STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395623	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandview Nursing and Rehabilitation	78 Woodbine Lane Danville, PA 17821

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 39929 Based on observations, review of select facility policy, and staff interview, it was determined the facility failed to ensure the necessary information for filing a grievance was posted and/or provided/available to residents or their representatives, and failed to make residents aware of the procedure for filing a concern/grievance, written or verbally, and the procedure to file an anonymous grievance as reported by five of five residents (Residents 111, 134, 60, 135, and 46) during a group meeting. Findings include: A review of the facility's policy entitled Grievance Policy (reviewed July 2024) indicated it is the facility's policy all grievances and complaints filed will be investigated and corrective actions will be taken to resolve the grievance. During a group interview conducted on September 25, 2024, at 10:30 AM with 5 alert and oriented residents, five of five residents in attendance (Residents 111, 134, 60, 135, and 46) stated they were unaware of how to file a grievance. The residents were unaware of any information posted in the facility regarding the grievance process and the location of grievance/concern submission boxes to submit an anonymous grievance. Observations of the facility's three nursing units conducted on September 24 and 25, 2024, revealed no postings regarding the facility's grievance policy. During an interview on September 25, 2024, at 10:00 AM with the Nursing Home Administrator and Director of Nursing were unable to provide evidence that residents were given the details of the grievance process to include procedures to identify the grievance official and the procedure for filing a concern/grievance, written or verbal and anonymous if requested, including the locations of boxes to place anonymous grievances. 28 Pa. Code 201.29(a)(b)(1) Resident rights 28 Pa. Code 201.18 (e)(4) Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395623	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
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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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on clinical record review and staff interview it was determined the facility failed to include, in the resident's baseline plan of care, minimum standards of care to fully address the resident's immediate needs upon admission for one resident out 30 sampled (Resident 300) Findings: A review of Resident 300's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included end stage renal disease (a condition that occurs when the kidneys stop functioning) and dependence on renal dialysis (a treatment that removes excess water, waste products, and toxins from the blood when the kidneys are no longer able to function properly). A review of physician's orders revealed an order initially dated September 17, 2024, for the resident to receive dialysis on Tuesdays, Thursdays, and Saturdays at 5:30 AM. Review of Resident 300's baseline care plan failed to identify the resident is dependent on renal dialysis, three times per week. Additionally, the care plan failed to identify any goals and objectives and failed to include interventions that address his current needs related to dialysis. Interview with the Director of Nursing on September 27, 2024, at approximately 1:20 PM confirmed the facility failed to ensure this resident's baseline care plan included the minimum healthcare information necessary to properly care for this resident immediately upon his admission, which would address this resident's specific health and safety concerns to prevent decline or injury. 28 Pa Code 211.12 (d)(1)(2)(3)(5) Nursing Services.

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on a review of clinical records and staff interviews it was determined the facility failed to develop and implement an individualized discharge plan for one of 30 residents reviewed (Resident 134) to reflect the resident's discharge goals. Findings Include: Clinical record review revealed that Resident 134 was admitted to the facility on [DATE], with diagnoses to include alcohol abuse. Review of a quarterly Minimum Data Set Assessment (MDS- a federally mandated standardized assessment process completed at specific intervals to plan resident care) dated August 31, 2024, indicated the resident had a BIMS (brief interview mental screener that aids in detecting cognitive impairment) score of 9 indicating moderate cognitive impairment. The resident was independent with all activities of daily living. During an interview with Resident 134 on September 25, 2024, he indicated he does not want to be in the facility. When asked if social services was assisting him with a potential discharge to the community, he stated that no one was helping him with discharge planning. A review of the clinical record revealed there was no documented evidence of discharge planning for Resident 134's since admission on June 15, 2023 regarding discharge planning. A review of the resident's comprehensive care plan, reviewed during the survey ending September 27, 2024, revealed no documented evidence that an individualized discharge plan was developed, and revised, as needed to reflect the resident's current desire for discharge or long-term placement at the facility. During an interview with the Director of Nursing on September 26, 2024, at 12:00 PM confirmed there was no documented evidence of a current discharge goal and plan for this resident. 28 Pa. Code 201.25 Discharge policy. 28 Pa. Code 211.11(d)e Resident care plan.

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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	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on observation, review of clinical records, and resident and staff interviews it was determined that the facility failed to provide services consistent with professional standards of practice by failing to follow physician orders for bowel protocol for one resident (Resident 68) to promote normal bowel activity to the extent practicable and failed to follow physician orders for the consistent application of a prescribed therapeutic measures, wheelchair leg rests, for one resident of 30 sampled (Resident 136). Findings include: According to the American Academy of Family Physicians (The American Academy of Family Physicians is one of the largest medical organizations in the US founded to promote the science and art of family medicine) the primary goal of constipation management should be symptom improvement, and the secondary goal should be the passage of soft, formed stool without straining at least three times per week. A review of the facility policy titled Bowel Protocol last reviewed by the facility, June 2024, indicated the purpose was to promote proper elimination patterns and avoid fecal impaction (when stool becomes stuck in the colon and blocks the bowel). Staff would document BM's (bowel movements)6 every shift, assess the resident's normal elimination pattern and administer laxative as ordered by the medical provider. Staff were to notify the medical provider if no results from the administered medication(s) per the bowel regimen. A review of the clinical record revealed that Resident 68 had physician orders dated April 19, 2024, for the following bowel regimen: - Milk of Magnesia (MOM) Suspension 400 mg/5ML (Magnesium Hydroxide), Give 30 ml by mouth as needed for constipation if no BM (bowel movement) after the second day. -Glycerin Adult Suppository (Laxative) , insert 1 suppository rectally as needed for constipation if no BM on the third day and no result from MOM. -Fleet Oil Enema (Mineral Oil), insert 1 application rectally as needed for constipation if no BM on the fourth day and no result from the suppository. Review of Resident 68's Documentation Survey Report v2 for July 2024, revealed that Resident 68 did not have a bowel movement on July 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 2024. Review of Resident's Medication Administration Record (MAR) for July 2024, revealed no documented evidence that nursing administered the prescribed bowel protocol during the time period without a bowel movement to promote bowel activity. There was no documented evidence the staff had notified the physician the resident went ten consecutive days, July 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 2024, without a bowel movement. (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	Review of Resident 68's Documentation Survey Report v2 for August 2024, revealed that Resident 68 did not have a bowel movement on August 24, 25, 26, 27, 28, 2024. Review of Resident's Medication Administration Record (MAR) for August 2024, revealed no documented evidence that nursing administered the prescribed bowel protocol during the time period without a bowel movement to promote bowel activity. There was no documented evidence that staff had notified the physician the resident went five consecutive days, August 24, 25, 26, 27, 28, 2024, without a bowel movement. During an interview with the Director of Nursing (DON) on September 27, 2024, at 9:20 AM, the DON was unable to provide evidence the physician ordered bowel protocol was followed for Resident 68 during the period without bowel activity stated above, nor evidence of timely physician notification. A review of the clinical record revealed that Resident 136 was admitted to the facility on [DATE], with diagnoses to include cerebral infarction (stroke). An annual Minimum Data Set assessment (MDS-standardized assessment completed at specific intervals to identify specific resident care needs) dated July 9, 2024, indicated the resident was severely cognitively impaired, was non-ambulatory, used a wheelchair, and was dependent on staff for mobility. A physician order dated November 9, 2023, noted an order for leg rests on the wheelchair only when transporting the resident. Observation on September 26, 2024, at 9:40 AM revealed Resident 136 was in the hallway in a scoot chair (type of wheelchair which is close to the ground and allows the user mobility by using the feet) without leg rests attached. At this time, Employee 4 (nurse aide) was cueing Resident 136 to lift his feet to transport the resident down the hall. Resident 136 did not respond to the cueing to lift his feet. Employee 4 (nurse aide) then slowly pulled Resident 136 down the hall backwards in the scoot chair. Interview with the rehab therapy director on September 26, 2024, at 11:30 AM confirmed that leg rests were to be applied to Resident 136's scoot chair (allows user mobility by using the feet) during transport for safety, as per physician order. Interview with Employee 4 (nurse aide) on September 26, 2024, at 12:00 PM revealed that Resident 136's wheelchair leg rests were not available to apply to the resident's scoot chair. Observation of Resident 136's room and closet with Employee 4 (nurse aide) confirmed the resident's wheelchair leg rests were not available in the resident's room. During an interview with the director of nursing (DON) on September 26, 2024, at approximately 1:30 PM, the DON confirmed that Resident 136 was to be provided the wheelchair leg rests for transport as ordered. The facility failed to follow physician orders for Resident 136's therapeutic device by ensuring they were available for use. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.5(f) Medical records

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on a review of clinical records and staff interview, it was determined the facility failed to develop and implement an individualized person-centered plan to render trauma informed care to a resident with a diagnosis of Post-Traumatic Stress Disorder for one out of 30 residents reviewed (Resident 137). Findings include: A review of the clinical record revealed that Resident 137 was admitted to the facility on [DATE], with diagnoses that included Post Traumatic Stress Disorder (PTSD a mental health condition that's caused by an extremely stressful or terrifying event, either being part of it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety and uncontrollable thoughts about the event). The resident's current care plan, in effect at the time of review on September 27, 2024, did not identify the resident's PTSD symptoms or triggers related to this diagnosis and resident specific interventions to meet the resident's needs for minimizing triggers and/or re-traumatization. The facility failed to develop and implement an individualized person-centered plan to address, this resident's diagnosis of PTSD according to standards of practice to promote the resident's emotional well-being and safety. Interview with the Director of Nursing on September 27, 2024, at 10:00 AM confirmed the facility was unable to demonstrate the facility provided culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for resident's experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident. 28 Pa Code 211.12 (d)(3)(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** 39929 Based on a review of clinical records, facility staffing records, and resident and staff interviews it was determined the facility failed to efficiently deploy sufficient nursing staff to provide timely and quality care to each resident including 4 residents out of 30 sampled (Residents 101, 68, 60, and 135). Findings include: A review of the clinical record revealed that Resident 68 was admitted to the facility on [DATE], with diagnoses to include diabetes (body has trouble controlling blood sugar and using it for energy), muscle weakness, and need for assistance with personal care. A review of the quarterly minimum data set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated June 13, 2024, revealed the resident was cognitively intact, with a BIMS score of 15 (Brief Interview for Mental Status - a tool to assess cognitive function. A score of 13-15 indicates cognitively intact responses) and required staff assistance for activities of daily living, transferring, and mobility. During an interview with Resident 68 on September 24, 2024, at 12:00 PM, the resident stated he only gets one shower a week. He reported he would prefer to get more than one shower a week because my hair gets greasy and I wear a brief so sometimes I smell. He reported that he feels he is offered only one shower a week due to staff shortages. He stated, there just aren't enough staff to take care of everyone. A review of the clinical record revealed that Resident 101 was admitted to the facility on [DATE], with diagnoses to include cerebral infarction (stroke). A review of a significant change minimum data set assessment dated [DATE], revealed the resident was cognitively intact, with a BIMS score of 15, and required staff assistance for transferring and mobility. During an interview September 26, 2024, at 12:00 PM, Resident 101 stated the call bells are not timely answered and he often waits an hour for requests such as a drink. Resident 101 stated he feels there are not enough staff to answer the call bells timely and to provide showers as often as he would like. Resident 101 stated he only receives one shower per week. Resident 101 stated he would like a shower daily but does not feel that the facility would be able to provide a daily shower as per his preference based on limited available staff. A review of the clinical record revealed that Resident 60 was admitted to the facility on [DATE], with diagnoses to include chronic obstructive pulmonary disease. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a significant change minimum data set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated September 10, 2024, revealed the resident was cognitively intact, with a BIMS score of 14 (Brief Interview for Mental Status - a tool to assess cognitive function. A score of 13-15 indicates cognitively intact responses) and required staff assistance for activities of daily living, transferring, and mobility. During an interview with Resident 60 on September 25, 2024, at 10:00 AM, the resident stated she only gets one shower a week. She stated sometimes she doesn't even get the one shower a week and then goes up to two weeks without a shower. She further stated she feels she is offered only one shower a week due to staff shortages and the fact that she requires an assist of two in a hoyer lift (mechanical lift). Review of Resident 60's clinical record revealed the resident's tasks indicated the resident was to be showered every Tuesday, this documentation supported the residents statements as only one shower had been documented in the last thirty days with bed baths being completed on the other Tuesdays during the last 30 days. A review of the clinical record revealed that Resident 135 was admitted to the facility on [DATE], with diagnoses to include aphasia (a comprehension and communication reading, speaking, or writing disorder resulting from damage or injury to a specific area in the brain). A review of a quarterly minimum data set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated July 22, 2024, revealed the resident was moderately cognitively impaired, with a BIMS score of 9 (Brief Interview for Mental Status - a tool to assess cognitive function) and required staff assistance for activities of daily living, transferring, and mobility. During an interview with Resident 135 on September 25, 2024, at 10:00 AM, the resident stated he only gets one shower a week. Further stated that sometimes he doesn't even get the one shower a week and then goes up to two weeks without a shower. Review of Resident 135's clinical record revealed the resident's tasks indicated the resident was to be showered every Thursday, this documentation supported the residents statements as only one shower had been documented in the last thirty days with bed baths being completed on the other Thursdays during the last 30 days. Based on a review of nurse staffing and resident census and staff interview, it was determined the facility failed to consistently provide minimum general nursing care hours to each resident daily. A review of the facility's staffing levels revealed that on the following dates the facility failed to provide minimum nurse staffing of 3.2 hours of general nursing care to each resident: September 7, 2024, 2024 - 2.96 direct care nursing hours per resident. September 8, 2024 - 3.11 direct care nursing hours per resident. September 14, 2024 - 2.83 direct care nursing hours per resident. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	September 15, 2024 - 3.13 direct care nursing hours per resident. September 20, 2024 - 3.14 direct care nursing hours per resident. September 21, 2024 - 3.02 direct care nursing hours per resident. September 22, 2024 - 2.73 direct care nursing hours per resident. September 23, 2024 - 3.15 direct care nursing hours per resident. The facility failed to provide sufficient nursing staff to provide the necessary services to meet the clinical, safety and care needs of the residents residing in the facility. Interview with the administrator on September 26, 2024, at 1:15 PM confirmed that call bells should be promptly answered. The administrator failed to provide documented evidence the decision for only a weekly shower was Resident 101's preference and failed to provide evidence that residents were being showered as indicated. The facility failed to deploy sufficient nursing staff in a manner to provide quality care and services to residents. 28 Pa. Code 211.12 (c)(d)(4)(5)(f.1)(3) Nursing services 28 Pa. Code 201.18 (b)(1)(3)(e)(1) Management

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on a review of clinical records and staff interview, it was determined the facility failed to develop and implement an individualized person-centered plan to address a resident's dementia-related behavioral symptoms for one resident (Resident 38) out of 30 residents sampled. Findings include: A review of the clinical record revealed that Resident 38 was admitted to the facility on [DATE], with diagnoses to include dementia (a chronic condition that causes a loss of cognitive function, such as thinking, remembering, and reasoning, that interferes with daily life) with psychotic disturbances (severe mental disorder that cause abnormal thinking and perceptions). An Admission MDS Assessment (Minimum Data Set - a federally mandated standardized assessment completed periodically to plan resident care) dated August 17, 2024, revealed the resident was severely cognitively impaired. A review of a nursing progress note dated August 30, 2024, at 9:46 AM revealed the resident was noted to be screaming and yelling out. When staff questions resident as to what is wrong the resident indicates nothing is wrong. Further it was indicated the resident continued to be heard yelling for her husband and dog. The documentation failed to indicate any interventions attempted to address the resident's behavioral symptoms to meet the resident's needs at that time. A review of a nursing progress note dated August 31, 2024, at 5:29 AM revealed the resident had difficulty sleeping through out the night. The resident was noted to be calling out incoherently and yelling for no apparent reason. It was indicated that staff attempted to redirect the resident however, the resident continued to holler throughout the night. Facility staff failed to identify how they attempted to redirect the resident. The documentation failed to address what interventions the facility staff implemented to try to determine the cause of the yelling and deescalate the resident's behaviors. A review of a nursing progress note dated September 2, 2024, at 5:57 AM revealed the resident was having issues sleeping throughout the night. The resident was hollering out incoherently. The resident had ripped her incontinence brief into pieces on two separate occasions. The resident threw her blankets on the floor and her stuffed animal across the room. Documentation indicated the resident's needs were met but the resident continued to have behaviors. The staff failed to identify how the resident's needs were met since the resident continued to have behaviors. The staff failed to provide the resident with person centered interventions to try and manage the resident behaviors. A review of a nursing progress note dated September 5, 2024, at 6:35 AM revealed the resident had multiple tearful episodes that included the resident screaming out with incoherent stories. Documentation indicated the resident could only be redirected for short periods of time with snacks and 1:1 conversation. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a nursing progress note dated September 5, 2024, at 8:04 AM revealed the resident continued to have behaviors of yelling out and arguing with herself. No documented interventions were implemented at that time. A review of a progress note dated September 11, 2024, at 6:29 AM indicated the resident had multiple episodes of screaming out during the night. It was noted the resident was hard to redirect and was very tearful. Staff indicated they offered 1:1 socialization and snacks which have been ineffective in the past. A review of a nursing progress note dated September 12, 2024, at 11:28 PM revealed the resident was behavioral and attempting to climb out of bed. The resident was noted to be calling out. The resident was brought out to the common area for safety. The facility failed to document interventions implemented to address the resident's behavioral health needs. A review of documentation dated September 17, 2024, at 10:54 AM revealed the resident was agitated, restless, and yelling out throughout the shift. The facility failed to identify any interventions implemented to alleviate the resident's behavioral symptoms. A review of a nursing progress note dated September 19, 2024, at 10:14 PM indicated the resident was yelling and screaming out during the shift. It was noted the resident was unable to be redirected. The staff failed to identify how they attempted to redirect the resident or document any interventions attempted to stop the resident's behaviors. A review of a nursing progress note dated September 23, 2024, at 3:33 AM revealed the resident was yelling throughout the night. Staff indicated they attempted to redirect the resident but the resident continued to yell and rip up her incontinence brief. The staff failed to identify how they attempted to redirect the resident and failed to implement person center interventions to address the resident's behaviors. A review of a progress note dated September 23, 2024, at 8:32 AM revealed the resident continued to exhibit behaviors. The resident was noted to be screaming from her room sating she wanted her dog and that she needed help. Further, it was indicated when staff approached her, she would be consoled but as they left the room the behaviors would continue. A review of a nursing progress note dated September 23, 2024, at 3:09 PM indicated the resident was heard screaming from her room. Upon entering the room, the resident was found seated on her bed with her incontinence brief torn to shreds. The resident had stated she wanted someone to get her out of the facility. Documentation indicated staff placed her back in bed and she was and noted she was a tiny bit calmer for a few minutes. No documented evidence was found that facility staff had implemented person center interventions to address the resident's behavioral health needs. A review of the resident's plan of care initially dated August 15, 2024, revealed the resident has cognitive loss related to dementia. The dementia care plan failed to indicate an individualized person-centered plan to address, modify and manage this resident's dementia-related behaviors. The resident's care plan for dementia failed to include individualized interventions based on an assessment of the resident's preferences, social/past life history, customary routines, and interests in an effort to manage the resident's dementia-related behavioral symptoms. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Grandview Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 78 Woodbine Lane Danville, PA 17821	

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's plan of care for the resident being at risk for behavioral symptoms initially dated August 6, 2024, revealed the facility did not identify and add diversional activities to attempt to alleviate the resident's behavioral symptoms until September 24, 2024, during the survey. The facility staff failed to develop and implement effective interventions to manage the dementia care needs and behaviors of Resident 38. An interview with the Nursing Home Administrator on September 27, 2024, at approximately 1:20 PM failed to provide evidence that an effective individualized person-centered plan to address and manage the resident's dementia-related behaviors was implemented. 28 Pa, Code 211.12 (c)(d)(1)(3)(5) Nursing services 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 2-1.29(a) Resident rights.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on clinical record review and staff interview, it was determined the facility failed to show adequate monitoring of behaviors and potential adverse consequences of psychoactive medication and failed to consistently attempt non-pharmacological interventions prior to the administration of psychoactive drugs for one resident out of 30 residents reviewed (Resident 126). Findings include: Review of Resident 126's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included anxiety, adjustment disorder (a group of symptoms, such as stress, anxiety, feeling sad or hopeless, and physical symptoms that can occur after you go through a stressful life event), and non-traumatic subarachnoid hemorrhage (bleeding in the brain that occurs without head trauma). A review of physician orders revealed the resident had the following orders for Ativan (psychotropic antianxiety medication) : August 6, 2024, Ativan 0.5mg give 1 tablet by mouth every eight hours as needed for anxiety until August 12, 2024. August 19, 2024, Ativan 0.5mg give 1 tablet by mouth every eight hours as needed for anxiety for 14 days. September 4, 2024, Ativan 0.5mg give 1 tablet by mouth every eight hours as needed for traumatic subdural hematoma with agitated states and anxiety for 7 days. September 18, 2024, Ativan 0.5mg give 1 tablet by mouth every eight hours as needed for anxiety for 14 days. A review of an order administration note dated August 11, 2024, at 7:47 PM revealed the resident received a dose of the as needed Ativan. The facility failed to document the specific behaviors the resident was exhibiting for the Ativan to be administered. Non-pharmacological interventions were not attempted prior to the administration of the as needed antianxiety medication. A review of an order administration note dated September 5, 2024, at 12:41 PM revealed the resident received a dose of the as needed Ativan. The facility failed to document the specific behaviors the resident was exhibiting for the Ativan to be administered. Non-pharmacological interventions were not attempted prior to the administration of the as needed antianxiety medication. A review of an order administration note dated September 10, 2024, at 12:11 PM revealed the resident received a dose of the as needed Ativan. The facility failed to document non-pharmacological interventions attempted prior to the administration of the as needed antianxiety medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of an order administration note dated September 11, 2024, at 3:03 PM revealed the resident received a dose of the as needed Ativan. The facility indicated interventions were ineffective but failed to identify what type interventions were implemented and deemed ineffective. A review of an order administration note dated September 19, 2024, at 10:50 AM revealed the resident received a dose of the as needed Ativan. The facility failed to document the specific behaviors the resident was exhibiting for the Ativan to be administered. Non-pharmacological interventions were not attempted prior to the administration of the as needed antianxiety medication. Interview with the Director of Nursing on September 27, 2024, at approximately 1:20 PM confirmed that nursing staff failed to record adequate monitoring for behaviors and confirmed that nonpharmacological interventions were not consistently being attempted prior to the administration of the as needed antianxiety drug. Based on a review of clinical records, facility staffing records, and resident and staff interviews it was determined the facility failed to efficiently deploy sufficient nursing staff to provide timely and quality care to each resident including . residents out of 30 sampled (Residents 101, 68 .). Findings include: A review of the clinical record revealed that Resident 68 was admitted to the facility on [DATE], with diagnoses to include diabetes (body has trouble controlling blood sugar and using it for energy), muscle weakness, and need for assistance with personal care. A review of the quarterly minimum data set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated June 13, 2024, revealed the resident was cognitively intact, with a BIMS score of 15 (Brief Interview for Mental Status - a tool to assess cognitive function. A score of 13-15 indicates cognitively intact responses) and required staff assistance for activities of daily living, transferring, and mobility. During an interview with Resident 68 on September 24, 2024, at 12:00 PM, the resident stated that he only gets one shower a week. He reported he would prefer to get more than one shower a week because my hair gets greasy and I wear a brief so sometimes I smell. He reported that he feels he is offered only one shower a week due to staff shortages. He stated, there just aren't enough staff to take care of everyone. A review of the clinical record revealed that Resident 101 was admitted to the facility on [DATE], with diagnoses to include cerebral infarction (stroke). A review of a significant change minimum data set assessment dated [DATE], revealed the resident was cognitively intact, with a BIMS score of 15, and required staff assistance for transferring and mobility. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview September 26, 2024, at 12:00 PM, Resident 101 stated that call bells are not timely answered and that he often waits an hour for requests such as a drink. Resident 101 stated that he feels there are not enough staff to answer the call bells timely and to provide showers as often as he would like. Resident 101 stated that he only receives one shower per week. Resident 101 stated that he would like a shower daily but does not feel that the facility would be able to provide a daily shower as per his preference based on limited available staff. Interview with the administrator on September 26, 2024, at 1:15 PM confirmed that call bells should be promptly answered. The administrator failed to provide documented evidence that the decision for only a weekly shower was Resident 101's preference. The facility failed to deploy sufficient nursing staff in a manner to provide quality care and services to residents. 28 Pa. Code 201.5 (f)(ix) Medical records 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 48277 Based on observation, select facility policy review and staff interview, it was determined the facility failed to implement and adhere to procedures to ensure acceptable storage and use by dates for multi-dose medications on one of four medication carts and two of two medication storage rooms observed (West medication cart #3, [NAME] medication storage room, and East medication storage room). Findings include: A review of facility policy titled Administering Medications last reviewed by the facility June 2024, revealed the expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-use container, the date opened shall be recorded on the container. A review of the manufacturer instructions for the storage of Lantus Insulin vials, Insulin Aspart vials, Insulin Lispro vials, and Fiasp vials (medications used to manage diabetes) revealed the vials should be stored in the refrigerator until ready for use. Once the insulin vials are taken out of the refrigerator for use, they may be used for up to 28 days and should discarded after 28 days, even if they still have insulin remaining in the vial. Observation of the [NAME] Hall medication cart #3 on September 26, 2024, at 9:20 AM in the presence of Employee 1 (registered nurse), revealed a vial of Lantus injectable 100 ml opened, used, and dated August 26, 2024, a vial of Lantus injectable 100 ml opened, used, and dated August 27, 2024, two vials of Insulin Aspart injectable 100 ml opened, used, and dated August 27, 2024, a vial of Fiasp insulin injectable 100 ml opened, used, and dated August 26, 2024, and two vials of Fiasp insulin injectable 100 ml opened, used, and dated August 27, 2024. Interview with Employee 1 at the time of the observation on September 26, 2024, at 9:20 AM revealed the above medications were beyond the manufacturers recommended 28-day discard date and the medications should have been removed from the medication cart and discarded. Observation of the medication room on the [NAME] Wing on September 26, 2024, at 9:35 AM, in the presence of Employee 2 (licensed practical nurse) of medication stored in the medication refrigerator, revealed a multi-dose vial of Aplisol (solution used for screening tuberculosis) that had been opened, available for use, and dated August 4, 2024. Review of the manufacturer dosage and administration for Aplisol revealed that vials in use for more than 30 days should be discarded. Interview with Employee 2 at the time of the observation on September 26, 2024, at 9:35 AM confirmed the Aplisol vial was dated when opened on August 4, 2024, and was beyond the manufacturer recommended use by date (30 days) and had not been discarded within 30 days of opening. Observation of the medication room on the East Wing on September 26, 2024, at 9:45 AM, in the presence of Employee 3 (registered nurse) of medication stored in the medication refrigerator, revealed a multi-dose vial of Aplisol that had been opened, available for use, and not dated when opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Employee 3 at the time of the observation on September 26, 2024, at 9:45 AM confirmed that the Aplisol vial was opened and not dated. Interview with the Nursing Home Administrator on September 26, 2024, at 1:30 PM, confirmed that the facility failed to adhere to acceptable storage and use by dates for multi-dose medications. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on review of clinical records and staff interview, it was determined the facility failed to offer routine annual dental services for one Medicaid payor source out of four residents sampled (Resident 77) for dental services. Findings include: Review of the clinical record of Resident 77 revealed admission to the facility on [DATE], and the resident's payor source was Medicaid. There was no documented evidence at the time of the survey ending September 27, 2024, the resident had been offered dental services in the past year. Interview with the Director of Nursing on September 27, 2024, at approximately 9:30 AM confirmed the facility had not offered Resident 77 routine dental services in the past year. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 21738 Based on observation, resident and staff interviews and a review of meal service delivery schedule it was determined the facility failed to consistently maintain sufficient staffing in the dietary department to effectively and efficiently carry out the functions of the food and nutrition service department. Findings include: Interview with the food service director (FSD) on September 24, 2024, at 9:30 AM revealed she is also cooking on this date for the breakfast and lunch meals. The FSD noted the food and nutrition services department was attempting to hire additional staff. Interview with Resident 48, a cognitively intact resident, on Tuesday September 24, 2024, at 11:30 AM revealed the past Sunday she did not receive supper until 7:45 PM at night. Review of the facility's Food Cart Delivery Schedule revealed the last cart of lunch trays was expected to arrive on the [NAME] Nursing Unit at 12:30 PM. Observation of the [NAME] Nursing Unit lunch meal on September 24, 2024, revealed the last cart of lunch trays did not arrive until 1:00 PM (30 minute delay). Interview with Resident 101, a cognitively intact resident, on September 26, 2024, at 11:45 AM confirmed his meals have been late at times and the past weekend he did not receive supper until 7:45 PM Interview with the FSD on September 26, 2024, at 1:00 PM confirmed meal trays were often late (greater than 15 minutes of the posted meal time) due to the need for more dietary staff. The FSD confirmed on Sunday September 22, 2024, residents' supper meal trays were late and she was made aware that some residents did not get supper until 7:45 PM. Interview with the nursing home administrator on September 26, 2024, at approximately 1:30 PM failed to provide documented evidence that sufficient staffing to support the operations of the food and nutrition service department were consistently available daily to ensure the timely arrival and delivery of meals to residents as scheduled. 28 Pa. Code 201.18 (e)(1)(3)(6) Management

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 21738 Based on observation, a review of facility's planned menus, and resident and staff interview it was determined the facility failed to accommodate individual food preferences to the extent possible, to increase resident satisfaction with meals for residents which included 8 residents of 30 residents reviewed (Residents 48, 128, 101, 111, 134, 60, 135, and 46). Findings include: During an interview with Resident 48, a cognitively intact resident, on September 24, 2024, at 11:30 AM the resident stated many times milk or sugar are not provided with meals. Resident 48 also stated at times an alternate meal is not always available for the main entree and the only choice is a peanut butter and jelly sandwich. Resident 48 stated this morning there was no juice available for breakfast. Review of a grievance filed by Resident 48 on August 23, 2024, revealed a concern there was no bacon for breakfast, no milk, and no sugar. The response to the grievance included that sugar packets were ordered and now available. The response noted gallons of bulk milk were available at the time however, there was no explanation as to why the milk was not provided to the resident. The grievance did not address why bacon was not provided for breakfast. During a group interview conducted on September 25, 2024, at 10:30 AM with 5 alert and oriented residents, five of five residents in attendance (Residents 111, 134, 60, 135, and 46) indicated the facility runs out of items they like on their trays. They stated recently the facility had run out of juice and sugar packets. Observation during the lunch meal in the main dining room on September 24, 2024, at 12:15 PM revealed Resident 128 did not receive the planned vegetable on the menu, green beans, with her lunch. Resident 128 did not receive an alternate vegetable in place of the green beans. Interview with the foodservice director (FSD) at this time confirmed that cooked tomatoes were available as an alternate vegetable for the lunch meal. The FSD confirmed the alternate vegetable was to be offered to residents who did not like green beans. Cooked tomatoes were provided to Resident 128 after the surveyor inquiry and Resident 128 confirmed she likes cooked tomatoes. Interview with the FSD on September 26, 2024, at 10:30 AM confirmed the facility did not have juice for breakfast on September 24, 2024. The FSD confirmed in the past the facility had run out of sugar. During interview with Resident 101, a cognitively intact resident, on September 26, 2024, at 11:45 AM the resident indicated he would like to have a double entree with his meals. Resident 101 stated when he requests an extra entree at mealtime he is told that he has to wait until everyone is served and if there is enough of the entree available, then he would be provided an extra serving. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the FSD on September 27, 2024, at 10:30 AM confirmed the ordered food supply was to be in adequate amounts to ensure that menu items and regularly provided foods were available. The FSD confirmed that residents' preferences were to be accommodated to the extent possible. The FSD confirmed staff were to ensure that alternates were offered to residents. 28 PA. Code 201.18 (b)(3)Management. 28 Pa. Code 211.6 (a)Dietary services.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. 21738 Based on review of the Menu Committee Minutes and resident and staff interviews, it was determined the facility failed to ensure that residents' drink preferences were honored for 7 of seven residents reviewed (Residents 48, 101, 111, 134, 60, 135, and 46). Findings include: Review of Menu Committee Minutes dated, May 1, 2024, revealed that 37 residents were in attendance. During the meeting the residents in attendance were informed that soda will no longer be available unless a resident has an upset stomach. Ginger Ale will be offered in that occurrence. Residents were informed the break room vending machines offer soda (no price provided). Also, BINGO prizes at times consist of soda. During an interview on September 24, 2024, at 11:30AM with Resident 48, a cognitively intact resident, revealed she was upset the facility was no longer offering soda. Resident 48 stated the vending machine price was too high. Resident stated her family has been providing her with soda since the facility had stopped providing soda as a beverage choice. During a group interview conducted on September 25, 2024, at 10:30 AM with 5 alert and oriented residents, five of five residents in attendance (Residents 111, 134, 60, 135, and 46) stated they were very upset the facility was no longer offering soda. All five residents stated they were not made aware prior to the facility removing soda from the menu that it would be removed. They further stated the vending machine price is too high for them and not all their families can accomodate bringing soda in for them. During interview on September 26, 2024, at 11:45 AM Resident 101, a cognitively intact resident, revealed he was upset that the facility was no longer offering soda. Resident 101 stated the vending machine price was too expensive (over $2.00 per bottle). Resident 101 also stated he has no family to bring in soda for him. Resident 101 further stated he does not attend BINGO and even at BINGO you might not win a game in order to get the soda prize. Interview with the foodservice director (FSD) on September 26, 2024, at 10:30 AM confirmed that a few months ago corporate made the decision to not offer soda as a drink preference. The FSD confirmed that Ginger Ale is available for residents when they have an upset stomach. Interview with the administrator on September 26, 2024, at 1:30 PM confirmed that corporate made the decision to remove soda as a beverage preference. The administrator confirmed there were residents at the facility who enjoyed soda as a beverage choice, but soda had no nutritional value and was too expensive to provide to the residents on an as requested basis. The administrator failed to provide documented evidence that residents which included Residents 48, 101, 111, 134, 60, 135, and 46 were provided with drinks based on individual preferences and which the facility had provided as a beverage choice in the recent past. 28 Pa. Code 201.29(a) Resident Rights.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on observation and staff interview, it was determined the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in the kitchen in one of three resident pantries (West Nursing Unit). Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). Observation during the initial tour of the kitchen in the presence of the foodservice director (FSD) on [DATE], at 9:20 PM revealed four cases of meat directly on the floor outside the walk-in freezer. Interview with the FSD at this time confirmed that a food delivery was just made to the facility and the cases of meat should have been placed on a pallet to ensure they did not have direct contact with the floor prior to being placed in the freezer. Observation of the [NAME] Nursing Unit resident pantry on [DATE], at 12:00 PM revealed 12 four-ounce containers of milk in the refrigerator with a sell by date of [DATE]. Observation of the facility ice machine located on the first floor on [DATE], at 10:00 AM revealed a heavy build-up of a black and pink colored substance on the end of the condensation hose (a hose which drains excess water from the ice machine). Observation on the East Nursing Unit during the lunch meal on [DATE], at 12:50 PM revealed the exterior surface of the food delivery cart which contained resident meal trays was visibly soiled with a build-up of dirt and debris. Observation of the kitchen on [DATE], at 10:00 AM revealed the following sanitation concerns: There was a rag in the handwashing sink. A pan identified as clean, stored on a shelf, was visibly soiled and greasy to touch. The surface of the two-tiered shelf located under the steamer was rusted and visibly soiled. The metal back splash of the stovetop was heavily scorched and in need of cleaning. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Grandview Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 78 Woodbine Lane Danville, PA 17821	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The perimeter of the floors throughout the kitchen had a build-up of debris and were visibly soiled. There were four stained ceiling tiles above the dishwasher. The chemical bucket lid located under the dishwasher had a build-up of dirt and debris. Brooms located in the broom closet within the kitchen were stored in direct contact with the floor and not on the hooks located in the closet. Interview with the foodservice director on [DATE], at 10:30 AM confirmed the dietary department and resident pantries were to be maintained in a sanitary manner and that expired food items were to be discarded. 28 Pa. Code 201.18 (e)(2.1) Management 28 Pa. Code 211.6 (f) Dietary services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 41581 Based on review of select facility policies, the facility's infection control log and staff interview, it was determined the facility failed to maintain and implement a comprehensive program to monitor and prevent infections in the facility. Findings included: A review of facility policy entitled Infection Prevention and Control Program last reviewed June 2024, indicated the facility must establish an infection prevention and control program under which it identifies, investigates, controls, and prevents infections in the facility. The policy indicated the facility must maintain a record of incidents and corrective actions related to infections. A review of the facility's infection control data revealed the facility's infection control program failed to reflect an operational system to monitor and investigate causes of infection and manner of spread. There was no evidence of a system, which enabled the facility to analyze clusters, changes in prevalent organisms, or increases in the rate of infection in a timely manner. A review of facility infection control logs for September 2023 through September 2024 revealed the facility did not have accurate tracking of infections for the months September 2023 through May 2024. A review of clinical records indicated that Resident 70 was treated for was treated for cellulitis in the month of September 2023. Resident 36 was treated for a urinary tract infection in the month of November 2023. Resident 2 was treated for a urinary tract infection in the month of November 2023. An interview with the Director of Nursing (DON) on September 27, 2024, at approximately 10:35 AM revealed the infection control tracking logs could not be located prior to her starting at the facility in June of 2024. Interview with the Infection Preventionist on September 27, 2024, at approximately 10:45 AM confirmed the facility infection control logs were not complete and failed to maintain a comprehensive program to monitor and prevent infections. The facility failed to demonstrate that its infection control program included, at a minimum, a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, and visitors following accepted standards and guidelines. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services. 28 Pa. Code 211.10(c)(d) Resident care policies.

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on observation, and staff interviews, it was determined the facility failed to consistently provide a fully functioning call system to provide direct communication from the resident to the caregivers for three of 3 nursing units. Observations on the Pavilion Nursing Unit on September 26, 2024, at 11:30 AM revealed when call bells are activated resident room numbers will scroll across a [NAME]. Staff assigned to care for residents must have a pager in their possession which is audible. Further observations revealed there were no pagers on the unit behind the nursing station for employees. An interview with Employee 5 RN (registered nurse) on September 26, 2024, at approximately 11:35 AM revealed she did not have a required pager on her to be alerted to the residents' call bells. An interview with Employee 6 NA (nurse aide) on September 26, 2024, at 11:37 AM revealed the employee did not have a pager to be alerted to the residents' call bells. An interview with Employee 7 LPN (license practical nurse) on September 26, 2024, at 11:39 AM revealed it was her first day on the unit and she was not aware she needed to carry a pager for the call bell system, and did not have a pager in her possession. An interview with Employee 8 NA on September 26, 2024, at 11:42 AM revealed there is not enough pagers on the unit for staff and she did not have the required pager in her possession to be alerted if the call bell is activated. An interview with Employee 9 NA on September 26, 2024, at 11:46 AM revealed the employee did have a pager but there normally isn't enough for everyone on the unit. The employee stated if she sees one, she will take it. The employee stated the pagers are required for the call bell system since the bells themselves don't ring. She stated the pager will make a sound when the resident rings their bell. Observations on the [NAME] Nursing Unit on September 26, 2024, at 11:30 AM revealed a basket of pagers were behind the nursing station desk. An interview with Employee 2 (LPN) on September 26, 2024, at 11:35 AM revealed she did not have her pager. An interview with Employee 17 (nurse aide) on September 26, 2024, at approximately 11:40 AM revealed that she did not have her pager. An interview with Employee 19 (nurse aide orientee) on September 26, 2024, at approximately 11:45 AM revealed that he did not have a pager and was trained to watch the scrolling screen located in the halls which identifies when call bells are activated and the location of the resident who needs assistance. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Employee 18 (nurse aide) on September 26, 2024, at approximately 11:55 AM revealed that she had a pager but that it was not working. Observations on the East Nursing Unit on September 26, 2024, at 11:50 AM revealed no pagers were behind the nursing station desk. An interview with Employee 10 NA on September 26, 2024, at 11:56 AM revealed the she did not have a pager and there is only 3 pagers to the unit. The employee indicated there were no pagers to be found that morning at the start of her shift. An interview with Employee 11, NA on September 26, 2024, at approximately 12:00 PM revealed she just came back from her break, and she did not have a pager. When the employee asked where she would get a pager the employee showed the surveyor where they would get the pagers. The pagers were to be located at the nurse's station. The employee confirmed at that time there were not any pagers for her to utilize. A review of the facility regulatory compliance history, revealed the same deficient practice was cited by the State Survey Agency during a survey on March 12, 2024, whereas the call bell system was not properly utilized by failing to ensure staff were aware of the requirement of using a pager to respond to residents' requests for assistance via the nurse call bell system and failed to ensure call system pagers were available for use. At that time, the facility reported that the problem was corrected by audits to ensure there was an adequate supply of pagers available to staff and education was provided regarding the expectation of staff to wear pagers while on duty and report any issues related to the function or availability of the pagers. Interview with the nursing home administrator (NHA) on September 27, 2024, at approximately 9:35 AM confirmed the facility failed to properly utilize the call bell system to provide timely care and services to the residents in the facility. 28 Pa. Code 201.18 (b)(1)(3)(e)(2.1)(3) Management 28 Pa. Code 205.28 (c)(1) Nurses' station. 28 Pa. Code 211.12 (c) Nursing services.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 39929 Based on review of facility policies and staff training records, as well as staff interviews, it was determined the facility failed to provide dementia management training for five of five employees (Employees 12, 13, 14, 15, and 16). Findings include: The facility's policy regarding abuse, last reviewed July 2024, revealed that staff were to receive training on abuse and dementia management. Review of the education records/personnel files of employees hired in the last four months, revealed the following: Employee 12 was hired on September 12, 2024. There was no documented evidence that Employee 12 received dementia management training. Employee 13 was hired on September 6, 2024. There was no documented evidence that Employee 13 received dementia management training. Employee 14 was hired on August 1, 2024. There was no documented evidence that Employee 14 received dementia management training. Employee 15 was hired on July 2, 2024. There was no documented evidence that Employee 15 received dementia management training. Employee 16 was hired on July 31, 2024. There was no documented evidence that Employee 16 received dementia management training. Interview with the Director of Nursing on September 27, 2024, at 12:26 p.m. was unable to provide evidence that newly hired staff were trained on dementia care. 28 Pa. Code 201.19 (7) Personnel policies and procedures. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.20 (b) Staff development.