STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395618	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mulberry Healthcare and Rehabilitation Cent	411 1/2 W Mahoning Street Punxsutawney, PA 15767

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 43856 Based on review of policies and clinical records, as well as observations and resident and staff interviews, it was determined that the facility failed to determine if residents were safe to self-administer medications for one of 29 residents reviewed (Resident 10). Findings include: The facility's medication administration policy, dated July 19, 2024, indicated that residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. A admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 10, dated August 28, 2024, revealed that the resident was cognitively intact and required assistance from staff for daily care needs. Physician's orders for Resident 10, dated August 23, 2024, included an order for the resident to receive 20 grams(gm)/30 milliliter (ml) of Lactulose Encephalopathy Oral Solution (a medication used to treat constipation) 30 ml by mouth one time a day for constipation. Observations during medication administration on October 16, 2024, at 8:30 a.m. revealed that Licensed Practical Nurse 5 prepared Resident 10's medications, which included 30 ml of Lactulose Encephalopathy Oral Solution. After administering Resident 10's pills, she placed the Lactulose Encephalopathy Oral Solution on the over-bed table and left the room. Interview with Licensed Practical Nurse 5 on October 16, 2024, at 8:31 a.m. confirmed that she left the Lactulose Encephalopathy Oral Solution with Resident 10 and would go back and check if the resident took the medication. Interview with the Nursing Home Administrator on October 17, 2024, at 12:24 p.m. confirmed that Licensed Practical Nurse 5 should have observed Resident 10 take the Lactulose Encephalopathy Oral Solution and should not have left it with the resident, and that there was no assessment to determine if Resident 10 was safe to self-administer her medications. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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	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. 47819 Based on observations and staff interviews, it was determined that the facility failed to provide a safe, clean, and homelike environment related to residents' wheelchairs for three of 29 residents reviewed (Residents 6, 33, 53). Findings include: The facility's policy for Homelike Environment, dated May 16, 2024, revealed that residents are provided with a safe, clean, comfortable and homelike environment. Observations of Resident 6's wheelchair on October 17, 2024, at 10:26 a.m. revealed that the vinyl material on both arm rests was torn. Observations of Resident 33's wheelchair on October 17, 2024, at 3:01 p.m. revealed that the vinyl material on both arm rests was cracked and torn. Observations of Resident 53's wheelchair on October 17, 2024, at 2:57 p.m. revealed that the vinyl material on the left arm rest was cracked and torn. Interview with the Maintenance Director on October 17, 2024, at 3:03 p.m. revealed that the wheelchair armrests for Residents 6, 33, and 53 were cracked and torn and peeling and that they should be replaced. 28 Pa. Code 201.29(j) Resident Rights. 28 Pa. Code 207.2(a) Administrator's Responsibility.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 38012 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to notify the state ombudsman and/or the resident and resident's responsible party in writing regarding the reason for transfers/discharge to the hospital for five of 29 residents reviewed (Residents 8, 30, 36, 55, 102). Findings include: A nursing note for Resident 8, dated July 23, 2024, at 7:19 p.m., revealed that the resident was admitted to the hospital with kidney failure. There was no documented evidence that a written notice of Resident 8's transfer to the hospital was provided to the resident's responsible party regarding the reason for transfer. An annual MDS assessment for Resident 30, dated September 6, 2024, revealed that the resident was cognitively intact, required assistance with daily care needs, and had diagnosis that included heart failure, high blood pressure, and morbid obesity. A nursing note for Resident 30, dated May 31, 2024, at 8:40 p.m., revealed that the resident had a change in condition and was transferred to the local emergency room . There was no documented evidence that a written notice of Resident 30's transfer to the hospital was provided to the resident's responsible party regarding the reason for transfer. An admission MDS assessment for Resident 36, dated September 3, 2024, revealed that the resident was cognitively intact, required assistance with daily care needs, and had diagnosis that included high blood pressure and left hip fracture. A nursing note for Resident 36, dated October 10, 2024, at 11:40 a.m., revealed that the resident was transferred to the local emergency room for a blood transfusion. A nursing note, dated October 11, 2024, at 8:30 a.m., revealed that the resident was admitted for osteomyelitis (infection in the bone). There was no documented evidence that a written notice of Resident 36's transfer to the hospital was provided to the resident's responsible party and/or the ombudsman. A quarterly MDS assessment for Resident 55, dated July 8, 2024, revealed that the resident was cognitively impaired, required assistance with daily care needs, and had diagnosis that included high blood pressure, diabetes, and Alzheimer's. A nursing note for Resident 55, dated May 29, 2024, revealed that the resident was unresponsive during care and was transferred to the emergency room . (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	As of October 18, 2024, there was no documented evidence that a written notice of Resident 55's transfer to the hospital was provided to the resident's responsible party and/or the ombudsman. A nursing note for Resident 102, dated September 26, 2024, at 7:32 p.m., revealed that the resident was admitted to the hospital. There was no documented evidence that a written notice of Resident 102's transfer to the hospital was provided to the resident's responsible party regarding the reason for transfer. Interview with the Director of Nursing on October 18, 2024, at 1:00 p.m. confirmed that the facility did not provide a written notice to the state ombudsman and the resident or the resident's responsible party when a resident was transferred to the hospital for Residents 8, 30, 36, 55, and 102. 28 Pa. Code 201.25 Discharge Policy. 28 Pa. Code 201.29(f)(g) Resident Rights.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 38012 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to provide a written notice of the facility's bed-hold policy to the resident and/or the resident's representative at the time of a transfer for five of 29 residents reviewed (Residents 8, 30, 36, 55, 102). Findings include: A nursing note for Resident 8, dated July 23, 2024, at 7:19 p.m., revealed that the resident was admitted to the hospital with kidney failure. There was no documented evidence that the resident and/or the responsible party was notified about the facility's bed-hold policy at the time of the above transfer to the hospital for Resident 8. An annual (MDS) assessment for Resident 30, dated September 6, 2024, revealed that the resident was cognitively intact, required assistance with daily care needs, and had diagnosis that included heart failure, high blood pressure, and morbid obesity. A nursing note for Resident 30, dated May 31, 2024, at 8:40 p.m., revealed that the resident had a change in condition and was transferred to the local emergency room . There was no documented evidence that a written notice of Resident 30's transfer to the hospital was provided to the resident's responsible party regarding the reason for transfer. An admission (MDS) assessment for Resident 36, dated September 3, 2024, revealed that the resident was cognitively intact, required assistance with daily care needs, and had diagnosis that included high blood pressure and left hip fracture. A nursing note for Resident 36, dated October 10, 2024, at 11:40 a.m., revealed that the resident was transferred to the local emergency room for a blood transfusion. A nursing note, dated October 11, 2024, at 8:30 a.m., revealed that the resident was admitted for osteomyelitis (infection in the bone). There was no documented evidence that the resident and/or the responsible party was notified about the facility's bed-hold policy at the time of the above transfer to the hospital for Resident 36. A quarterly MDS assessment for Resident 55, dated July 8, 2024, revealed that the resident was cognitively impaired, required assistance with daily care needs, and had diagnosis that included high blood pressure, diabetes, and Alzheimer's. A nursing note for Resident 55, dated May 29, 2024, revealed that the resident was unresponsive during care and was transferred to the emergency room . (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	As of October 18, 2024, there was no documented evidence that the resident and/or the responsible party was notified about the facility's bed-hold policy at the time of the above transfer to the hospital for Resident 55. A nursing note for Resident 102, dated September 26, 2024, at 7:32 p.m., revealed that the resident was admitted to the hospital. There was no documented evidence that the resident and/or the responsible party was notified about the facility's bed-hold policy at the time of the above transfer to the hospital for Resident 102. Interview with the Director of Nursing on October 18, 2024, at 1:00 p.m. confirmed that the required written bed-hold information was not provided at the time of transfer to the hospital for Resident's 8, 30, 36, 55, and 102. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(3) Management.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 38012 Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for five of 29 residents reviewed (Residents 5, 8, 27, 46, 47). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated that the intent of Section N was to record the number of days, during the seven days of the assessment period, that any type of injection, insulin, and/or select medications were received by the resident. Section N0415F Antibiotic Medications and Section N0415I Antiplatelet Medications (medication used to prevent blood from clotting) was to be coded if the resident took the medication during the seven-day look-back period. Physician's orders for Resident 5, dated August 12, 2024, included an order for the resident to receive a pneumonia vaccine to be administered at Rite Aid on August 12, 2024. A nursing note for Resident 5, dated August 12, 2024, at 12:16 p.m., revealed that the resident received a pneumonia vaccine on August 12, 2024, at Rite Aid. An annual MDS assessment for Resident 5, dated August 14, 2024, revealed that Section N0300 indicated that the resident did not receive an injection of any type in the last seven days. Interview with the Registered Nurse Assessment Coordinator (who was responsible for the collection of MDS information) on October 18, 2024, at 10:34 p.m. confirmed that Section N0300 was coded inaccurately for Resident 5, who received a pneumonia injection during the assessment period. The RAI User's Manual, dated October 2024, revealed that Section N0415I Antiplatelet Medications was to be coded is taking if the resident used an antiplatelet during the seven-day assessment period. A quarterly MDS for Resident 8, dated August 5, 2024, revealed that Section N0415I was not coded, indicating that the resident did not receive an antiplatelet during the look-back assessment period. A physician's order for Resident 8, dated July 31, 2024, revealed that the resident was to receive 81 milligrams (mg) aspirin (an antiplatelet) daily. A review of the Medication Administration Record (MAR) for Resident 8, dated July 2024, revealed that the resident received aspirin daily during the look-back period. An interview with the RNAC on October 18, 2024, at 10:34 a.m. confirmed that the assessment for Resident 8 was coded incorrectly. The RAI User's Manual, dated October 2024, which gives instructions for completing MDS assessments, dated October 2024, revealed that Section N0415F Antibiotic Medications was to be coded is taking if the resident used an antibiotic during the seven-day assessment period. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly MDS for Resident 27, dated August 2, 2024, revealed that Section N0415F was not coded, indicating that the resident did not receive an antibiotic during the look-back assessment period. A physician's order for Resident 27, dated July 16, 2024, revealed that the resident was to receive antibiotic ointment to the left fourth toe daily until healed. A review of the MAR for Resident 27, dated August 2024, revealed that the resident received the antibiotic ointment daily during the look-back period. An interview with the RNAC on October 18, 2024, at 10:34 a.m. confirmed that the assessment for Resident 27 was coded incorrectly. Physician's orders for Resident 46, dated July 10, 2024, included an order for the resident to receive 81 milligrams(mg) of aspirin (Antiplatelet Medication) one time a day. A review of the residents MAR, dated August 2024, revealed that the resident received the medication during the seven-day look-back period. A significant change MDS assessment for Resident 46, dated August 19, 2024, revealed that Section N0415I indicated that the resident did not receive an antiplatelet medication during the assessment period. Physician's orders for Resident 47, dated January 17, 2024, included an order for the resident to receive 81 mg of aspirin one time a day. A review of the Residents MAR, dated July 2024, revealed that the resident received the medication during the seven-day look-back period. A quarterly MDS assessment for Resident 47, dated July 19, 2024, revealed that Section N0415I indicated that the resident did not receive an antiplatelet medication during the assessment period. Interview with the RNAC on October, 18, 2024, at 10:34 a.m. confirmed that Section N0415I was inaccurately coded for Residents 46 and 47 and should have been coded for antiplatelet medications during the seven-day look-back assessment. 28 Pa. Code 211.5(f) Clinical Records.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48809 Based on review of clinical records, as well as family and staff interviews, it was determined that the facility failed to ensure that residents were provided with showers as scheduled for one of 29 residents reviewed (Resident 19). Findings include: An admission Minimum Data Set (MDS) assessment (a federally-mandated assessment of the resident's abilities and care needs) for Resident 19, dated September 10, 2024, revealed that the resident was cognitively intact and required moderate assistance from staff for personal care needs. Resident 19's care plan, dated September 6, 2024, revealed that the resident preferred showering two times per week on Wednesday and Sunday evening shift. Review of Resident 19's bathing records for September and October 2024 revealed that the resident received a bed bath on September 18, 2024, and a shower on October 9, 2024. There was no documented evidence to indicate that Resident 19 received a shower on the other scheduled days for September and October 2024. Interview with Resident 19's daughter on October 15, 2024, at 1:30 p.m. revealed that the resident has only received two showers since being admitted to the facility. Interview with the Director of Nursing on October 16, 2024, at 2:18 p.m. confirmed that there was no documented evidence in Resident 19's medical record of the resident receiving any other showers except the ones mentioned above. 28 Pa. Code 211.12(d)(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. 38012 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders were followed for three of 29 residents reviewed (Residents 10, 37, 47). Findings include: The facility's policy regarding medication administration, dated May 16, 2024, revealed that medications are administered in accordance with prescriber orders, including any required time frame. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 10, dated August 28, 2024, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnosis of gastro-esophageal reflux disease. Physician's orders for Resident 10, dated August 23, 2024, included an order for the resident to receive 1 gram (gm) of Sucralfate (a medication used to treat conditions of the digestive tract) one table by mouth before meals and at bedtime for gastric protection. Observations during medication administration on October 16, 2024, at 8:25 a.m. revealed that Licensed Practical Nurse 5 prepared Resident 10's medications, which included 1 gm Sucralfate. Licensed Practical Nurse 5 administered 1 gm Sucralfate to Resident 10 at 8:30 a.m. after she had consumed her breakfast meal. Interview with Licensed Practical Nurse 5 on October 16, 2024, at 8:31 a.m. confirmed that Resident 10 should have been given 1 gm Sucralfate before the breakfast meal per physician orders. Interview with Nursing Home Administrator on October 17, 2024, at 12:24 p.m. confirmed that Resident 10 should have been given 1 gm Sucralfate prior to eating the breakfast meal and it was not. A review of the facility's policy regarding Nutritional Assessment, dated May 16, 2024, revealed that the resident's intake would be adequate and that total intake of supplements ordered for weight loss would be documented within the resident's clinical record. A quarterly Minimum Data Set (MDS) assessments (required assessments of a resident's abilities and care needs) for Resident 37, dated July 19, 2024, revealed that the resident was cognitively impaired and had diagnoses that included Alzheimer's disease (decline in memory). A nutritionist's note for Resident 37, dated October 1, 2024, revealed that the resident had a weight loss of 29 pounds since March 2024 and that she was to receive 90 ml of a health shake (2.0 supplement) four times per day to prevent further weight loss. A physician's order for Resident 37 included an order for the resident to have 90 ml of 2.0 Supplement (for weight increase) four times a day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 37's October 2024 Medication Administration Record (MAR) revealed on October 2, 2024, the resident received 120 ml at 9:00 a.m.; 120 ml at 1:00 p.m.; 120 ml at 5:00 p.m.; and 90 ml at 9:00 p.m. On October 3, 2024, the resident received 90 ml at 9:00 a.m.; 90 ml at 1:00 p.m.; 0 ml at 5:00 p.m.; and 0 ml at 9:00 p.m. On October 4, 2024, the resident received 120 ml at 9:00 a.m.; 120 ml at 1:00 p.m.; 90 ml at 5:00 p.m.; and 90 ml at 9:00 p.m. On October 5, 2024, the resident received 120 ml at 9:00 a.m.; 120 ml at 1:00 p.m.; 90 ml at 5:00 p.m.; and 90 ml at 9:00 p.m. On October 6, 2024, the resident received 120 ml at 9:00 a.m.; 120 ml at 1:00 p.m.; 90 ml at 5:00 p.m.; and 90 ml at 9:00 p.m. On October 7, 2024, the resident received 120 ml at 9:00 a.m.; 120 ml at 1:00 p.m.; 120 ml at 5:00 p.m.; and 90 ml at 9:00 p.m. On October 8, 2024, the resident received 120 ml at 9:00 a.m.; 120 ml at 1:00 p.m.; 120 ml at 5:00 p.m.; and 30 ml at 9:00 p.m. On October 9, 2024, the resident received 90 ml at 9:00 a.m;, 0 ml at 1:00 p.m.; 90 ml at 5:00 p.m.; and 20 ml at 9:00 p.m. On October 11, 2024, the resident received 120 ml at 9:00 a.m.; 120 ml at 1:00 p.m.; 120 ml at 5:00 p.m.; and 120 ml at 9:00 p.m. On October 12, 2024, the resident received 0 ml at 9:00 a.m.; 0 ml at 1:00 p.m.; 90 ml at 5:00 p.m.; and 0 ml at 9:00 p.m. On October 13, 2024, the resident received 0 ml at 9:00 a.m.; 60 ml at 1:00 p.m.; 120 ml at 5:00 p.m.; and 90 ml at 9:00 p.m. On October 14, 2024, the resident received 120 ml at 9:00 a.m.; 120 ml at 1:00 p.m.; 20 ml at 5:00 p.m.; and 20 ml at 9:00 p.m. On October 15, 2024, the resident received 0 ml at 9:00 a.m.; 45 ml at 1:00 p.m.; 45 ml at 5:00 p.m.; and 45 ml at 9:00 p.m. On October 16, 2024, the resident received 0 ml at 9:00 a.m.; 60 ml at 1:00 p.m.; 60 ml at 5:00 p.m.; and 60 ml at 9:00 p.m. On October 17, 2024, the resident received 0 ml at 9:00 a.m.; 0 ml at 1:00 p.m.; 90 ml at 5:00 p.m.; and 120 ml at 9:00 p.m. An interview with the Director of Nursing on October 17, 2024, at 2:05 p.m. confirmed that there was no way to tell if the resident was receiving the correct amount of supplement or not due to the inconsistent documentation on the residents MAR and that it was important to know if she was consuming it or not because of her weight loss. A quarterly MDS assessment for Resident 47, dated July 19, 2024, revealed that the resident is cognitively impaired, requires assistance from staff for daily care needs, has history of falls, and diagnosis that include dementia and blood pressure. A care plan, dated February 3, 2024, indicated that the resident is to have bilateral fall mats. Physician's orders for Resident 47, dated October 9, 2024, included an order for the resident to receive 5 percent Permethrin cream apply one time a day to whole body neck down for rash and to apply Permethrin cream one time a day on October 16, 2024. Review of the Medication Administration Record (MAR) for Resident 47, dated October 2024, revealed no documented evidence that the resident received Permethrin cream on October 9, 2024. Interview with the Director of Nursing on October 18, 2024, at 10:52 a.m. confirmed that there was no documented evidence that Resident 47 received the first dose of 5 percent Permethrin cream on October 9, 2024, and that the dose was missed. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician's orders for Resident 47, dated June 19, 2024, included an order for the resident to receive Humalog Insulin Lispro (Humalog - a rapid-acting insulin) based on a sliding scale (the amount of insulin is based on the result of a fingerstick blood sugar test) before meals. The sliding scale included giving 3 units of insulin for a blood sugar of 100-150 milligrams per deciliter (mg/dL), 5 units for a blood sugar of 151-250 mg/dL, 7 units for a blood sugar of 251-300 mg/dL, 9 units for a blood sugar of 301-350 mg/dL, 13 units for a blood sugar of 351-400 mg/dL, 13 units for a blood sugar of 401-450 mg/dL, repeat fingerstick blood sugar test in two hours and if still above 400, notify the physician. Resident 47's fingerstick blood sugar test result on October 16, 2024, at 7:00 a.m. was 216, which indicated that he should receive 5 units of Humalog Insulin Lispro before the breakfast meal Observations during medication administration on October 16, 2024, at 8:45 a.m. revealed that Licensed Practical Nurse 5 prepared Resident 47's medications, which included 5 units of Humalog Insulin Lispro. Licensed Practical Nurse 5 administered 5 units of Humalog Insulin Lispro to Resident 47 on October 16, 2024, at 8:47 a.m. after he had consumed his breakfast meal. Interview with Licensed Practical Nurse 5 on October 16, 2024, at 8:47 a.m. confirmed that Resident 47 should have been given 5 units of Humalog Insulin Lispro before the breakfast meal per physician orders. Interview with Nursing Home Administrator on October 17, 2024, at 12:24 p.m. confirmed that Resident 47's 5 units of Humalog Insulin Lispro should have been given prior to him eating the breakfast meal and it was not. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47819 Based on review of manufacturer's instructions, clinical records, and written safety and resident information, as well as observations and staff interviews, it was determined that the facility failed to ensure the residents' environment remained as free of accident hazards as is possible by ensuring that mechanical lifts used to transfer residents were equipped with hanger bar latches as required on one of two lifts in use (Invacare 450 Full Body Mechanical Lift), placing the safety of the residents in an Immediate Jeopardy situation. The facility also failed to provide an environment that was free of accident hazards for residents who were at risk for falls by failing to follow care-planned interventions for one of 29 residents reviewed (Resident 47). Findings include: The manufacturer's instructions for the use of the Invacare Reliant 450 mechanical lift (a device that uses hydraulic power to lift and transfer residents between surfaces), dated 2016, revealed a diagram of the lift showing a swivel bar attached to the hydraulic arm of the lift. Each side of the swivel bar had three hooks for the sling to be attached. Each of the hooks had a hanger bar latch to prevent the sling from coming off the hook. The maintenance instructions for the swivel bar indicated that after the first year of use, the hooks of the swivel bar and the mounting brackets of the boom were to be inspected every three months for wear, and that regular maintenance of the lifts and accessories was necessary to ensure proper operation. Once the patient was elevated a few inches off the surface of the stationary object (wheelchair, commode or bed), and before moving the patient, staff were to check to make sure that the sling was properly connected to the hooks of the hanger bar, and if any attachments were not properly in place, the patient was to be lowered back onto the stationary object. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 30, dated September 6, 2024, revealed that the resident was cognitively intact, required assistance with transfers, and had diagnosis that included heart failure, high blood pressure, and morbid obesity. Observations on October 15, 2024, at 2:20 p.m. in the North wing hallway revealed an Invacare Reliant 450 full body mechanical lift that was missing two hanger bar latches on two hooks on one side of the swivel bar and was missing one hanger bar latch on a hook that was on the the other side of the swivel bar. Interview with Nurse Aide 4 on October 15, 2024, at 2:21 p.m. revealed that she did not know what the hanger bar latches were or why they were missing. Observations on October 15, 2024, at 2:41 p.m. revealed that Nurse Aide 1 and Nurse Aide 2 transferred Resident 30 from her wheelchair to her bed using the Invacare Reliant 450 full body mechanical lift that was missing three of the six hanger bar latches. Interview with Nurse Aide 1 and Nurse Aide 2 at that time revealed that the hanger bar latches had been missing for a while, but they were never told to stop using the mechanical lift because of it. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A telephone interview on October 15, 2024, at 3:15 p.m. with a representative for Invacare confirmed that the hanger bar latches are necessary for resident safety to prevent to the sling from sliding off the lift hook. Interview with the Nursing Home Administrator on October 15, 2024, at 3:52 p.m. revealed that she was not aware that the hanger bar latches were missing. On October 15, 2024, at 3:52 p.m. the Nursing Home Administrator was given the Immediate Jeopardy template and informed that the health and safety of the residents were placed in Immediate Jeopardy due to the facility's failure to ensure that the Invacare Reliant 450 full body mechanical lift had the hanger bar latches necessary for resident safety. An immediate action plan was submitted and contained the following: Invacare Lift Reliant 450 model was immediately removed from use and tagged out for maintenance. Secondary lift Joerns Hoyer 700 will be utilized for all full body mechanical lifts until clips can be obtained for the Invacare lift. The Nursing Home Administrator contacted Invacare and Direct Supply companies for immediate replacement of the latch kit to be sent overnight for replacement of missing hanger bar latch clips. Staff will be educated to assess lifts prior to each use and alert the Maintenance Director for any missing hanger bar latch clips or any identified issues with mechanical lifts. The Maintenance Director or designee will assess the mechanical lifts daily for five days, then weekly for four weeks, then monthly for two months for any ongoing need for repairs. A list of residents who required transfers with a full body mechanical lift, provided by the facility October 15, 2024, revealed that there were 12 residents in the facility who required transfers with the Invacare Reliant 450 full body mechanical lift. The Immediate Jeopardy was lifted on October 15, 2024, at 5:45 p.m. when it was confirmed that the Invacare Reliant 450 full body mechanical lift was removed from use and staff were educated on identifying mechanical issues regarding the mechanical lift. The facility's fall risk policy, dated May 16, 2024, indicated that staff will implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls. A quarterly MDS assessment for Resident 47, dated July 19, 2024, revealed that the resident was cognitively impaired, required assistance from staff for daily care needs, had history of falls, and diagnoses that included dementia. A care plan for Resident 47, dated February 3, 2024, indicated that the residents was to have bilateral fall mats. Observation of Resident 47 on October 15, 2024, at 10:56 a.m. revealed that the fall mats were folded up beside the resident's bedside table. Interview with Registered Nurse 3 on October 15, 2024, at 11:00 a.m. confirmed that the Resident 47 is care-planned for bilateral fall mats, and they should be in place and they were not. Interview with the Nursing Home Administrator on October 15, 2024, at 5:35 p.m. confirmed that the resident is care planned for bilateral fall mats and that they should have been in place. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	28 Pa. Code 211.10(c)(d) Resident Care Policies. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47819 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure the accountability of controlled medications (drugs with the potential to be abused) for three of 29 residents reviewed (Residents 5, 28, 30). Findings include: The facility's policy regarding Medication Administration, dated May 16, 2024, revealed that staff are required to document the administration of medication in the resident's medical record. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated August 14, 2024, revealed that the resident is cognitively impaired, required assistance from staff for daily care needs, and had diagnoses that include high blood pressure, dementia, and pain in left lower leg. Physician's orders for Resident 5, dated April 28, 2024, included an order for the resident to receive one 5/325 milligram (mg) tablet of Oxycodone/Acetaminophen (a controlled narcotic pain medication) orally every eight hours for pain. A review of the controlled drug record (a form that accounts for each tablet/pill/dose of a controlled drug) for Resident 5 for August, September, and October 2024 indicated that a dose of 5/325 mg of Oxycodone was signed out on August 26, 2024, at 4:15 a.m.; August 28, 2024, at 5:00 a.m.; August 29, 2024, at 5:57 a.m.; September 9, 2024, at 3:15 a.m.; September 26, 2024, at 8:30 p.m.; October 7, 2024, at 12:30 a.m.; and October 14, 2024, at 3:15 a.m. However, Resident 5's clinical record contained no documented evidence that the signed-out tablet of Oxycodone was administered to the resident on the dates that were mentioned. Interview with the Director of Nursing on October 17, 2024, at 11:18 a.m. confirmed that there was no documented evidence that staff administered the Oxycodone to Resident 5 on the dates mentioned above. A quarterly MDS assessment for Resident 28, dated August 22, 2024, revealed that the resident is cognitively intact, required assistance from staff for daily care needs, and was receiving hospice care. Physician's orders for Resident 28, dated August 17, 2024, included an order for the resident to receive 1 milligram (mg) of Lorazepam (a controlled medication for anxiety) orally every two hours as needed for anxiety or restlessness. A review of the controlled drug record for Resident 28 for October 2024 indicated that a 1 mg dose of Lorazepam was signed out on October 1, 2024, at 7:00 p.m. However, Resident 28's clinical record contained no documented evidence that the signed-out dose of Lorazepam was administered to the resident on the date that was mentioned. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing on October 17, 2024, at 11:19 a.m. confirmed that there was no documented evidence that staff administered Lorazepam to Resident 28 on the date mentioned above. An annual MDS assessment for Resident 30, dated September 6, 2024, revealed that the resident was cognitively intact, required assistance with daily care needs, and had diagnoses that included heart failure. Physician's orders for Resident 30, dated July 27, 2024, included an order for the resident to receive 5 mg of Oxycodone every four hours as needed for moderate to severe pain. A review of the controlled drug record for Resident 30 for August 2024 and October 2024 indicated that a dose of Oxycodone was signed out on August 17, 2024, at 11:40 p.m.; August 25, 2024, at 3:45 a.m.; October 2, 2024, at 6:40 p.m.; and October 12, 2024, at 8:53 p.m. However, Resident 30's clinical record contained no documented evidence that the signed-out dose of Oxycodone was administered to the resident on the dates that were mentioned. Interview with the Director of Nursing on October 17, 2024, at 11:18 a.m. confirmed that there was no documented evidence that staff administered Oxycodone to Resident 30 on the dates mentioned above. 28 Pa. Code 211.9(h) Pharmacy Services. 28 Pa. Code 211.12(d)(1) Nursing Services.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 47968 Based on review of facility policies and clinical records, as well as interviews with staff, it was determined that the facility failed to ensure that pharmacy recommendations related to drug irregularities were acted upon by a physician for two of 17 residents reviewed (Residents 7, 37). Findings include: Review of the facility's policy regarding the Role of the Consultant Pharmacist, dated May 16, 2024, revealed that the pharmacist will review the resident's medications and notify the physician of any irregularities. The physician will then make any necessary adjustments to the resident's medication. A quarterly Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 7, dated August 13, 2024, revealed that the resident was cognitively impaired and had diagnoses that included Alzheimer's disease. A progress note for Resident 7, dated April 19, 2024, revealed that a Medication Record Review (MRR) was completed by the pharmacist with medication changes recommended. There was no documented evidence in the clinical record to indicate that the MRR, with recommendations, was reviewed by the physician. A progress note for Resident 7, dated September 10, 2024, revealed that a MRR was completed by the pharmacist with medication changes recommended. There was no documented evidence in the clinical record to indicate that the MRR, with recommendations, was reviewed by the physician. A progress note for Resident 7, dated October 14, 2024, revealed that a MRR was completed by the pharmacist with medication changes recommended. There was no documented evidence in the clinical record to indicate that the MRR, with recommendations, was reviewed by the physician. A quarterly MDS assessment for Resident 37, dated July 19, 2024, revealed that the resident was cognitively impaired and had diagnoses that included Alzheimer's disease. A progress note for Resident 37, dated April 19, 2024, revealed that a MRR was completed by the pharmacist indicating that recommendations were made to prescriber, see medication regiment review report. There was no documented evidence in the clinical record to indicate that the MRR, with recommendations, was reviewed by the physician. A progress note for Resident 37, dated July 24, 2024, revealed that a MRR was completed by the pharmacist with medication changes recommended. There was no documented evidence in the clinical record to indicate that the MRR, with recommendations, was reviewed by the physician. A progress note for Resident 37, dated August 23, 2024, revealed that a MRR was completed by the pharmacist with medication changes recommended. There was no documented evidence in the clinical record to indicate that the MRR, with recommendations, was reviewed by the physician. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note for Resident 37, dated September 10, 2024, revealed that a MRR was completed by the pharmacist with medication changes recommended. There was no documented evidence in the clinical record to indicate that the MRR, with recommendations, was reviewed by the physician. A progress note for Resident 37, dated October 14, 2024, revealed that a MRR was completed by the pharmacist with medication changes recommended. There was no documented evidence in the clinical record to indicate that the MRR, with recommendations, was reviewed by the physician. An interview with the Director of Nursing on October 17, 2024, at 12:11 p.m. revealed that the physician had not been responding to MRR/pharmacist recommendations since April 2024, and confirmed that the Medication Regimen Reviews for Residents 7 and 37 were not addressed. 28 Pa. Code 211.5(f) Clinical Records. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing Services.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 43856 Based on review of clinical records, as well as observations and staff interviews, it was determined that the facility failed to maintain a medication administration error rate that was less than five percent. Findings include: Observations during medication administration on October 16, 2024, revealed that two medication administration errors were made during 35 opportunities for error, resulting in a medication administration error rate of 5.71 percent. Physician's orders for Resident 10, dated August 23, 2024, included an order for the resident to receive 1 gram (gm) of Sucralfate (a medication used to treat conditions of the digestive tract) by mouth before meals and at bedtime for gastric protection. Observations during medication administration on October 16, 2024, at 8:25 a.m. revealed that Licensed Practical Nurse 5 prepared Resident 10's medications, which included 1 gm Sucralfate. Licensed Practical Nurse 5 administered 1 gm Sucralfate to Resident 10 at 8:30 a.m. after she had consumed her breakfast meal. Interview with Licensed Practical Nurse 5 on October 16, 2024, at 8:31 a.m. confirmed that Resident 10 should have been given 1 gm Sucralfate before the breakfast meal per physician orders. Physician's orders for Resident 47, dated June 19, 2024, included an order for the resident to receive Humalog Insulin Lispro (Humalog - a rapid-acting insulin) based on a sliding scale (the amount of insulin is based on the result of a fingerstick blood sugar test) before meals. The sliding scale included giving 3 units of insulin for a blood sugar of 100-150 milligrams per deciliter (mg/dL), 5 units for a blood sugar of 151-250 mg/dL, 7 units for a blood sugar of 251-300 mg/dL, 9 units for a blood sugar of 301-350 mg/dL, 13 units for a blood sugar of 351-400 mg/dL, 13 units for a blood sugar of 401-450 mg/dL, repeat fingerstick blood sugar test in two hours and if still above 400, notify the physician. Resident 47's fingerstick blood sugar test result on October 16, 2024, at 7:00 a.m. was 216, which indicated that he should receive 5 units of Humalog Insulin Lispro before the breakfast meal. Observations during medication administration on October 16, 2024, at 8:45 a.m. revealed that Licensed Practical Nurse 5 prepared Resident 47's medications, which included 5 units of Humalog Insulin Lispro. Licensed Practical Nurse 5 administered 5 units of Humalog Insulin Lispro to Resident 47 on October 16, 2024, at 8:47 a.m. after he had consumed his breakfast meal. Interview with Licensed Practical Nurse 5 on October 16, 2024, at 8:47 a.m. confirmed that Resident 47 should been given 5 units of Humalog Insulin Lispro before the breakfast meal per physician orders. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Nursing Home Administrator on October 17, 2024, at 12:24 p.m. confirmed that Resident 10 should have been given 1 gm Sucralfate prior to eating the breakfast meal and it was not, and Resident 47's 5 units of Humalog Insulin Lispro should have been given prior to eating the breakfast meal and it was not. 28 Pa. Code 211.12(d)(1)(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. 43856 Based on review of facility policy and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that medications were properly labeled in one of two medication carts reviewed, and failed to label a multi-dose vial with the date it was opened in one of one medication room reviewed. Findings include: The facility's policy regarding storage and dating of medications and biologicals, dated May 16, 2024, indicated that the facility stores all medications and biologics in locked compartments under proper temperature, humidity and light controls. Medications dispensed by the pharmacy shall be labeled with the resident's name, medication name, dose, instructions and route of administration. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. The manufacturer's instructions for Aplisol (an injectable medication used to detect exposure to the bacteria that causes tuberculosis), dated March, 2016, indicated that opened and in-use vials of Aplisol were to be discarded in 30 days. Observations in the medication refrigerator on October 15, 2024, at 10:56 a.m. revealed that there was one 1. 0 milliliter (ml) vial of Aplisol in a box. The safety cap (a plastic cap put on by the manufacturer and that is removed prior to withdrawing the medication) was missing from the vial, and neither the vial or box was labeled with a date opened. Interview with Registered Nurse 3 on October 15, 2024, at 10:58 a.m. confirmed that neither the vial of Aplisol or the box that contained it were labeled with a date opened. Observations of the East medication cart on October 16, 2024, at 11:05 a.m. revealed that there were 10 tablets of Zofran (a medication used to prevent nausea) in foil packs in the bottom drawer that were not labeled with resident information. Interview with Licensed Practical Nurse 6 on October 15, 2024, at 11:06 a. m. confirmed that the tablets were not labeled with resident information, and she was not sure which resident they belonged to. Licensed Practical Nurse 6 disposed of the medication in the approved container used for disposal. Interview with the Nursing Home Administrator on October 16, 2024, at 2:15 p.m. confirmed that the Aplisol should have been labeled with the date that it was opened and the Zofran should have been labeled with the required information to indicate the residents name, medication name, dose, instructions and route of administration. 28 Pa. Code 211.9(a)(1) Pharmacy Services.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 43856 Based on review of facility policies, resident interviews, observations, and staff interviews, it was determined that the facility failed to serve food items at appetizing temperatures. Findings include: The facility's policy regarding food temperatures, dated May 16, 2024, revealed that all hot items should be 135 Fahrenheit (F) or above. Cold products shall be 41 F or below. Foods failing to register these temperatures must be reheated/chilled until acceptable temperatures are reached. Observations of the lunch meal service on October 16, 2024, at 12:00 p.m. revealed that the last cart containing a test tray left the kitchen at 12:05 p.m. and arrived on the short hall at 12:07 p.m. Trays were passed to the residents and the last resident was served at 12:19 p.m. The test tray was removed from the cart at 12:20 p.m. and the temperature of the coffee was 110 F, the meat balls were 122 F, the pasta was 133 F, and the green beans were 80 F. The coffee, meatballs, pasta and green beans were lukewarm and not palatable. Interview with the Dietary Manager at the time of the observations confirmed that the coffee, meatballs and green beans were not at an appropriate temperature. Interview with Nursing Home Administrator on October 16, 2024, at 2:15 p.m. confirmed that food should be at 135 degrees F and be palatable. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 211.6(c) Dietary Services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43856 Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to ensure that food was served under sanitary conditions, failed to store food in accordance with professional standards of food service safety, and failure to ensure that dietary staff wore appropriate hair coverings in the kitchen. Findings include: The facility's policy regarding Food Preparation, Service and Sanitation, dated May 16, 2024, revealed that food and nutrition service employees were to prepare, distribute and serve food in a manner that complies with safe food handling practice by cleaning and sanitizing work surfaces and food-contact equipment between uses, following food code guidelines. Recommended storge practices include keeping all shelving and floors clean and dry at all times, wrap all food well to prevent freezer burn, and all opened and partially used foods shall be dated, labeled and sealed before being returned to a storage area. Food and nutrition services staff are to wear hair restraints so that hair does not contact food. Observations in the main kitchen's walk-in freezer on October 15, 2024, at 9:27 a.m. revealed a bag of donut holes and a bag of cookie dough that were not sealed or labeled with the dates they were opened. Observations in a dry storage area of the kitchen on October 15, 2024, at 9:30 a.m. revealed three loaves of bread with an expiration date of October 11, 2024, and four loaves of bread with an expiration date of October 12, 2024. Observation of the ice machine in the main kitchen on October 15, 2024, at 10:00 a.m. revealed a brown, removable substance around the opening to the inside of the ice machine where the ice was located. Observations during the lunch meal tray line on October 16, 2024, at 11:55 a.m. revealed a stack of seven dishes on the bottom shelf of a utility cart that had dust, debris, and soiled oven mitts on it, and the Dietary Manager had a hair net on her head that did not completely cover all her hair. Interview with the Dietary Manager on October 16, 2024, at 12:45 p.m. confirmed that all items in the kitchen that are opened should be secured and labeled with the date it was opened, she confirmed that the bread was out dated and that she purchases several loaves and freezes them for future use; however, she had no process in place to document when the bread was removed from the freezer. The Dietary Manager also confirmed that the ice machine is cleaned by the Maintenance department and should not have a removable substance on it, that the dishes should be stored in a clean area and not on a shelf with dust and debris on it, and she should have all her hair covered by a hair net while in the kitchen. Interview with the Nursing Home Administrator on October 16, 2024, at 2:15 p.m. confirmed that all of the above mentioned kitchen concerns should not be occurring in the kitchen and that there should be a process in place to ensure safe food handling and storage in the kitchen. 28 Pa. Code 211.6(f) Dietary Services.

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	395618	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mulberry Healthcare and Rehabilitation Cent	411 1/2 W Mahoning Street Punxsutawney, PA 15767

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 47819 Based on review of job descriptions and the deficiencies cited during the current survey, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to assume responsibility for effective management of the facility to ensure that the facility operated in compliance with state regulations and codes by not ensuring that mechanical lifts used to transfer residents were equipped with hanger bar latches without which the resident's health and safety are jeopardized for one of 29 residents reviewed (Resident 30). Findings include: The job description for the NHA, dated May 16, 2024, indicated that they must be knowledgeable of and demonstrate the ability to provide quality care by fostering a safe environment for residents and staff, providing emotional and psychological support for the residents within the facility, direct the day-to-day operation of the facility to ensure the highest degree of quality care is maintained at all times in accordance with current state and federal standards, and implement and enforce company policies and procedures to that end. The position description for the DON, dated May 16, 2024, indicated that the DON is to provide expert professional knowledge and skills necessary to plan, organize, develop, and direct the overall operation of the resident care department in accordance with all current regulatory standards to ensure the highest degree of quality care. The deficiencies cited under the Code of Federal Regulatory Groups for Long-Term Care, 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices (F689) revealed that the NHA and DON failed to fulfill their essential job duties for ensuring that the residents' environment remained free of accident hazards. Refer to F689. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(1)(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. 38012 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that clinical records were complete and accurately documented for one of 29 residents reviewed (Resident 102). Findings include: A quarterly MDS for Resident 102, dated July 31, 2024, indicated that the resident was cognitively intact, had a feeding tube (a tube surgically inserted into the stomach), and had pressure ulcers. A physician's order, dated October 9, 2024, included an order to empty and record drainage from Penrose drain (a tube surgically inserted to drain fluid from a wound) in the right hip every shift. A review of Resident 102's Medication Administration Review (MAR), dated October 2024, revealed that staff emptied the Penrose drain. A surgical note for Resident 102, dated October 8, 2024, revealed that the resident had surgery to clean out a pressure ulcer and the Penrose drain was sewn into the resident's pressure ulcer in the right hip and through the right buttock in order to create a tract for the wounds to heal. The Penrose drain would not be emptied, should be left alone for two weeks, then removed. Interview with the Director of Nursing on October 17, 2024, at 9:33 a.m. revealed that the Penrose drain cannot be emptied and the staff should not have charted that they drained it. 28 Pa. Code 211.5(f) Clinical Records.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 43856 Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plan of corrections for an annual survey ending December 7, 2023, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending October 18, 2024, identified repeated deficiencies regarding accurate completion of Minimum Data Set (MDS) assessments (mandated assessments of residents' abilities and care needs); quality of care; accidents and hazards; pharmacy services; medication storage; food procurement-storing, preparing and serving food under sanitary conditions; complete and accurate medical records; and following proper infection control practices. The facility's plan of correction for a deficiency regarding the accuracy of assessment, cited during the survey ending December 7, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F641, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding accuracy of assessments. The facility's plan of correction for a deficiency regarding quality care, cited during the surveys ending December 7, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding quality care. The facility's plan of correction for a deficiency regarding safety and accident hazards, cited during the survey ending December 7, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F689, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding accidents and hazards. The facility's plans of correction for deficiencies regarding pharmacy services, cited during the survey ending December 7, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F755, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding pharmacy services. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's plan of correction for a deficiency regarding labeling and storing medications, cited during the survey ending December 7, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F761, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding secure storage of medications. The facility's plan of correction for a deficiency regarding food storage and sanitation, cited during the survey ending December 7, 2023, revealed that audits would be completed, and the results of the audits would be presented at the quarterly QAPI meeting. The results of the current survey, cited under F812, revealed that the QAPI committee was ineffective in maintaining compliance with the regulation regarding food procurement-storing, preparing and serving food under sanitary conditions. The facility's plan of correction for a deficiency regarding complete and accurate medical records, cited during the survey ending December 7, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F842, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding complete and accurate medical records. The facility's plans of correction for deficiencies regarding infection control, cited during the survey ending December 7, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F880, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding proper infection control practices. Refer to F641, F684, F689, F755, F761, F812, F842, F880. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(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. 43856 Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to ensure that proper infection control practices were followed while providing medications for one of 29 residents reviewed (Resident 19). Findings include: The facility's medication administration policy, dated May 16, 2024, indicated that only persons licensed or permitted by the state to prepare, administer and document the administration of medications may do so and that staff will follow established facility infection control procedures (e.g. handwashing, aseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 19, dated September 9, 2024, indicated that the resident was alert, could understand, and required assistance from staff for her daily care needs. Observations on October 16, 2024, at 8:15 a.m. during medication pass revealed that Licensed Practical Nurse 5 was preparing medications for Resident 19 and dropped one of the pills inside a drawer in the medication cart. Licensed Practical Nurse 5 reached in the drawer with her bare hands and retrieved the pill, then proceeded to tape the pill to the back of the medication card that she took it from. Licensed Practical Nurse 5 stated that she did not want to waste it and wanted to save it for the next medication pass. Interview with Licensed Practical Nurse 5 on October 16, 2024, at 8:16 a.m. confirmed that she did retrieve the pill from the drawer with her bare hands and taped it to the back of the medication card and she should not have. Interview with the Nursing Home Administrator on October 16, 2024, at 2:15 p.m. confirmed that Licensed Practical Nurse 5 should not have retrieved the pill with her bare hands and taped it to the back of the medication card. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.