STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395646	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hill Rehabilitation & Healthcare Center	827 Georges Station Road Greensburg, PA 15601

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to routinely conduct care plan meetings and invite the resident or interested family member to attend for two of 26 residents reviewed (Residents 3, 20). Findings include: The facility's policy regarding care plan conferences, dated February 19, 2025, indicated that the intent was to promote a care plan conference which ensured that the resident and/or responsible party would have the opportunity to review and participate in the development of the care plan. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated May 28, 2025, indicated that the resident was understood and understands, required assistance with activities of daily living, and had diagnoses that included Parkinson's. Interview with Resident 3, dated June 17, 2025, at 1:27 p.m., revealed that the resident stated the facility does not conduct care plan meetings with her or invite her responsible party. There was no documented evidence in Resident 3's medical record that a care plan meeting was conducted, or that the resident and/or responsible party was invited to a care plan meeting. An annual MDS assessment for Resident 20, dated March 7, 2025, indicated that the resident was cognitively impaired, required assistance with activities of daily living, and had diagnoses that included dementia with behavioral disturbances. There was no documented evidence in Resident 20's medical record that a care plan meeting was conducted, or that the resident and/or responsible party was invited to a care plan meeting. Interview with the Nursing Home Administrator and Social Service Director on June 18, 2025, at 1:36 p.m. confirmed that care plan meetings were not being held at least quarterly as required. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 201.24(e)(4) admission Policy.

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on a review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to maintain the dignity of one of 26 residents reviewed (Resident 45) who had an indwelling urinary catheter (a flexible tube inserted into the bladder to drain urine). Findings include: A facility policy for Quality of Life - Dignity, dated February 19, 2025, indicated that residents shall be treated with dignity and respect at all times. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by helping the resident to keep urinary catheter bags covered. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 45, dated May 26, 2025, indicated that the resident had moderate cognitive impairment, had an indwelling urinary catheter, and had diagnoses that included neurogenic bladder (lack of bladder control due to brain, spinal cord or nerve problems). Observations of Resident 45 on June 16, 2025, at 2:15 p.m. revealed that the resident was lying in his bed with his urinary catheter drainage bag that contained urine hanging on his bed frame and visible from the hallway. Interview with Licensed Practical Nurse 1 on June 16, 2025, at 2:20 p.m. revealed that the urinary drainage bags usually come with a privacy cover; however, Resident 45's catheter drainage bag did not have a privacy cover. Interview with the Nursing Home Administrator on June 16, 2025, 2:31 p.m. confirmed that all catheter bags should have a privacy cover. 28 Pa. Code 201.29(c) Resident Rights.

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on clinical record reviews and staff interviews, it was determined that the facility failed to provide the required notice to the resident or the resident's representative following the end of their Medicare coverage for one of 26 residents reviewed (Resident 44). Findings include: A Skilled Nursing Facility Beneficiary Protection Notification Review form, completed by the facility and dated February 10, 2025, revealed that Medicare coverage for Resident 44 started on January 11, 2025, and that her last covered day was February 12, 2025. The form indicated that the facility initiated discontinuation from Medicare Part A coverage, and that the resident's benefit days were not exhausted. The Advanced Beneficiary Notice of Non-coverage for Resident 44 was not issued. Interview with the Nursing Home Administrator on June 18, 2025, at 12:37 p.m. confirmed that Resident 44 was not provided with an Advanced Beneficiary Notice of Non-coverage as required when their Medicare coverage ended. 28 Pa. Code 201.18(e)(1) Management.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to notify the resident and the resident's representative, in writing regarding the reason for transfer to the hospital and to ensure that a bed-hold notice was provided to the resident's responsible party for two of 26 residents reviewed (Residents 29, 36). Findings include: The facility's policy regarding bed-holds and returns, dated February 19, 2025, indicated that residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold policies. Residents, regardless of payer source are provided written notice about these policies at least twice: notice one well in advance of any transfer (for example, in the admission packet); and notice two at the time of transfer (or if the transfer was an emergency, within 24 hours). An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 29, dated March 25, 2025, indicated that the resident had moderate cognitive impairment, required assistance from staff for daily care needs, and had diagnoses that included dementia. A nurse's note for Resident 29, dated January 1, 2025, at 3:22 a.m., revealed that the resident was sent to the hospital for evaluation of pneumonia. A nurse's note at 6:26 a.m. revealed that the resident was admitted to the hospital. There was no documented evidence that written notification of transfer was provided to Resident 29 and the resident's representative, and no documented evidence that a bed-hold notice was provided to the resident's responsible party as required. Interview with the Nursing Home Administrator on June 18, 2025, at 12:37 p.m. confirmed that a written notification of hospital transfer was not provided to Resident 29 and their representatives, and that a bed-hold notice was not provided to Resident 29's responsible party as required. A quarterly MDS assessment for Resident 36, dated May 7, 2025, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and had a diagnoses that included heart failure, hypertension (high blood pressure), and kidney failure. Nursing notes for Resident 36, dated May 20, 2025, at 2:00 a.m. revealed that the resident complained of persistent shortness of breath and generalized fatigue, and requested to go to the hospital for evaluation. At 8:30 a.m. the resident was admitted to the hospital. There was no documented evidence that written notification of transfer was provided to the resident and the resident's representative, and no documented evidence that a bed-hold notice was provided to the resident's responsible party as required. Interview with the Nursing Home Administrator on June 18, 2025, at 2:19 p.m. confirmed that a written notification of hospital transfer was not provided to Resident 36 and their representatives, and that a bed-hold notice was not provided to Resident 36's responsible party as required. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.29(j) Resident Rights.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on a 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 (MDS) assessments for nine of 26 residents reviewed (Residents 2, 3, 7, 13, 14, 18, 20, 40, 42). Findings include: The RAI User's Manual, dated October 2025, indicated that Section B0700 (make self-understood) should be coded with either clearly understood, usually understood, sometimes understood, or rarely/never understood. Section C0100 (should brief interview for mental status be conducted) should be completed if the resident is at least sometimes understood verbally, in writing, or using another method. Section C0100 was to be coded No (0) or Yes (1) to determine whether a Brief Interview for Mental Status (BIMS) (an assessment to determine a resident's cognitive status) should be attempted with the resident. The instructions for determining if a BIMS interview should be attempted indicated that if the resident was at least sometimes understood (verbally or in writing) then the BIMS interview was to be attempted with the resident and coded in Sections C0200 through C0500. If the resident was rarely/never understood, then the BIMS interview was not to be attempted, and a Staff Assessment of Mental Status was to be completed instead and coded in Sections C0600 through C1000. The instructions for determining a resident mental status Section D0100 was to be coded zero (0) No if a mood interview was not to be conducted with the resident because the resident was rarely/never understood and/or unable to respond, and one (1) Yes if a mood interview should be conducted with the resident. The RAI Manual indicated that a mood interview should be attempted with all residents. A quarterly MDS assessment for Resident 2, dated March 7, 2025, revealed that the resident is understood and understands, Section C0100 was coded Yes (1) that a BIMS assessment was to be conducted; however, Sections C0200-C0500 were coded as not assessed. Section D0150 was also coded Yes (1) that resident mood interview Section D0150 was to be conducted; however, the section was coded as not assessed. A quarterly MDS assessment for Resident 3, dated May 28, 2025, revealed that the resident is understood and understands, Section C0100 was coded Yes (1) that a BIMS assessment was to be conducted; however, Sections C0200-C0500 were coded as not assessed. Section D0150 was also coded Yes (1) that resident mood interview Section D0150 was to be conducted; however, the section was coded as not assessed. A quarterly MDS assessment for Resident 7. dated May 4, 2025, revealed that the resident was able to make herself understood and was able to understand others. Section C0100 was coded Yes (1) that a BIMS assessment was to be conducted; however, Sections C0200-C0500 were coded as not assessed. A quarterly MDS assessment for Resident 14, dated May 9, 2025, revealed that the resident was able to make himself understood and was able to understand others. Section C0100 was coded Yes (1) that a BIMS assessment was to be conducted; however, Sections C0200-C0500 were coded as not assessed. Section D0100 was also coded Yes (1) that a resident mood interview was to be conducted; however, the Section D0150 was coded as not assessed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly MDS assessment for Resident 18, dated May 16, 2025, revealed that the resident was able to make himself understood and was able to understand others. Section C0100 was coded Yes (1) that a BIMS assessment was to be conducted; however, Sections C0200-C0500 were coded as not assessed. Section D0100 was also coded Yes (1) that a resident mood interview was to be conducted; however, the Section D0150 was coded as not assessed. A quarterly MDS assessment for Resident 40, dated May 19, 2025, revealed that the resident is understood and understands, Section C0100 was coded Yes (1) that a BIMS assessment was to be conducted; however, Sections C0200-C0500 were coded as not assessed. Section D0150 was also coded Yes (1) that resident mood interview Section D0150 was to be conducted; however, the section was coded as not assessed. Interview with the Nursing Home Administrator on June 17, 2025, at 2:21 p.m. confirmed that the above-mentioned MDS assessments for Residents 2, 3, 7, 14, and 40 were coded inaccurately and that Sections C0200-0500 and Section D0150 should have been completed per the RAI manual. The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (required assessments of a resident's abilities and care needs), dated October 2025, revealed that Section N0415F1 Antibiotic Medications (medication used to for infections) was to be coded if the resident took the medication during the seven-day look-back period. Physician's orders for Resident 13, dated April 21, 2025, included an order for the resident to receive 1 gram of methenamine hippurate (an antibiotic) two times a day. The resident's Medication Administration Record (MAR) for May 2025 revealed that the resident received methergine Hippurate from May 1 through May 31, 2025. A quarterly MDS for Resident 13, dated May 2, 2025, revealed that Section N0401F1 was not coded, indicating that the resident did not receive antibiotic medication during the seven-day look-back assessment period. Interview with the Nursing Home Administrator on June 18, 2025, at 11:07 a.m. confirmed that Resident 13's quarterly MDS assessment was coded to indicate that the resident did not receive an antibiotic during the look-back period. Physician's orders for Resident 20, dated June 7, 2023, included an order for the resident to receive 1 gram of methenamine (an antibiotic) two times a day. The resident's Medication Administration Record (MAR) for March 2025 revealed that the resident received methenamine twice a day during the seven-day look-back assessment period. An annual MDS for Resident 20, dated March 7, 2025, revealed that Section N0401F was not coded, indicating that the resident did not receive antibiotic medication during the seven-day look-back assessment period. Interview with the Nursing Home Administrator on June 17, 2025, at 2:21 p.m. confirmed that Resident 20's MDS assessment was coded inaccurately, and that the resident did receive antibiotics during the look-back period. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician's orders for Resident 42, dated April 29, 2025, included an order for the resident to have Magic Mix (1:1:1:1) of Silvadene (antibiotic), hydrocortisone (steroid medication), nystatin (antifungal medication), and zinc cream (used to prevent skin irritation) applied to his right buttocks daily. Resident 42's Treatment Administration Records (MAR's) for April and May 2025 revealed that the resident received Magic Mix to his right buttocks daily from April 30 through May 31, 2025. A quarterly MDS for Resident 42, dated May 2, 2025, revealed that Section N0401F1 was not coded, indicating that the resident did not receive an antibiotic medication during the seven-day look-back assessment period. Interview with the Nursing Home Administrator on June 18, 2025, at 11:07 a.m. confirmed that Resident 42's quarterly MDS assessment was coded incorrectly, and did not indicate that the resident received an antibiotic during the look-back period. 28 Pa. Code 211.5(f) Clinical Records.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to develop individualized care plans for four of 26 residents reviewed (Residents 13, 20, 36, 45). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 13, dated May 2, 2025, indicated that the resident was cognitively intact and was frequently incontinent of bowel and bladder. Physician's orders for Resident 13, dated April 21, 2025, included an order for the resident to receive Methenamine Hippurate (an antibiotic) two times a day for preventative measures. A Certified Registered Nurse Practitioner's note, dated April 22, 2025, indicated that Resident 13 had chronic urinary tract infections and was to continue suppressive therapy with Methenamine Hippurate. However, there was no documented evidence that a care plan was developed to address Resident 13's long term antibiotic use. An interview with the Director of Nursing on June 17, 2025, at 1:53 p.m. confirmed that there was no care plan in place to address Resident 13's antibiotic use. An annual MDS assessment for Resident 20, dated March 7, 2025, indicated that the resident was understood and could understand, required assistance from staff for her daily care needs, and had medical diagnoses that included dementia. Physician's orders for Resident 20, dated June 7, 2023, included an order for the resident to receive Methenamine (an antibiotic) two times a day for recurrent urinary tract infections. However, there was no documented evidence that a care plan was developed to address Resident 20's antibiotic use. An interview with the Nursing Home Administrator on June 17, 2025, at 2:21 p.m. confirmed that there was no care plan in place to address Resident 20's antibiotic use. A quarterly MDS assessment for Resident 36, dated May 15, 2024, revealed that the resident was cognitively intact, had a pressure ulcer, received dialysis, and had diagnoses that included renal failure. Physician's orders for Resident 36, dated May 23, 2025, included orders for the resident to receive dialysis on Tuesdays, Thursdays and Saturdays, and physician's orders, dated June 1, 2025, included an order for the resident's bed to be equipped with a bariatric air mattress. However, there was no documented evidence that a care plan was developed to address Resident 36's air mattress or for dialysis. Observations on June 16, 2025, at 10:30 a.m. revealed that Resident 36 was in bed with an air mattress in place. A nursing note, dated June 17, 2025, at 9:39 a.m. revealed the resident left the facility for dialysis. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing on June 17, 2025, at 1:53 p.m. confirmed that there were no care plans developed for the resident's use of an air mattress or dialysis treatments. An admission MDS assessment for Resident 45, dated May 26, 2025, indicated that the resident had moderate cognitive impairment, had an indwelling urinary catheter (a flexible tube inserted into the bladder to drain urine), required assistance from staff for daily care needs, and had diagnoses that included neurogenic bladder (lack of bladder control due to brain, spinal cord or nerve problems). However, there was no documented evidence that a care plan was developed to address Resident 45's use of an indwelling urinary catheter. Observations of Resident 45 on June 16, 2025, at 2:15 p.m. revealed the resident lying in his bed with his urinary catheter drainage bag containing urine hanging on his bed frame. Interview with the Director of Nursing on June 17, 2024, a 12:34 p.m. confirmed that Resident 45 had an indwelling urinary catheter and that there was no care plan in place to address the care and treatment needs related to the resident's indwelling urinary catheter. 28 Pa. Code 201.24(e)(4) admission Policy. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on review of the Pennsylvania Nurse Practice Act, facility policies, and clinical records, as well as staff interviews, it was determined that the facility failed to obtain a physician's orders for a medication for one of 26 residents reviewed (Resident 13). This deficiency was cited as past non-compliance. Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain and restore the well-being of individuals. The facility's policy regarding medication administration, dated February 19, 2025, indicated that medications were to be administered in accordance with the prescriber's orders, including any required time frame. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 13, dated May 2, 2025, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included respiratory failure. A physician's order, dated April 9, 2025, included an order for 875-125 milligrams (mg) of Amoxicillin Potassium Clavulanate (antibiotic). A nursing note, dated April 19, 2025, revealed that at 10:00 a.m. Resident 13 was given Amoxicillin Potassium Clavulanate, and then complained of shortness of breath. Registered Nurse 2 thought the reaction could be related to the new medications and administered 1 gram of Epinephrine (used to treat emergency allergic reactions) in her right thigh. The resident was then sent to the hospital for evaluation and treatment. A review of Resident 13's clinical record revealed no documented evidence of a physician's order to administer Epinephrine. Interview with the Nursing Home Administrator on June 18, 2025, at 11:18 a.m. confirmed that Registered Nurse 2 administered Epinephrine to Resident 13 without a physician's order. Following identification that a medication was administered without a physician's order, the facility's corrective actions included: Resident 13 was transferred to the hospital for evaluation and treatment. Medication Administration Records (MAR's) and progress notes for all residents in house were checked to ensure medications were being administered per physician's orders. Education was provided to licensed staff regarding administering medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Audits were completed five times a week for two weeks, then biweekly for two weeks, and then monthly for one month to ensure all medications that were administered had a physician's order. The findings were reviewed with the quality assurance performance improvement committee. A review of the facility's corrective actions revealed that they were in compliance with F658 on April 22, 2025. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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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. Based on review of policies, clinical records, and bathing records, as well as staff interviews, it was determined that the facility failed to ensure that residents were provided with showers/baths as scheduled for one of 24 residents reviewed (Resident 5). Findings include: The facility's policy regarding baths/showers, dated February 19, 2025, revealed that staff were to document the date and time that the resident's shower was provided. Staff were to notify the charge nurse or supervisor if the resident refused the shower or bath. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated May 26, 2025, revealed that the resident was cognitively intact and was dependent on staff for showers/baths. The resident's care plan, dated June 1, 2025, revealed that staff were to assist her to bathe/shower as needed. Interview with Resident 5 on June 16, 2025, at 10:30 a.m. revealed that she was upset that she was not getting her showers as scheduled. Current bathing records indicated that Resident 5 was to receive a bath/shower every Wednesday and Saturday during the evening shift. Review of Resident 5's bathing records for May and June 2025 confirmed that there was no documented evidence that a shower/bath was offered or provided on Saturday May 31 and June 7, 2025. Interview with the Director of Nursing on June 18, 2025, at 1:12 p.m. confirmed that there was no documented evidence that Resident 5 was provided showers/baths as scheduled, and there was no evidence of refusals. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that the resident environment remained as free from accident hazards as possible by failing to complete an air mattress safety assessment to identify potential safety hazards for two of 26 residents reviewed (Residents 20, 36). Findings include: The facility's policy regarding air mattresses, dated February 19, 2025, indicated that support surfaces will be utilized in accordance with manufacturer recommendations (including considerations for contraindications) a schedule for inspection and replacement will be established accordingly. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 20, dated March 7, 2025, indicated that the resident was understood and understands, required assistance from staff for her daily care needs, and had medical diagnoses that included dementia. Physician's orders for Resident 20, dated June 1, 2025, included an order for the resident's bed to be equipped with a perimeter air mattress. There was no documented evidence that the use of an air mattress was assessed for potential safety hazards prior to the air mattress being placed on Resident 20's bed. Observations on June 16, 2025, at 10:15 a.m. revealed that Resident 20 was in bed with an air mattress in place. Interview with the Director of Nursing on June 17, 2025, at 12:26 p.m. confirmed that there were no specific assessments completed to ensure that the use of an air mattress was safe for Resident 20. A quarterly MDS assessment for Resident 36, dated May 15, 2024, revealed that the resident was cognitively intact and had a pressure ulcer. Physician's orders for Resident 36, dated June 1, 2025, included an order for the resident's bed to be equipped with a bariatric air mattress. There was no documented evidence that the use of an air mattress was assessed for potential safety hazards prior to the air mattress being placed on Resident 36's bed. Observations on June 16, 2025, at 10:30 a.m. revealed that Resident 36 was in bed with an air mattress in place. Interview with the Director of Nursing on June 17, 2025, at 1:53 p.m. confirmed that there were no specific assessments completed to ensure that the use of an air mattress was safe for Resident 36. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure urinary output was monitored for three of 26 residents reviewed (Residents 39, 40, 45) who had an indwelling urinary catheter (a flexible tube inserted into the bladder to drain urine), and failed to ensure that physician's orders were obtained for an indwelling urinary catheter for one of 26 residents reviewed (Resident 45). Findings include: A facility policy for urinary catheters care, dated February 19, 2025, indicated that staff were to review the resident's care plan to assess for any special needs of the resident and maintain an accurate level of the resident's daily output per facility policy and procedure. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 39, dated June 3, 2025, indicated that the resident had moderate cognitive impairment, had an indwelling urinary catheter, required assistance from staff for daily care needs, and had diagnoses that included an infection and inflammatory reaction due to an indwelling urethral catheter. A care plan for Resident 39, dated June 1, 2025, indicated that the resident required a foley catheter (type of indwelling catheter) and that staff were to report any changes in the amount, color, or odor of the resident's urine. Physician's orders for Resident 39, dated May 29, 2025, included for the resident to have a foley catheter for urinary retention. There was no documented evidence that staff were measuring the resident's urine output per facility policy. A quarterly MDS assessment for Resident 40, dated May 19, 2025, revealed that the resident was understood and understands, required assistance with daily care needs, had nephrostomy tube (a tube inserted into the kidney to excrete urine), and had medical diagnoses that included heart failure and high blood pressure. A care plan, dated May 24, 2024, revealed that staff were to monitor urinary output every shift per facility policy, Review of Resident 40's clinical record revealed no documented evidence that the resident's indwelling urinary catheter output was documented during the day shift on May 20, 23, 28, 31, and June 1, 6, 8, 10, 2025; during the evening shift on May 19, 20, 21, 22, 23, 24, 25, 28, 29, 30, 31, 2025, and June 1, 4, 5, 6, 9, 10, 11, 15, 2025; and during the night shift on May 20, 22, 24, 25, 26, 29, and June 10, 15, 2025. Interview with the Director of Nursing on June 17, 2025, at 12:26 p.m. confirmed that there was no documented evidence that Resident 40's nephrostomy output was documented on the dates and times listed above. An admission MDS assessment for Resident 45, dated May 26, 2025, indicated that the resident had moderate cognitive impairment, had an indwelling urinary catheter, required assistance from staff for daily care needs, and had diagnoses that included neurogenic bladder (lack of bladder control due to brain, spinal cord or nerve problems). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record for Resident 45, dated May 2025 and June 2025, revealed no documented evidence of a physician's order for an indwelling urinary catheter or for catheter care. Observations of Resident 45 on June 16, 2025, at 2:15 p.m. revealed the resident lying in his bed with his urinary catheter drainage bag containing urine hanging on his bed frame. There was no documented evidence that staff were measuring the resident's urinary output per facility policy. Interview with the Director of Nursing on June 17, 2025, a 12:34 p.m. confirmed that Resident 45 did not have a physician's order for the use or care of an indwelling urinary catheter, and also confirmed that there was no documented evidence that catheter care was being provided. Interview with the Director of Nursing on June 18, 2025, a 11:29 p.m. confirmed that there was no documented evidence that staff were measuring urine output per facility policy for Residents 39 and 45. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that residents were provided with proper ileostomy care for one of 26 residents reviewed (Resident 42). Findings include: The facility's policy regarding colostomy/ileostomy care (care for an artificial opening in the bowel), dated February 19, 2025, indicated that staff were to review the resident's care plan to assess for any special needs of the resident. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 42, dated May 2, 2025, indicated that the resident was cognitively intact, required assistance or total dependence on staff for daily care tasks, and had an ileostomy. A care plan, dated May 8, 2023, revealed that Resident 13 had an ileostomy, he wore products, and they were to be changed as needed. Physician's orders, dated April 22, 2025, included an order for the resident to have the barrier and pouch to his right abdominal ileostomy be changed every three days and as needed. The order indicated staff were to use a #6921 Coloplast Mio 55 millimeter(mm) light convex barrier (baseplate around stoma), a #18641 Coloplast Mio 60 mm high output pouch (collection bag), a #12035 brava 2 mm ring barrier (a moldable ring designed to create a seal between an ostomy baseplate and the skin, protecting against leakage and skin irritation), and a 120700 Brava elastic barrier extender c curved (elastic strip that helps secure the ostomy barrier to the skin and prevents it from lifting or rolling up). Observations of Resident 42 on June 18, 2025, at 11:55 a.m. revealed that the resident had an ileostomy bag in place and it was leaking. He stated his pouch did not leak in the hospital, but since his return from the hospital his ileostomy pouch has been leaking. He stated that it leaked all of the time and it had recently been changed three times in one day. Observations on June 18, 2025, at 11:56 a.m. revealed that the facility's ileostomy supplies included a [NAME] 8531 premier flextend lock and roll 2 1/2 64 mm drain pouch. Interview with Registered Nurse 3 at that time revealed that the facility used the same colostomy/ileostomy supplies for all residents who required colostomy/ileostomy products and was the only product they had in the building. Interview with the Director of Nursing on June 18, 2025, at 12:36 p.m. confirmed that staff should have been using the ileostomy supplies ordered by the physician. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that long-term intravenous catheters were flushed as ordered by the physician for one of 26 residents reviewed (Resident 36). Findings include: The facility's policy regarding flushing intravenous (IV) catheters (a thin tube inserted into a vein and used long-term for the administration of fluids and/or medications), dated February 19, 2025, indicated that the catheter was to be flushed with 10 milliliters of saline (sterile salt water solution) before and after medication administration. A nursing note for Resident 36, dated May 2, 2025, at 4:54 p.m. revealed that he was readmitted to the facility and required IV therapy. Physician's orders, dated May 3, 2025, included an order for the resident to receive 2 grams of IV Meropenem solution (an antibiotic) one time a day on Tuesdays, Thursdays and Saturdays after dialysis for ESBL (Extended-Spectrum Beta-Lactamase- refers to enzymes produced by certain bacteria that make them resistant to many common antibiotics) until May 12, 2025. The resident's Medication Administration Record (MAR) for May 2025 revealed that staff administered Meropenem solution through the midline daily on May 6, 8, and 10, 2025. There was no documented evidence that staff flushed Resident 36's midline before and after the administration of IV Meropenem on May 6, 8, and 10, 2025. Interview with the Director of Nursing on June 18, 2025, at 12:07 p.m. confirmed that there was no documented evidence that Residents 36's midline was flushed before and after medication administration on the above dates. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure that a resident who needed respiratory care was provided such care consistent with professional standards of practice and the resident's person-centered care plan for one of 26 residents reviewed (Resident 2). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated March 7, 2025, revealed that the resident was understood/understands, required assistance with daily care tasks, had diagnoses that included heart failure and high blood pressure, and required supplemental oxygen. Physician's orders, dated August 29, 2023, included an order for the resident to receive continuous oxygen at a flow rate of 3 liters per minute by nasal cannula (tubes that deliver oxygen into the nostrils). Physician's orders, dated August 29, 2023, included orders to change oxygen tubing and canister every Tuesday night and as needed. Observations on June 15, 2025, at 10:15 a.m. and June 16, 2025, at 10:15 a.m. revealed that the tubing being used by the resident was dated June 4, 2025, and humidification bottle tubing was dated May 20, 2025. Interview with Licensed Practical Nurse 1 on June 16, 2025, at 10:32 a.m. confirmed that Resident 2's oxygen set-up was dated June 4, and May 20, 2025. The nurse indicated that the oxygen set-up was usually replaced every Tuesday night. Interview with the Nursing Home Administrator on June 16, 2025, at 1:49 p.m. confirmed that Resident 2's oxygen set-up should have been replaced weekly on June 10, 2025, according to physician's orders. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that a safety assessment was completed for side rail/enabler use for one of 26 residents reviewed (Resident 29). Findings include: The facility's policy regarding bed safety, dated February 19, 2025, indicated that the resident's sleeping environment shall be assessed by the interdisciplinary team, considering the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. To try to prevent deaths/injuries from the beds and related equipment, the facility shall promote the inspection of all beds and related equipment as part of the regular bed safety program to identify risks and problems including potential entrapment risks. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 29, dated March 25, 2025, indicated that the resident was moderately cognitively impaired, required assistance with care needs, had a history of falls, and had diagnoses that included dementia. Physician's orders for Resident 29, dated June 1, 2025, included for the resident to have bilateral enabler bars (type of equipment that is positioned on the side of a bed to assist residents who may need additional support with safety and/or mobility) Observations of Resident 29 on June 18, 2025, at 8:15 a.m. revealed that the resident's bed was equipped with bilateral enabler bars. There was no documented evidence that Resident 29 was assessed for potential safety hazards prior to the enabler bars being applied to the resident's bed. Interview with the Director of Nursing on June 18, 2025, at 11:42 a.m. confirmed that bed rail/enabler safety assessment was not completed for Resident 29. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on review of nurse aides' dates of hire and their most recent performance review dates, it was determined that the facility failed to complete an annual nurse aide performance evaluation for one of three nurse aides reviewed (Nurse Aide 4). Findings include: A list of nurse aides provided by the facility revealed that based on their months and days of hire, an annual performance evaluation was due in March 2025 for Nurse Aide 4. However, there was no documented evidence that an annual performance evaluation was completed as required for Nurse Aide 4. Interview with the Human Resource director on June 18, 2025, at 1:41 confirmed that she could provide no evidence that an annual performance evaluation was completed as required for Nurse Aide 4. 28 Pa. Code 201.18(e)(1) Management.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain accountability for controlled medications (drugs with the potential to be abused) for three of 26 residents reviewed (Residents 7, 36, 40). Findings include: A facility policy regarding medication administration, dated February 19, 2025, indicated that the individual administering the medication initials the resident's Medication Administration Record (MAR) on the appropriate line after giving each medication and before administering the next ones. A facility policy regarding controlled substances, dated February 19, 2025, indicated that waste and/or disposal of controlled medication are done in the presence of the nurse and a witness who also signs the disposition sheet. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 7, dated May 4, 2025, indicated that the resident was able to make herself understood and could understand others, required assistance with care needs, was taking an opioid medication (a controlled medications used to treat pain), was receiving hospice services, and had diagnoses that included dementia. Physician's orders for Resident 7, dated April 19, 2025, included an order for the resident to receive a 12 microgram per hour (mcg/hr) Fentanyl (opioid medication) transdermal patch (delivers a specific dose of medication through the skin) every three days for pain management, removing it per schedule. Review of the Medication Administration Record, as well as the controlled drug record (a form that accounts for each tablet/pill/dose of a controlled drug) for Resident 7 for April 2025, May 2025, and June 2025 revealed that a 12 mcg/hr Fentanyl patch was removed from Resident 7 on April 22, 25, 28; May 1, 4, 13, 16, 19, 22, 25, 28; and June 3, 6, 9, and 12. There was no documented evidence that the Fentanyl transdermal patch that was removed was disposed of in the presence of the nurse and a witness per facility policy. Interview with the Director of Nursing on June 17, 2025, at 2:47 p.m. confirmed that there was no documented evidence that the Fentanyl transdermal patches removed from Resident 7 on the above-mentioned dates and times were disposed of in the presence of the nurse and a witness per the facility's policy. A quarterly MDS assessment for Resident 36, dated May 7, 2025, revealed that the resident was cognitively intact, had occasional pain, received pain medication as needed, and received an opioid (a controlled pain medication). Physician's orders for Resident 36, dated March 24 and May 1, 2025, included orders for the resident to receive 50 milligrams (mg) of Tramadol (opioid medication) every four hours as needed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A controlled drug accountability record (tracks each dose of a controlled medication) for Resident 36's Tramadol revealed that one tablet was signed out on the controlled drug log on April 19 at 3:00 p.m.; April 22 (no time listed); April 24 at 7:00 a.m.; May 9 at 8:00 a.m.; May 10 at 3:00 a.m.; June 3 at 8:00 p.m.; June 10 at 8:45 a.m.; and June 12, 2025, at 7:36 a.m. There was no documented evidence in the clinical record to indicate that the signed-out doses of Tramadol were administered to Resident 36 on the above dates and times. Interview with the Director of Nursing on June 18, 2025, at 12:07 p.m. confirmed that there was no documented evidence that staff administered the controlled drugs to Resident 36 on the dates and times mentioned above. A quarterly MDS assessment for Resident 40, dated May 19, 2025, revealed that the resident was understood and could understand, required assistance with daily care needs, and has medical diagnoses that include heart failure and high blood pressure. Physician's orders for Resident 40, dated January 24, 2025, included an order for the resident to receive 50 milligrams (mg) of Tramadol (opioid medication) every eight hours for pain. Review of Resident 40's MAR for March 2025, April 2025, May 2025, and June 2025 revealed that one 50 mg tablet of Tramadol was signed-out for administration to the resident on March 17, 2025, at 10:08 a.m.; March 18, 2025, at 9:00 p.m.; March 23, 2025, at 7:09 a.m.; March 27, 2025, at 6:40 a.m.; April 2, 2025, at 8:00 p.m.; April 4, 2025, at 7:24 p.m.; April 6, 2025, at 8:25 p.m.; April 13, 2025, at 7:15 a.m.; April 14, 2025, at 7:00 a.m.; April 25, 2025, at 5:50 p.m.; May 10, 2025, at 11:40 p.m.; May 15, 2025, at 9:20 a.m.; May 23, 2025, at 9:00 p.m.; June 2, 2025, at 6:45 a.m.; and June 11, 2025, at 7:00 a.m. However, the resident's clinical record contained no documented evidence that the signed-out tablets of Tramadol were administered to the resident on these dates. Interview with the Director of Nursing on June 17, 2025, confirmed that there was no documented evidence that staff administered the controlled drugs to Resident 40 on the dates mentioned above. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from significant medication errors for one of 26 residents reviewed (Resident 7). Findings include: The facility policy for administering medications, dated February 19, 2025, indicated that medications are administered in accordance with prescriber orders, and that the individual administering medications checks the label three times to verify the right resident, right medication, right dosage, right time, and right method of administration before giving the medication. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 7, dated May 4, 2025, indicated that the resident was able to make herself understood and could understand others, required assistance with care needs, was receiving hospice services, and had diagnoses that included dementia. Physician's orders for Resident 7, dated April 16, 2025, indicated for the resident to receive 10 milligrams (mg) of diazepam (controlled drug medication used to treat anxiety) gel every two hours as needed for agitation. Review of the controlled drug record (a form that accounts for each tablet/pill/dose of a controlled drug), dated May 7, 2025, indicated that the diazepam delivered to the facility was provided in 0.5 milliliter (ml) syringes and that two 0.5 ml syringes were to be administered per dose. However, on May 16 at 10:34 p.m.; June 4 at 12:00 a.m., 12:00 p.m., 2:00 p.m. and 5:00 p.m.; June 5 at 12:35 a.m., and 7:49 p.m.; June 7 at 11:38 p.m.; June 8 at 6:40 a.m. and 10:00 p.m.; and June 11 at 9:30 p.m., only one 0.5 ml syringe of diazepam was signed out on the controlled drug record as administered. Interview with the Nursing Home Administrator on June 18, 2025, at 12:37 p.m. confirmed that staff were signing out and administering only one 0.5 ml syringe of diazepam on the above-mentioned dates and times when they should have been administering two 0.5 ml syringes. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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Oak Hill Rehabilitation & Healthcare Center	827 Georges Station Road Greensburg, PA 15601

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to provide a separately-locked, permanently-affixed compartment in the refrigerator for the storage of controlled drugs in one of one medication rooms reviewed. Findings include: The facility's policy regarding controlled substances, dated February 19, 2025, indicated that that controlled substances are separately locked in permanently affixed compartments. Observations in the facility's medication room on the French unit on June 18, 2025, at 7:36 a.m. revealed one locked compartment in the medication refrigerator that was not secured to a shelf and was able to be removed from the refrigerator. This unsecured, locked compartment contained one unopened bottle of liquid Ativan (a controlled medication used to treat anxiety). Interview with Registered Nurse 3 at the time of the observation confirmed that the locked compartment box that contained Ativan was not permanently affixed to the refrigerator. Interview with the Nursing Home Administrator on June 18, 2025, at 10:10 a.m. confirmed that the locked box in the medication room refrigerator should have been permanently affixed to the refrigerator. 28 Pa. Code 211.9(a)(1) Pharmacy Services.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on review of planned, written menus, as well as observations and staff interviews, it was determined that the facility failed to follow their pre-approved planned menu. Findings included: An interview with a group of residents on June 16, 2025, at 11:12 a.m. revealed that they did not always get what was on the menu. Review of the posted menus for the lunch meal on Monday, June 16, 2025, revealed that residents were to receive honey pot roast, fried potatoes, seasoned red cabbage, bread pudding, dinner roll with margarine, and a beverage. Observations in the main dining room on June 16, 2025, at 12:35 p.m. during the lunch meal revealed that there was no dinner roll or margarine provided to the residents. Observations on June 16, 2025, at 12:38 p.m. revealed that Resident 42 did not receive a dinner roll with margarine with his lunch meal. Interview with the Dietary Manager on June 16, 2025, at 12:45 p.m. confirmed that the dinner roll and margarine were not provided to the residents and he was unaware that they were to get a dinner roll with the lunch meal. 28 Pa. Code 211.6(a) Dietary Services.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations and staff interviews, it was determined that the facility failed to serve food that was palatable. Findings include: Review of the posted menus for the lunch meal on Tuesday, June 17, 2025, revealed that residents were to receive a smothered pork chop, mashed potatoes, steamed broccoli, pineapple delight cake, dinner roll with margarine, and a beverage. A test tray for the lunch meal on the French Hall on June 17, 2025, revealed that the cart left the kitchen at 11:53 a.m., arrived on the nursing unit at 11:54 a.m., and the last resident was served at 12:14 p.m. The test tray was tasted at 12:14 p.m. and the broccoli was mushy and not palatable. Interview with the Dietary Manager on June 17, 2025, at 12:14 p.m. confirmed that the broccoli was overcooked and was mushy. 28 Pa. Code 211.6(b) Dietary services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of facility cleaning records, as well as observations and staff interviews, it was determined that the facility failed to ensure that ice was made and stored in sanitary ice machines for one of one ice machines (pantry room) and failed to store and serve food under sanitary conditions. Findings include: The facility's cleaning records for the ice machine, dated May 20, 2025, revealed that the interior was sanitized and the outside of the ice machine was cleaned on this date. Observations of the pantry on June 18, 2025, at 9:18 a.m. revealed that the ice machine had a build up of a white, slimy substance on the plastic dispenser that the ice came out of and on the black metal screen that the leftover ice fell onto. Observations of the pantry refrigerator revealed three small containers of fresh blue berries that were not dated or labeled. Interview with the Dietary Manager on June 18, 2025, at 9:21 a.m. confirmed that the ice machine needed cleaned and the containers of fresh blueberries should have been labeled and dated. 28 Pa. Code 211.6(f) Dietary Services.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on a review of clinical records and facility investigations, as well as staff interviews, it was determined that the facility failed to ensure that residents' clinical records were complete and accurately documented for two of 26 residents reviewed (Residents 5, 29), and that documentation of an incident was part of the clinical records for one of 26 residents reviewed (Resident 29). Findings include: An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated March 27 , 2025, indicated that the resident was moderately cognitively impaired, required assistance with care needs, had a history of falls, and had diagnoses that included dementia. Review of nurse aide documentation for Resident 5, dated June 2025, revealed that there was no nurse aide documentation completed on each shift for bed mobility, bedtime snacks, bowel and bladder continence, fluid intake, personal hygiene, toilet use, and transfers on June 1, 3, 5-10, 12, 14, and 15, 2025. A quarterly MDS assessment for Resident 29, dated March 25, 2025, indicated that the resident was moderately cognitively impaired, required assistance with care needs, had a history of falls, and had diagnoses that included dementia. Review of incident investigations for Resident 29 provided by the facility revealed that an incident report was completed on March 27, 2025, when the resident was observed lying on the floor in his room next to his bed. An incident report was completed on April 6, 2025, when the resident fell out of his wheelchair onto the floor while he was coloring. There was no documented evidence in Resident 29's clinical record of the falls or registered nurse assessments after the falls on March 27, 2025, and April 6, 2025. Review of nurse aide documentation for Resident 29 dated May 2025 and June 2025 revealed that there was no nurse aide documentation completed for daily tasks on the dayshift on May 1, 4, 7, 9, 11, 12, 14, 15, 20, 22, 23, 24, 27, 28, 29, or June 1, 3, 5, 7, 10, 13, and 14. There was no nurse aide documentation completed for daily tasks on the evening shift on May 10, 11, 12, 14, 16, 19, 20, 22, 23, 24, 26, 30, or June 1, 6, 9, 10, 11, and 14. There was no nurse aide documentation completed for daily tasks on the night shift on May 2, 10, 16, 17, 23, 24, 29, 30, or June 2, 3, 4, 6, 7, 8, and 14. Interview with the Director of Nursing on June 17, 2025, at 2:47 p.m. confirmed that Resident 29 did fall on March 27, 2025, and April 6, 2025, and that there was no documented evidence in the resident's clinical record of the falls or of registered nurse assessments after the falls. Interview with the Director of Nursing on June 18, 2025, at 1:12 p.m. confirmed that Residents 5 and 29 were receiving all of their care; however, staff were not documenting the care they provided in the clinical record and should have been. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 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 plans of corrections for State Survey and Certification (Department of Health) surveys ending June 13, 2024; October 22, 2024; and April 21, 2025, 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 June 18, 2025, identified repeated deficiencies related to a failure to notify residents' of a change in Medicare coverage, to provide services provided to meet professional standards, to prevent accident hazards, to prevent issues with oxygen therapy, that nurse aide performance evaluations were completed timely, to prevent issues with the accountability of controlled medications (drugs with the potential to be abused), properly store and label medications, store and prepare food under sanitary conditions, and ensuring that clinical records were complete and accurately documented The facility's plan of correction for a deficiency regarding notification of changes to Medicare coverage, cited during the survey ending June 13, 2024, 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 F582, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding notification of changes to Medicare coverage. The facility's plan of correction for a deficiency regarding services provided meet professional standards, cited during the survey ending October 22, 2024, 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 F658, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding services provided meet professional standards. The facility's plans of correction for deficiencies regarding providing a safe environment free of accident hazards, cited during the survey ending June 13, 2024, revealed that the facility developed plans of correction that included completing audits and reporting 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 correcting deficient practices related to safety and accident-free environments. The facility's plan of correction for a deficiency regarding failure to provide respiratory care and treatment as ordered by the physician, cited during the survey ending June 13, 2024, 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 F695, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to administering oxygen as ordered. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's plan of correction for a deficiency regarding nurse aide evaluations not being completed, cited during the survey ending on June 13, 2024, revealed that audits would be conducted and the results of the audits would be brought before the QAPI committee for further monitoring. The results of the current survey, cited under F730, revealed that the QAPI committee was ineffective in maintaining compliance with the regulation regarding completing nurse aide evaluations. The facility's plan of correction for a deficiency regarding pharmacy services, cited during the survey ending June 13, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting 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 failed to successfully implement their plan to ensure ongoing compliance with regulations regarding pharmacy services. The facility's plan of correction for a deficiency regarding storing/labeling medications properly, cited during the survey ending June 13, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting 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 correcting deficient practices related to storing/labeling medications properly. The facility's plan of correction for a deficiency regarding food storage and labeling, cited during the surveys ending June 13, 2024 and April 21, 2025, revealed that audits would be conducted and the results of the audits would be brought before the QAPI committee for further monitoring. The results of the current survey, cited under F812, revealed that the QAPI committee was ineffective in maintaining compliance with the regulation regarding food storage and labeling. The facility's plans of correction for deficiencies regarding complete medical record documentation, cited during the surveys ending on June 13, 2024 and October 22, 2024, revealed that audits would be conducted and the results of the audits would be brought before the QAPI committee for further monitoring. The results of the current survey, cited under F842, revealed that the QAPI committee was ineffective in maintaining compliance with the regulation regarding complete medical records. Refer to F582, F658, F689, F695, F730, F755, F761, F812, F842. 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. Based on review of policies and residents' clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that proper hand washing/hand hygiene was completed during wound care and it was determined that the facility failed to follow infection control guidelines from the Centers for Medicare/Medicaid Services (CMS) and the Centers for Disease Control (CDC) to reduce the spread of infections and prevent cross-contamination for one of 26 residents reviewed (Resident 20). Findings include: The facility's policy regarding hand hygiene, dated February 19, 2025, revealed that hand hygiene was to be performed whether or not gloves were worn when/after touching inanimate objects that were likely to be contaminated with microorganisms, and after contact with blood, body fluids, mucous membranes, secretions, or excretions. CDC guidance on isolation precautions and Implementation of Personal Protective Equipment (PPE) use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDRO's - bacteria that have become resistant to certain antibiotics, and these antibiotics can no longer be used to control or kill the bacteria), dated July 12, 2022, indicates that MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. CMS updated its infection prevention and control guidance effective April 1, 2024. The recommendations now include the use of EBP during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, in addition to residents who have an infection or colonization with a CDC-targeted or other epidemiologically important MDRO when contact precautions do not apply. The facility's policy regarding EBP, dated February 19, 2025, revealed that EBP is an approach of targeted gown and glove use during high-contact resident care activities, designed to reduce transmission of MDROs as recommended by Centers for Medicare and Medicaid Services (CMS) guidance aligned with CDC recommendations. Enhanced Barrier Precautions may be applied when Contact Precautions do not otherwise apply to residents with: Wounds or indwelling medical devices, regardless of MDRO colonization status EBP for wound and indwelling medical devices will end when healed or removed. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 20, dated March 7, 2025, indicated that the resident was understood and understands required assistance from staff for her daily care needs, and had diagnoses that included dementia. Physician's orders for the resident, dated June 5, 2025, included an order to treat the pressure ulcer on the sacrum (buttocks) daily and as needed by applying Santyl (a wound care ointment to promote healing), cleaning the area with soap and water, apply santyl to wound bed and apply calcium alginate to wound and cover with dry dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations during wound care on June 17, 2025, at 9:27 a.m. revealed that Licensed Practical Nurse 5 gathered supplies for wound care, put them on Resident 20's bedside table, and placed a garbage bag to collect soiled materials. She did not wear a gown per the enhanced barrier precautions policy. Resident 20 was lying on her side and Licensed Practical Nurse 5 donned gloves removed residents brief and removed the old dressing. She then removed her gloves and threw the old dressing and gloves into the garbage bag. Then she reached into her pocket and donned new gloves. She then used soap and water to clean the wound bed, patted dry, and applied Santyl and calcium alginate and dry dressing. Interview with Licensed Practical Nurse 5 on June 17, 2024, at 10:19 a.m. confirmed that she should have used hand sanitizer prior to putting on new gloves, but she did not, and she did not wear a gown per the enhanced barrier precautions policy during wound care. Interview with the Nursing Home Administrator on June 17, 2025, at 2:22 p.m. confirmed that the Licensed Practical Nurse should have washed her hands with soap and water or used a hand sanitizer after removing her gloves and prior to putting on new gloves. She also confirmed that enhanced barrier precautions were not followed per policy. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.