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	06/13/2025

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

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of facility policy, facility documents, and resident and staff interviews, it was determined that the facility failed to correct Resident Council concerns for a period of six months (January 2025 through June 2025). Findings: Review of facility policy, Resident Council, dated 2/18/25, indicated A Resident Council Response Form will be utilized to track issues and their resolution. The facility department related to any issues will be responsible for addressing the item(s) of concern. The Quality Assurance and Performance Improvement (QAPI) Committee will review information and feedback from Resident Council as part of their quality review. Issues documented on council response forms may be referred to the QAPI Committee, if applicable (i.e., the issue is of serious nature or if there is a pattern, etc.). Review of the Resident Council minutes and Grievances over the past six months, January 2025 through June 2025, revealed a pattern/trend with issues regarding residents not receiving ice water. During a Resident Council meeting on 6/11/25, at 10:30 a.m. interviews with alert and oriented Residents R3, R7, R21, R76, and R77, who all attend Resident Council meetings regularly, indicated that concerns of not receiving fresh ice water have not improved. Resident R77 indicated he/she only receives it if a family member is visiting and gets it for him/her. An interview with the Director of Nursing on 6/12/25, at approximately 12:30 p.m. confirmed that the facility had not corrected the Resident Council concerns regarding residents not receiving ice water from the January 2025, February 2025, March 2025, April 2025, May 2025, and June 2025 Resident Council meetings. No evidence was provided to ensure the residents' concerns verbalized and further stated in the Resident Council minutes for the past six months reviewed was noted of timely corrective actions. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (e)(1)(4) Management 28 Pa. Code 201.29(a) Resident rights

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to assure physician orders and resident's Pennsylvania Order for Life Sustaining Treatment (POLST- a legal document specifying the resident/responsible party choices regarding life-sustaining treatments) were consistent for two of 22 residents reviewed (Residents R46 and R60). Findings include: Review of facility policy entitled Advance Directives dated [DATE], revealed Upon admission, the resident will be provided with written information concerning the right to refuse or accept . and to formulate an advance directive ., Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. And The Director of Nursing Services . of advance directives so that appropriate orders can be documented in the resident's medical record . Review of Resident R46's clinical record revealed an admission date of [DATE], with diagnoses that included diabetes (a health condition that caused by the body's inability to produce enough insulin), dementia (a disease that affects short term memory and the ability to think logically), and chronic obstructive pulmonary disease (a disease that obstructs air flow from the lungs). Review of Resident R46's paper clinical record revealed a POLST dated [DATE], signed by the physician for Cardiopulmonary Resuscitation (CPR-emergency life-saving procedure that is done when breathing or a heartbeat has stopped and when performed immediately can double or triple chances of survival after cardiac arrest)- Full Code. Review of physician's orders revealed an order dated [DATE], for Do Not Attempt Resuscitation (DNR- allow natural death). Further review of Resident R46's clinical record revealed a second POLST dated [DATE], with no evidence of the resident and/or resident representatives' signature for Do Not Attempt Resuscitation (DNR- allow natural death). Review of Resident R60's clinical record revealed an admission date of [DATE], with diagnoses that included hypertension (high blood pressure), hyperlipidemia (high cholesterol), and hypothyroidism (a condition when the thyroid produces low amounts of thyroid hormones). Review of Resident R60's clinical record revealed an incomplete POLST dated [DATE], part A of the POLST was not filled out to indicate Resident R60's wishes of a Full Code or DNR. During an interview on [DATE], at 10:40 a.m. Licensed Practical Nurses Employees E8 and E9 revealed that during an emergent situation the staff refer to resident's paper chart to determine resident Life Sustaining wishes. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE], at 10:50 a.m. the Director of Nursing (DON) confirmed that Resident R46's POLST in the paper chart was for Full Code and Resident R46's electronic clinical record POLST was for DNR and lacked the resident and/or resident representatives' signature. He/she confirmed that Resident R60's POLST was incomplete and did not identify Resident R60's wishes of a Full Code or DNR. He/she also confirmed that a resident's advance directive should match in both paper and electronic records and advance directive should be complete indicating the resident and/or resident representative wishes. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.5(f)(i)(vii) Medical records 28 Pa. Code 211.10(c) Resident care policies

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of facility policy, clinical records and staff interview it was determined that the facility failed to provide the resident and/or resident representative with a written notice of the facility bed-hold policy (explanation of how long a bed can be held during a leave of absence and the cost per day) and failed to make certain that the necessary resident information was communicated to the receiving health care provider for one of four residents reviewed (Resident R46). Findings include: Review of facility policy entitled Transfer and Discharge (including AMA[against medical advice]) dated 2/18/25, revealed For a transfer to another provider, for any reason, the following information must be provided to the receiving provider: a. Contact information of the practitioner who is responsible for the care of the resident; b. Resident representative information, including contact information; c. Advance directive information; . and Provide a notice of transfer and the facility's bed hold notice policy to the resident and representative . Review of Resident R46's clinical record revealed an admission date of 11/3/22, with diagnoses that included diabetes (a health condition that caused by the body's inability to produce enough insulin), dementia (a disease that affects short term memory and the ability to think logically), and chronic obstructive pulmonary disease (a disease that obstructs air flow from the lungs). Review of Resident R46's clinical record revealed a progress note dated 4/8/25, at 4:55 p.m. identifying a transfer to the hospital. The clinical record lacked evidence that Resident R46's necessary clinical information was communicated to the receiving health care provider. Resident R46's clinical record also lacked evidence indicating that Resident R46 and/or their representative was provided with a copy of the facility bed-hold policy upon transfer. During an interview on 6/12/25, at 12:30 p.m. the Regional Nurse Consultant confirmed that there was no evidence that Resident R4 and/or their representative was provided with a copy of the facility bed-hold policy that included the cost per day; confirmed that there was no evidence that the necessary clinical information was provided to the receiving healthcare provider upon transfer; and also confirmed when the transfers occurred the resident and/or their representative should have been provided with bed hold policy and clinical information should be provided to the receiving healthcare provider upon transfer. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(c.3) (2) Resident rights

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide a written summary of the baseline care plan and order summary to the resident and/or representative for three of 26 residents reviewed (Residents R15, R51 and R89). Findings include: A facility policy entitled Care Plans-Baseline dated 2/18/25, revealed The resident and their representative will be provided a summary of the baseline care plan that includes but is not limited to: a. The initial goals of the resident; b. A summary of the resident's medications and dietary instructions; c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and d. Any updated information based on the details of the comprehensive care plan, as necessary. Resident R15's clinical record revealed an admission date of 4/18/25, with diagnoses that included sacrococcygeal disorders (a range of conditions affecting the sacrum and coccyx [triangular bone and tailbone at the base of the spine], including pain, tumors, and structural abnormalities), end stage renal disease (a condition where the kidneys cannot remove waste and balance fluids), hemiplegia and hemiparesis following cerebral infarction (paralysis, muscle weakness affecting one side of the body after a stroke), and diabetes mellitus (a condition when your blood sugar is too high). R15's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R15 and/or his/her representative. Resident R51's clinical record revealed an admission date of 3/20/25, with diagnoses that included dementia (thinking and social symptoms that interfere with daily living), atrial fibrillation (irregular heartbeat), and weakness. R51's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R51 and/or his/her representative. Resident R89's clinical record revealed an admission date of 9/04/24, with diagnoses that included dementia, orthostatic hypotension (blood pressure drops upon sitting up or standing up from lying down), and fracture of the nasal bones. R89's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R89 and/or his/her representative. During an interview on 6/12/25, at approximately 11:35 p.m. the Regional Clinical Consultant confirmed there was no evidence that a written summary of the baseline care plan and order summary were provided to Resident R15, Resident R51, or Resident R89 and/or their representative. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.10(c) Resident care plan 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing Services

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to ensure that a resident with limited range of motion received physician ordered treatment and services to prevent further decrease in range of motion for one of three residents reviewed (Resident R5). Findings include: Review of facility policy entitled Resident Mobility and Range of Motion dated 2/18/25, indicated Residents with limited range of motion (ROM) will receive treatment and services to increase and/or prevent a further decrease in ROM. And Residents with limited mobility will receive appropriate services, equipment . to maintain or improve mobility . Review of Resident R5's clinical record revealed an admission date of 2/4/25, with diagnoses that included hemiplegia and hemiparesis (a condition where a person is paralyzed and unable to move one side of their body and muscle weakness), hypertension (high blood pressure), and sleep apnea (a condition when a person repeatedly stops and starts breathing when they are sleeping). Review of Resident R5's clinical record revealed a physician order for LAFO (a device to support the left lower leg and foot) to be donned (put on) in AM and doffed (taken off) with PM care, skin checked prior to and after donn/doff AFO dated 5/19/25. Review of Resident R5's plan of care for ADL (activities of daily living) self-care deficit related to impaired mobility revealed an intervention for LAFO to be donned on AM care and doffed with PM care with an initiated date of 5/19/25. Review of Resident R5's clinical record revealed documentation lacked evidence that LAFO was applied as ordered. Observations on 6/10/25, at 3:00 p.m. and again at 3:40 p.m. revealed Resident R5 sitting in his/her wheelchair with no LAFO to their left foot/leg. Observations on 6/11/25, at 9:15 a.m., 10:30 a.m., 12:30 p.m., and again at 1:30 p.m. revealed Resident R5 sitting in his/her wheelchair with no LAFO to their left foot/leg. Observations on 6/12/25, at 9:00 a.m., 11:10 a.m., and again at 12:50 p.m. revealed Resident R5 sitting in his/her wheelchair with no LAFO to their left foot/leg. During an interview on 6/12/25, at 12:50 p.m. the Regional Nurse Consultant confirmed that Resident R5 did not have a LAFO on his/her left foot/leg per physician's orders and also confirmed that Resident R5 should have his/her LAFO on their left foot/leg per physician's orders. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 211.10 (d) Resident care policies (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to provide oxygen according to physician's orders for one of one residents reviewed for respiratory services (Resident R18). Findings include: Review of facility policy entitled Oxygen Administration dated 2/18/25, revealed Verify that there is a physician's order for this procedure. Review the physician's orders . Turn on oxygen. Unless otherwise ordered, start the flow of oxygen at . and adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. Review of Resident R18's clinical record revealed an admission date of 11/7/20, with diagnoses that included chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), diabetes (a health condition that caused by the body's inability to produce enough insulin), and hypertension (high blood pressure). Review of Resident R18's physician's orders revealed an order dated 6/18/22, for oxygen at 2 liters/minute (LPM)via NC (nasal cannula-a thin tube with two prongs that fit into the resident's nostrils to deliver oxygen) every shift for shortness of breath. Observations on 6/10/25, at 1:25 p.m. revealed Resident R18 was sitting in their room with supplemental oxygen in place and oxygen concentrator liter flow set at 2 LPM. Activities Assistant Employee E10 removed Resident R18's nasal cannula at the time of observation and assisted the resident to an activity without re-applying oxygen. Resident R18 returned to their room at 2:30 p.m. During an interview on 6/10/25, at 2:40 p.m. Activities Assistant Employee E10 confirmed that Resident E18 went to and activity and did not have oxygen on until he/she returned to their room. During an interview on 6/10/25, at 2:47 p.m. Licensed Practical Nurse Employee E3 confirmed that Resident R18 should have his/her oxygen on at all times. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility policies and facility documents, observations, resident and staff interviews, it was determined that the facility failed to provide sufficient nursing staff and services to promote the physical and mental well-being and meet the needs for 10 of 26 residents interviewed (Residents R3, R7, R21, R27, R42, R60, R76, R77, R93, and R199). Findings include: Review of facility policy entitled, Answering the Call Light dated 2/18/25, revealed If the resident's request is something you can fulfill, complete the task within five minutes if possible. Review of facility policy entitled Resident Showers dated 2/18/25, revealed Residents will be provided showers as per request or as facility schedule protocols . Review of facility policy entitled Activities of Daily Living (ADLs), Supporting dated 2/18/25, revealed Appropriate care and services will be provided for residents who are unable to carry out ADLs . Hygiene (bathing .). Review of facility job descriptions for a Nursing Assistant (NA) revealed Attends to the individual needs of the residents, which may include assistance with grooming, bathing, oral hygiene, feeding, incontinent care, toileting, colostomy care, prosthetic appliances, transferring, ambulation, range of motion, communicating or other needs in keeping with the individuals' care requirements .Answers residents' call bells promptly and courteously . Interviews during the Resident Council meeting on 6/11/25, between 10:30 a.m. and 11:00 a.m., revealed five out of five alert and oriented residents in attendance stated they are not receiving fresh ice water, and it is worse when agency staff are working. R77 and R3 had concerns related to staff not responding to their call bells timely and it took 45 minutes to an hour for call bell response, indicating it is worse on the weekends and/or when agency staff are working. Review of resident council minutes over six months from January, February, March, April, May, and June of 2025, revealed the following: January 2025 resident council minutes revealed 10 out of 10 residents in attendance stated that ice water is not passed enough. February 2025 resident council minutes revealed nine out of 10 residents in attendance stated that ice water is not passed at each shift and staff is slow answering call bells. One resident stated he/she rang the call bell, and an agency staff answered, left and never returned. He/she rang again, and a facility NA helped him/her. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	March 2025 resident council minutes revealed three out of 16 residents in attendance stated that ice water is not passed at each shift and four out of 16 residents stated staff is slow answering call bells. April 2025 resident council minutes revealed eight out of eight residents in attendance stated that ice water is not passed at each shift, seven out of eight residents stated staff is slow answering call bells, and two out of eight residents stated they were not receiving their showers. May 2025 resident council minutes revealed seven out of eight residents in attendance stated that ice water is only provided if families get it for them or request it from staff and two out of eight residents stated they were not receiving their showers. June 2025 resident council minutes revealed residents are not receiving ice water regularly and call bells are not being answered timely. Review of the Grievance Logs from January, February, March, and April of 2025 revealed grievances related to call bell response time, residents not receiving showers, and fresh ice water not being passed. During an interview on 6/10/25, at 1:00 p.m. with alert and oriented Resident R27, he/she indicated that he/she waits for an hour at a time often to have his/her call bell responded to and does not receive ice water, unless he/she asks for it. Resident R27 stated, What happens to the residents who cannot ask for it? During an interview on 6/10/25, at 1:45 p.m. with alert and oriented Resident R42 he/she expressed that he/she was not receiving their showers because the shower room on their hall had no hot water. He/she expressed that the facility has other shower rooms that the staff could use. He/she expressed that their hair has not been washed since their last shower. Observation of the resident at the time of interview revealed Resident R42's hair appeared that it had not been washed. Follow up interview with Resident R42 on 6/11/25, at 9:30 a.m. revealed that the resident expressed that they are scheduled to get a shower on Tuesdays and Fridays on the afternoon shift. The resident expressed that he/she tracks their showers on the calendar in their phone and the last date marked was 5/27/25. Review of Resident R42's shower documentation revealed that he/she only received a shower on 5/27/25, 6/3/25, and 6/10/25, which was not on all of his/her scheduled shower days. During an interview on 6/10/25, at 1:30 p.m. with alert and oriented Resident R60 he/she expressed that they were not receiving showers because the shower room on their hall had no hot water. The resident expressed that he/she wanted to go to the other hall's shower room, but staff would never to that. Follow up interview on 6/11/25, at 2:05 p.m. revealed that Resident R60 expressed that they never refuse their shower, and is scheduled to get showers on Wednesdays and Saturdays on the afternoon shift. Review of Resident R60's shower documentation revealed that he/she received a shower on 5/21/25, and did not receive another shower until 6/11/25. The documented shower dates did not reflect his/her shower schedule. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/11/25, at 10:50 a.m. with alert and oriented Resident R93, revealed that they wait for an hour while sitting on the bedside toilet to have the call bell responded to by staff, and when he/she desires to get out of bed in the morning. During an interview on 6/11/25, at 1:00 p.m. alert and oriented Resident R199, indicated that they have not received a bath/shower since being admitted on [DATE]. Resident R199 asked for their hairbrush during the interview to itch their hair. Resident R199 stated, My hair is driving me crazy, it is so itchy due to not washing it. Review of Resident R199's shower documentation revealed that their shower days were Tuesdays and Fridays. The Director of Nursing (DON) confirmed that Resident R199 did not receive his/her scheduled shower on Tuesday, 6/10/25. During an interview on 6/11/25, at 2:06 p.m. the DON confirmed that residents have the right to get their showers when they are scheduled or when they request. He/she also confirmed that showers should be done per the resident's shower schedule or when requested by the resident. During an interview on 6/12/25, at approximately 12:30 p.m. the DON confirmed that residents have the right for fresh ice water throughout each day and to have their call bells answered timely to meet each resident's needs. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(4)(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. Based on review of facility policy, manufacturer's recommendations, observations, and staff interviews, it was determined that the facility failed to ensure that medications were properly dated when opened and discarded in a timely manner for two of three medication carts reviewed (A Wing medication and Skilled Wing medication cart). Findings include: Review of a facility policy entitled Medication Storage dated 2/18/25, revealed it is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Manufacturer's recommendations for Latanoprost (a type of eye drop), indicated that once a bottle is opened for use, it may be stored at room temperature up to 25 degrees Celsius (77 degrees Fahrenheit) for six weeks. Manufacturer's recommendations for Lantus (a long-acting insulin), indicated that an opened multiple-dose vial stored at room temperature should be discarded after 28 days. Observations of the A Wing's medication cart on 6/10/25, at approximately 2:30 p.m. revealed an opened bottle of Latanoprost eye drops without an open date, therefore the staff were unable to determine the discard date. Licensed Practical Nurse (LPN) Employee E1 confirmed at that time, that the opened bottle of Latanoprost lacked an open date, and staff were unable to determine the discard date. Observations of the Skilled Wing's medication cart on 6/10/25, at approximately 4:15 p.m. revealed an opened vial of Lantus without an open date, therefore the staff were unable to determine the discard date. LPN Employee E2 confirmed at that time, that the opened Lantus vial lacked an open date, and staff were unable to determine the discard date. During an interview with the Regional Clinical Director on 6/12/25, at 12:05 p.m. it was confirmed that insulins and eye drop medications should be properly labeled with an open date for staff to determine the discard date. 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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	06/13/2025

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of facility policies, observations, and staff interview, it was determined that the facility failed to serve food in a safe and sanitary manner during tray line and ensure that food was stored in accordance with standards for food safety in the main kitchen, and resident pantries (D Wing, A Wing, Skilled Wing pantries and Kitchen). Findings include: Review of a facility policy entitled Floor stock and Supplement Distribution dated 2/18/25, revealed discarding expired and unlabeled products ., Supplements such as . Med Pass . will be dated upon opening and will have a three day use by date ., and Cleaning and sanitizing the unit pantry and refrigerator/freezers. Review of a facility policy entitled Food: Safe Handling for Food from Visitors dated 2/18/25, revealed Label food with the resident name and the current date and daily monitoring for refrigerator storage duration and discard of any food items that have been stored for seven or greater days. Review of a facility policy entitled Staff Attire dated 2/18/25, revealed The Dining Service Director ensures that all staff members have their hair off the shoulders, confined in a hair net or cap . Observations during a kitchen tour on 6/10/25, at 11:15 a.m. revealed seven bulk packages of instant potatoes with an expiration date of 5/12/25 were in the dry storage area. Observations during tray line on 6/10/25, at 4:05 p.m. revealed a dietary aide placing food on resident trays not wearing a hair net/restraint. During an interview on 6/10/25, at 11:15a.m. and again at 4:05 p.m. the Dietary Manager confirmed that the seven bulk packages of instant potatoes were expired and that the dietary aide was not wearing a hair net/restraint during tray line while handling resident food. He/she also confirmed that the instant potatoes should have been discarded and that the dietary aide should be wearing a hair net/restraint while in the dietary department. Observations on 6/10/25, at 4:20 p.m. of the D Wing pantry refrigerator used for residents revealed a brown substance on the shelves, a dry thick red substance under the bottom two drawers, and a yellow substance on the door shelves. During an interview on 6/10/25, at the time of observation Nursing Assistant (NA) Employee E4 confirmed that the refrigerator was not clean. Observation on 6/10/25, at 4:27 p.m. of the A Wing pantry refrigerator used for residents revealed a clear plastic container of watermelon dated 5/29/25, with no resident name on the container, a carton of Med Pass with an open date of 6/4/25, a clear yellow sticky substance covering the shelf in the refrigerator, and the freezer had a large amount of ice built up. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/10/25, at the time of observation Licensed Practical Nurse (LPN) Employee E5 confirmed that the watermelon lacked a resident name and was beyond the use by date, the Med Pass was beyond the use by date, the refrigerator was not clean and there was a buildup of ice in the freezer. He/she also confirmed that the food items should be labeled and discarded by their use by date, and the refrigerator and freezer should be clean and free from ice buildup. Observations on 6/10/25, at 4:33 p.m. of the Skilled Wing pantry refrigerator used for residents revealed a carton of Med Pass with an open date of 6/4/25, a Styrofoam cup of pudding with no label or date, the refrigerator shelf had a clear yellow sticky substance, and the freezer had a large amount of ice buildup. During an interview on 6/10/25, at the time of observation NA Employee E6 confirmed that the Med pass was beyond the use by date, the Styrofoam cup of pudding was lacking a label and date, the refrigerator was not clean and there was a buildup of ice in the freezer. He/she also confirmed that the food items should be labeled and discarded by their use by date, and the refrigerator and freezer should be clean and free from ice buildup. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management

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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. Based on review of facility policies, observations, and staff interview, it was determined that the facility failed to prevent the potential for cross-contamination during completion of a wound dressing change for one of one residents reviewed (Resident R75). Findings include: Review of facility policy entitled Wound Care dated 2/18/25, indicated Wipe reuseable supplies with alcohol as indicated (i.e., scissor blades .) Review of facility policy entitled Cleaning and Disinfection of Resident Care-Items and Equipment dated 2/18/25, indicated Reusable items are cleaned and disinfected or sterilized between residents . Observations on 6/12/25, at 1:50 p.m. revealed Licensed Practical Nurse (LPN) Employee E7 completing a wound dressing change in Resident R75's room. During the dressing change LPN Employee E7 used scissors to cut the soiled dressing from Resident R75's right foot. LPN Employee E7 then placed the scissors on a towel covering Resident R75's bedside table. After completing the dressing change LPN Employee E7 picked up the scissors and placed them in their pocket without cleaning the scissors. During an interview on 6/12/25, at the time of observation, LPN Employee E7 confirmed that he/she cut the soiled dressing off of Resident R75's right foot with the scissors and placed the scissors in their pocket without cleaning them. He/she also confirmed that the scissors should have been cleaned before placing them in their pocket. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services