STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395607	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shippenville Nursing and Rehab	21158 Paint Boulevard Shippenville, PA 16254

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 48496 Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to maintain a clean and sanitary resident common area for one of four resident units (Alzheimer's Care Unit). Findings include: Review of facility policy entitled Quality of Life - Homelike Environment dated 2/18/25, indicated The facility staff and management shall maximize .the characteristics of the facility that reflect . homelike setting. Clean, sanitary and orderly environment. Observations on 2/29/25, at 10:00 a.m. of the Alzheimer's Care Unit (ACU) revealed three sitting chairs and a couch in the common area. The chairs and couch cushions had several areas of a brown substance which appeared to be stains caused from moisture. The arms of the furniture had rips in the fabric and the stuffing was coming out. On the wall in the common area was a box with television cable attached to it, the box was pulling off of the wall. Observations of a resident room revealed a curtain covering a window with the fabric on the back of the curtain ripped and hanging down. Observations of a wall in a resident room revealed below the window there were gouges in the wall. During an interview with the Nursing Home Administrator on 2/19/25, at 10:55 a.m. he/she confirmed that the furniture in the common area in the ACU had stains on the cushions and tears in the fabric, the cable box was not attached to the wall, the curtain in the resident room was ripped and the wall was in need of repair. He/she also confirmed that the furniture should be clean/without tears, the cable box should be connected to the wall, and the curtains and wall should be in good repair. 28 Pa. Code 201.14 (a) Responsibility of Licensee

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47356 Based on review of the Pennsylvania Code Title 49. Professional and Vocational Standards, facility job descriptions, clinical records, facility documents, and staff interviews, it was determined that the facility failed to follow nursing standards of practice to ensure medications are obtained from pharmacy in a timely manner for one of 12 residents reviewed (Resident R1). Findings include: Review of Pennsylvania Code Title 49. Professional and Vocational Standards 21.145. Functions of the Licensed Practical Nurse (LPN), (a) The LPN is prepared to function as a member of the health-care team by exercising sound nursing judgment based on preparation, knowledge, experience in nursing and competency. The LPN participates in the planning, implementation and evaluation of nursing care using focused assessment in settings where nursing takes place and 21.11. General functions of the Registered Nurse (RN) (a)(4) stated, Carries out nursing care actions which promote, maintain and restore the well-being of individuals and (b) The RN is fully responsible for all actions as a licensed nurse and is accountable to clients for the quality of care delivered and (d) The Board recognizes standards of practice and professional codes of behavior, as developed by appropriate nursing associations, as the criteria for assuring safe and effective practice. Review of facility job descriptions for LPNs and RNs revealed both are expected to utilize nursing knowledge and skills in the safe implementation of basic preventative therapeutic and rehabilitative nursing care of assigned resident as evidenced by documentation and observation of positive resident care outcomes, perform delegated nursing functions using established procedures, policies, guidelines and standards as observed by the registered nurse, and administer treatments, medications, and diets accurately. Review of Resident R1's clinical record revealed an admitted [DATE], with diagnoses that included dementia (a group of thinking and social issues that interfere with daily living), parkinsonism (a central nervous system disorder that affects movements), and anxiety. Resident R1's clinical record progress notes documented that on 11/04/2024, Resident R1 was tired and had a fever. He/she was tested for COVID, with positive results. At that time, the physician was contacted, and an order was received to give Paxlovid (300/100) (an antiviral medication used to treat mild to moderate COVID) oral tablet therapy give two tablets by mouth two times a day for COVID starting on 11/05/2024, for five days. Review of facility documents from pharmacy dated 11/1/2024, through 11/7/2024, revealed that the Paxlovid was never received from the pharmacy for Resident R1. Review of additional facility documents revealed six LPNs, and one RN failed to ensure the pharmacy was faxed the original order for the Paxlovid and failed to follow-up with the pharmacy once realizing the Paxlovid was ordered in the medication administration record for Resident R1 but was not available for several days. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/19/2025, at approximately 1:00 p.m. the Director of Nursing and the Regional Director of Clinical Operations confirmed that the Paxlovid ordered for Resident R1 was never received from the pharmacy, due to nursing staff's failure to fax the original order to the pharmacy and nursing staffs' failure to follow-up with the pharmacy regarding the status of the medication delivery. 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** 47356 Based on review of clinical records, facility documents, and staff interview, it was determined that the facility failed to follow physician's orders related to a medication order resulting in a delay in treatment for one of 12 residents reviewed (Resident R1). Findings include: Review of Resident R1's clinical record revealed an admitted [DATE], with diagnoses that included dementia (a group of thinking and social issues that interfere with daily living), parkinsonism (a central nervous system disorder that affects movements), and anxiety. Resident R1's clinical record progress notes documented that on 11/04/2024, Resident R1 was tired and had a fever. He/she was tested for COVID, with positive results. At that time, the physician was contacted, and an order was received to give Paxlovid (300/100) (an antiviral medication used to treat mild to moderate COVID) oral tablet therapy give two tablets by mouth two times a day for COVID starting on 11/05/2024, for five days. Review of facility documents from pharmacy dated 11/1/2024, through 11/7/2024, revealed that the Paxlovid was never received from pharmacy for Resident R1, therefore not administered during that time. During an interview on 2/19/2025, at approximately 1:00 p.m. the Director of Nursing and the Regional Director of Clinical Operations confirmed that the Paxlovid was never delivered from the pharmacy, causing a delay in treatment for Resident R1. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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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** 47356 Based on review of facility policies, clinical records, facility documents, and staff interviews, it was determined that the facility failed to maintain complete and accurate clinical records for one of 12 residents reviewed (Resident R1). Findings include: Review of facility policy entitled, Administering Medications dated 2/18/2025, revealed The individual administering the medication initials the resident's medication administration record (MAR) on the appropriate line after giving each medication and before administering the next ones. Review of the facility policy entitled, Change in a Resident's Condition or Status dated 2/18/2025, revealed The nurse will notify the resident's attending physician on call when there has been a need to transfer the resident to a hospital/treatment center . Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: it is necessary to transfer the resident to a hospital/treatment center .The nurse will record in the resident's medical record information relative to the changes in the resident's medical/mental condition or status. Review of the facility policy entitled Charting and Documentation dated 2/18/2025, revealed The following information is to be documented in the resident medical record: a. Objective observations; b. Medications administered; c. Treatments or services performed; d. Changes in the resident's condition; e. Events, incidents or accidents involving the resident . Review of Resident R1's clinical record revealed an admitted [DATE], with diagnoses that included dementia (a group of thinking and social issues that interfere with daily living), parkinsonism (a central nervous system disorder that affects movements), and anxiety. Resident R1's clinical record progress notes documented that on 11/04/2024, Resident R1 was tired and had a fever. He/she was tested for COVID, with positive results. At that time, the physician was contacted, and an order was received to give Paxlovid (300/100) (an antiviral medication used to treat mild to moderate COVID) oral tablet therapy give two tablets by mouth two times a day for COVID starting on 11/05/2024, for five days. Resident R1's MAR revealed that Resident R1 received his/her Paxlovid on 11/6/2024, at 8:00 p.m. , and on 11/8/2024, at 8:00 p.m. Review of facility documents from pharmacy dated 11/1/2024, through 11/7/2024, revealed that the Paxlovid was never received from pharmacy for Resident R1, therefore the documentation in the MAR was inaccurate. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident R1's clinical record progress notes documented that on 11/08/2024, he/she was Out at ER [emergency room]. There was no documented evidence in Resident R1's clinical record regarding Resident R1's change in condition and/or assessment that resulted in him/her being transferred to the ER. Additionally, Resident R1's clinical record lacked evidence that the physician, resident representative, emergency transport, and receiving emergency department were contacted regarding Resident R1's change in condition. During an interview on 2/19/2025, at approximately 1:00 p.m. the Director of Nursing and the Regional Director of Clinical Operations confirmed that the Paxlovid was never received from the pharmacy, therefore the documentation on the MAR for Resident R1 was inaccurate and that clinical record lacked evidence that Resident R1's change in condition and/or assessment that resulted in him/her being transferred to the ER and that the physician, resident representative, emergency transport, and receiving emergency department were contacted regarding Resident R1's change in condition was documented in the clinical record. 28 Pa. Code 211.5(f)(xiii)(ix) Medical Records 28 Pa. Code 211.12(d)(1)(5) Nursing Services