practical Nurse (LPN) Employee E21 failed to wear a gown while administering medication through Resident R91's G tube as required. Interview on 4/9/25, at 2:00 p.m. the Director of Nursing confirmed the facility failed to follow enhanced barrier precautions for one of four residents (Residents R91). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12 (d)(1)(5) Nursing services.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on observations, review of facility documentation, and staff interviews, it was determined that the facility failed to make certain that equipment was in safe operating condition for two of four crash carts and three of six Automated External Defibrillators (AED - a portable, electronic device designed to diagnose and treat life-threatening cardiac arrhythmias). Findings include: Review of facility policy Cardiopulmonary Resuscitation and Automated External Defibrillator: Basic Life Support dated [DATE], indicated the response team leader assures that staff members perform cardiopulmonary resuscitation (CPR-an emergency treatment that is done when someone's breathing or heartbeat has stopped) and utilizes the AED appropriately. The Material Manager Security assures that there is an adequate supply of disposable electrodes available. During an observation of the 2 East crash cart (a cart maintained with equipment used in cardiac emergencies) on [DATE], at 11:33 a.m. revealed a binder on the crash cart containing a Emergency Cart Log for [DATE]. Review of the check list sheet documentation failed to reveal that the cart was checked on [DATE], and [DATE]. Documentation also failed to reveal that the 2 East AED had been tested and operational on [DATE], and [DATE]. During an observation of the 2 [NAME] crash cart on [DATE], at 11:46 a.m. revealed a binder on the crash cart containing a blank Emergency Cart Log. Review of the binder failed to reveal any documentation that the crash cart had been checked and that the 2 [NAME] AED had been tested and operational in [DATE]. During an interview on [DATE], at 2:03 p.m. the Director of Nursing confirmed that the facility failed to make certain that equipment was in safe operating condition for two of four crash carts as required. During an observation of the Three East AED box on [DATE], at 12:45 p.m. revealed an AED with electrodes attached to the machine were present. An extra set of electrodes were in the AED box, however, were expired. The expiration date on the electrodes were dated [DATE]. During an interview on [DATE], at 1:30 p.m. the Nursing Home Administrator (NHA) stated that the county safety officer comes to the facility to service the AED's once a year. During an interview on [DATE], at 1:57 p.m. the NHA confirmed that the AED electrodes were expired, and that the facility failed to make certain that equipment was in safe operating condition for three of six AEDs. 28 Pa Code: 201.14(a) Responsibility of licensee.

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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 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on review of facility documents, and staff interview, it was determined that the facility failed to provide training on Quality Assurance and Performance Improvement (QAPI) for two of eight staff members (Employee E12, and E13). Findings include: Review of the Facility assessment dated [DATE], indicated that all personnel, including manager, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care. During an interview on 4/9/25, at 1:19 p.m. Assistant Director of Nursing (ADON) Employee E14 stated that education is conducted by calendar year running January through December. Review of facility education documents for the year 2024 revealed the following concerns: Review of Registered Nurse (RN) Employee E12's facility provided information did not include training on QAPI education. Review of RN Employee E13's facility provided information did not include training on QAPI education. During an interview on 4/11/25, at 10:05 a.m. the ADON confirmed that the facility failed to provide training on QAPI for two of eight 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) Staff development.