STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395651	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Rehabilitation & Healthcare Center	395 Middle Road Nanticoke, PA 18634

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 41460 Based on a review of select facility policy, the minutes from Resident Council meetings, and grievances lodged with the facility, and resident and staff interviews, it was determined that the facility failed to demonstrate sufficient efforts to respond and resolve resident and/or family complaints that includes concerns expressed during Resident council, including those voiced by eight residents. (Resident 1, 8, 13, 14, 15, 16, CR2 and CR6) The findings include: A review of facility policy entitled Grievance Policy last updated by the facility April 30, 2023, revealed that all grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the response. Upon receipt of a grievance and/or complaint, the grievance officer will review and investigate the allegations and submit a written report of such findings to the administrator within (5) working days or receiving the grievance and/or complaint. The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems. A review of a concern submitted by the Resident Council dated February 7, 2024, revealed that there were concerns expressed by Residents 14, 15, and 16, that the meals are being served cold more than half the time. At the time of the survey ending March 28, 2024, there was no evidence that the facility had responded to the residents' the concerns expressed during resident council regarding meal temperatures and there was no resolution to the concern that the food was being served cold more than half the time. A review of concern submitted by Resident CR6 on February 7, 2024, indicated that the resident rang the call bell to request staff assistance to go to the bathroom and didn't receive staff assistance for approximately 1 hour. There was no evidence that the facility evaluated the resident's concern with call bell response and lack of timely toileting assistance and of their efforts to resolve the resident's concerns regarding untimely staff assistance and staff's failure to respond to the resident's request timely. (continued on next page)

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of resident concern submitted by Resident CR2 dated February 16, 2024, revealed that the resident complained that staff on the 3 PM to 11 PM shift were not answering her call bell when she rang for assistance with her oxygen, assistance with a basin when she was vomiting, and that staff on the both the 3 PM to 11 PM and 11 PM to 7 AM shift wouldn't clean her up of vomit until she asked. The facility's plan to resolve concern/grievance indicated that the concerns would be investigated when the resident returned, however, the resident was discharged from the facility on February 20, 2024, prior to resolution of her complaint. A grievance submitted by Resident 8 on February 17, 2024, indicated that he had concerns about his hand, a wound being monitored and treated, and wanted to see the doctor, and he stated that the staff were ignoring him. Resident 8 further expressed concern that a particular nurse aide was rude to him, and that his room was not being cleaned. There was no evidence that the facility followed up on the resident's complaints, and no evidence of the actions taken to resolve the resident's complaint that staff were rude and/or ignoring his concerns. Review of resident concern submitted by family of Resident 13 on February 28, 2024, indicated that the resident's call bell was not within reach and when the resident wanted a drink, nothing was within the resident's reach. According to the concern, staff told the resident she could get it (a drink). The facility conducted staff interviews and according to one statement, staff did identify that at 7 AM on February 28, 2024, the resident's call bell was on the floor in front of the nightstand, there were no tissues, and her water was not in reach. Review of the facility plan to resolve concern revealed that as per staff statements, items were within reach and knocked away by resident. There was no evidence that the facility discussed findings with the resident and/or family to ascertain their satisfaction with the facility's efforts to resolve their complaints. A review a concern/grievance form lodged with the facility dated March 6, 2024, at 12:30 PM, filed on behalf of Resident 1 by a family/representative revealed concerns were expressed about the resident's treatment, care and violation of rights. It was noted that On this date a staff member received a call from the resident's family member stating that Resident 1 is being harassed by a certified nurse aide (CNA) and the resident has been crying and telling her how horrible she is being treated and that they don't take care of her. It was said that the CNA was verbally abusing the resident. This grievance was given to the Nursing Home Administrator (NHA). The plan to resolve this concern was to interview the staff member involved. The results of actions taken was the staff member was suspended pending the investigation and report to the State Survey Agency, Department of Health (DOH) and noted that the concern was resolved. Documentation of is the complainant satisfied with the resolution was not identified. Complainant remarks revealed that a PB22 was filed, investigation completed, and the resident changed rooms to a different floor. The investigation results were reported to family and the resident, but failed to identify by what means (written or verbal) or the family and resident's response to the facility's action to resolve the complaint. The resident and NHA signed this document, as completed, on March 8, 2024. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On March 7, 2024, at 10:00 AM a Report Form for Investigation of Alleged Abuse, Neglect, Misappropriation of Property (PB-22 was filed related to accusations of staff mentally abusing Resident 3 that includes refusing to answer call lights and telling other staff not to answer as well. The resident is care planned for two people care. A credible witness gave a statement related to this accusation made. The area office on aging and local police were notified of this incident. The conclusion of this investigation was that the resident was being cared for, however, it causes her anxiety that she must have two people in the room for her care due to her tendency to mistrust. The resident has been moved to a different floor; employees have been in serviced to be reassuring with residents to make them feel less anxious. An interview with a cognitively intact Resident 1 on March 28, 2024, at 12:17 PM revealed that she had an issue with a staff member that was occurring for quite some time, and she had reported it to the administration with no results until recently having her room changed to a different floor. The resident stated that this staff member would scream and flail her arms at her and the resident, on several occasions, would refuse to provide care and assist her. The resident believes that staff on her new floor are upset with her due to this incident because she still must wait for assistance for up to three hours, this occurs on a regular basis. The evening before this interview (on March 27, 2024) the resident stated that she needed her foley catheter flushed and she rang her call bell, staff came in and did not even listen to what she had to say, just replied we are busy we will be back. The resident stated that was having pain related to this and rang the bell again with no answer. She then called the nurses station on the previous floor to have them connect her to someone on her new floor and they hung up on her twice. Finally, she called a family member to contact a supervisor for assistance, which was three hours after initially requesting staff assistance. The resident went on to explain that she requires two staff members to assist her as she is paralyzed from the waist down and cannot do much for herself, she began to cry as she stated that she has a hard time getting one staff member to assist her, let alone two. She was fearful that this was going to continue to keep happening. The facility was unable to provide evidence at the time of the survey ending March 28, 2024, that the facility determined if the residents' felt that their complaints or grievances had been investigated and resolved through any efforts taken by the facility in response to the residents' concerns with untimely call bell response times, staff behavior and treatment of residents. Interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on March 28, 2024, at approximately 2:15 PM was unable to provide evidence of the facility's efforts to ascertain resident awareness and/or satisfaction with any actions taken by the facility to resolve or respond to the complaints and concerns raised by residents and family members. 28 Pa. Code 201.18 (e)(1)(2) Management 28 Pa. Code 201.29 (c) Resident rights

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on a review of clinical records and facility documentation, and staff, resident and family interview, it was determined the facility failed to develop operational policies and procedures, and follow CMS (Center for Medicare and Medicaid Services) guidance to protect the resident from unacceptable practices of disenrolling residents from the Medicare Advantage Plans by ensuring all risks of disenrolling are explained and the residents are competent in making the informed decision for nine of 20 reviewed (Resident 9, 10, 11, 12, CR3, CR4, CR5, CR6, and CR7). Finding include: A review of a CMS guidance entitled Memo to Long Term Care (LTC) Facilities on Medicare Health Plan Enrollment dated October 2021 revealed CMS continues to hear reports of the unacceptable practice of nursing facilities or skilled nursing facilities (collectively, long-term care or LTC facilities) disenrolling beneficiaries from Medicare health plans (Medicare Advantage plans with and without Part D, Medicare-Medicaid plans, or Programs of All-Inclusive Care for the Elderly (PACE)) without the beneficiary's or the beneficiary's representative's request, consent, knowledge, and/or complete understanding. Only a Medicare beneficiary, the beneficiary's authorized or designated representative, or the party authorized to act on behalf of the beneficiary under state law can request enrollment in or voluntary disenrollment from a Medicare health or drug plan. Further it is indicated changes in a beneficiary's health care coverage generally must be initiated by the beneficiary or their representative. If a beneficiary or their legal representative requests assistance from the LTC facility in changing the beneficiary's health care coverage, the LTC facility should take the following steps to help ensure changes to a beneficiary's health care coverage comply with regulations regarding enrollment/disenrollment and resident rights: 1) Explain orally and in writing the impact to the beneficiary if they change coverage (e.g., to a stand-alone prescription drug plan (PDP) and Original Medicare, or to a different Medicare health plan). 2) 2) Develop written policies and procedures regarding the process of assisting beneficiaries with changing their health care coverage. At a minimum, information should include the circumstances under which the facility can assist a beneficiary with a plan change. The need to obtain a document signed by the beneficiary or representative that acknowledges that the specific information regarding the impact of a change in coverage was provided to them orally and in writing, and that that the beneficiary and/or the representative understand the information. The need to obtain an attestation signed by the facility staff member that assisted with the change in enrollment, attesting that the beneficiary or representative requested the change and that the beneficiary or representative (as applicable) received and understood the minimum required information listed above. In cases where beneficiaries request disenrollment from PACE, LTC facilities that are contracted with PACE organizations should work directly with the PACE organization and the participant's interdisciplinary team to ensure the PACE participant receives the information required under the PACE regulations and to coordinate the transition of care, including as specified in their contract requirements. (continued on next page)

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It is indicted if a LTC facility cannot provide documentation of a beneficiary's request to change enrollment, this may suggest that the enrollment action was not initiated by the beneficiary or their legal representative and therefore was not legally valid. Lastly If the facility has the beneficiary sign documentation regarding their understanding of an enrollment change, CMS will expect to find that the beneficiary's assessed cognitive function also supports an ability to understand this type of information. If CMS becomes aware of enrollment actions that the beneficiary alleges were taken without their request, consent, knowledge, and/or complete understanding, CMS will expect the facility to provide the above noted documentation to support that it appropriately assisted the beneficiary with their choice to change coverage, including that the beneficiary's cognitive function supports such decision-making. A review of Resident 9's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included hemiplegia (paralysis of one side of the body) following cerebrovascular disease (condition that affect blood flow and the blood vessels in the brain) affecting the right dominate side and cognitive communication deficit. An admission Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated October 9, 2023, revealed that the resident was moderately cognitively impaired with a BIMS score of 9 (Brief Interview for Mental Status - a tool to assess cognitive function - a score of 8-12 indicates moderately cognitively impaired). Upon admission the resident's primary insurance payer was noted to be Blue Cross Medicare Advantage Plan. On January 1, 2024, the resident's primary insurance payer was changed to traditional Medicare. A review of a facility form entitled Medicare Advantage Disenrollment Form dated December 29, 2023, revealed a request to disenroll the resident from the resident's Medicare Advantage plan so that the resident may be covered under original Medicare benefits. Further review revealed the facility had the resident, who was moderately cognitively impaired, sign the form to disenroll. Next to the resident's signature it was written his responsible party (RP) was present when the resident signed but the resident is his own RP. A review of Resident 9's clinical record revealed no documented evidence of the date or time the resident initiated the want or desire to disenroll from his Blue Cross Medicare Advantage Plan. Further there was no documentation that the facility had assessed his cognitive function prior to explaining this change, and having the resident sign the disenrollment form to identify the resident's ability to understand this type of information and the effect it may have on the resident's Medicare health insurance, presently and in the future. A review of Resident 10's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included rhabdomyolysis (breakdown of muscle tissue. It results in the release of a protein, called myoglobin, into the blood) and heart failure. An Admission Minimum Data Set assessment dated [DATE], revealed that the resident was moderately cognitively impaired with a BIMS score of 11. (continued on next page)

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the resident's primary insurance payer revealed [NAME] Gold Medicare Advantage Plan was the resident's insurance plan on admission. On February 1, 2024, the resident's Medicare Advantage plan was changed to traditional Medicare. A review of a facility form entitled Medicare Advantage Disenrollment Form dated January 31, 2024, revealed a request to disenroll the resident from the resident's Medicare Advantage plan so that the resident may be covered under original Medicare benefits. The form was sign by the resident despite being moderately cognitively impaired. A review of Resident 10's clinical record revealed no documented evidence of the date or time the resident or his responsible party initiated a request, or expressed the desire, to disenroll from his Medicare Advantage Plan. There was no documentation the facility had assessed his cognitive function timely, prior to having the resident sign the disenrollment form to identify the resident's ability to understand this type of information. As indicated above the resident was moderately cognitively impaired and there was no documentation that the resident's responsible party was made aware of this disenrollment and was explained the risks of disenrollment and agreed to the change in the resident's Medicare plan. A review of Resident 11's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included Parkinson's Disorder (A disorder of the central nervous system that affects movement, often including tremor). A Quarterly Minimum Data Set assessment dated [DATE], revealed that 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). A review of the resident's primary insurance payer revealed Aetna Medicare Advantage Plan was the resident's insurance plan in February 2024. On March 1, 2024, the resident's Medicare Advantage plan was changed to traditional Medicare. A review of a facility form entitled Medicare Advantage Disenrollment Form dated February 22, 2024, revealed a request to disenroll the resident from the resident's Medicare Advantage plan so that the resident may be covered under original Medicare benefits. Further review of the form revealed no evidence that the the facility explained the disenrollment to the resident, who was cognitively intact. The facility instead, had the resident's RP sign the form for disenrollment. A review of Resident 11's clinical record revealed no documented evidence of the date or time the resident or his RP initiated the want or desire to disenroll from his Medicare Advantage Plan. A review of Resident 12's clinical record was admitted to the facility on [DATE], with diagnoses which included muscle weakness and cirrhosis of the liver (a type of liver damage where healthy cells are replaced by scar tissue). A Quarterly Minimum Data Set assessment dated [DATE], revealed that the resident was moderately cognitively intact with a BIMS score of 13. A review of the resident's insurance payer revealed Blue Cross Blue Shield Medicare Advantage Plan. On March 1, 2024, the resident's Medicare Advantage plan was changed to traditional Medicare. (continued on next page)

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a facility form entitled Medicare Advantage Disenrollment Form dated February 22, 2024, revealed a request to disenroll the resident from her Medicare Advantage plan so that the resident may be covered under original Medicare benefits. Further review of the form revealed the facility did not explain the disenrollment to the resident who was cognitively intact, but instead had the resident's RP sign the form for disenrollment. A review of Resident 12's clinical record revealed no documented evidence of the date or time the resident or his RP requested or expressed their desire to disenroll from her Medicare Advantage Plan. A review of Resident CR3's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included Parkinson's Disease and muscle wasting. An Admission Minimum Data Set assessment dated [DATE], revealed that the resident was moderately cognitively impaired with a BIMS score of 8. A review of the resident's primary insurance payer revealed [NAME] Gold Medicare Advantage Plan was the resident's insurance plan on admission. On January 1, 2024, the resident's Medicare Advantage plan was changed to traditional Medicare. A review of a facility form entitled Medicare Advantage Disenrollment Form dated December 29, 2023, revealed a request to disenroll the resident from the resident's Medicare Advantage plan so that the resident may be covered under original Medicare benefits. The form was sign by the resident's RP. A review of Resident CR3's clinical record revealed no documented evidence of the date or time the resident or his responsible party requested a change, or expressed a desire to disenroll from his Medicare Advantage Plan. A review of Resident CR4's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain). A Significant Change MDS Minimum Data Set assessment dated [DATE], revealed that the resident was moderately cognitively impaired with a BIMS score of 12. A review of the resident's primary insurance payer revealed [NAME] Gold Medicare Advantage Plan was the resident's insurance plan on admission. On January 1, 2024, the resident's Medicare Advantage plan was changed to traditional Medicare. A review of a facility form entitled Medicare Advantage Disenrollment Form dated December 29, 2023, revealed a request to disenroll the resident from the resident's Medicare Advantage plan so that the resident may be covered under original Medicare benefits. The form was signed with the resident's name, but indicated it was signed by the resident's responsible party. However, the resident's clinical record states the resident is her own RP. (continued on next page)

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident CR4's clinical record revealed no documented evidence of the date or time the resident expressed their desire to disenroll from her Medicare Advantage Plan. Further there was no documentation the facility had assessed her cognitive function prior to having the resident sign the disenrollment form to identify the resident's ability to understand this type of information. As indicated above the resident was moderately cognitively impaired and there was no documentation that the resident's emergency contact was made aware of this disenrollment and was explained the risks of disenrollment and agreed to the change in the resident's Medicare plan. A review of Resident CR5's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included atrial fibrillation (An irregular, often rapid heart rate that commonly causes poor blood flow) and diabetes. An Admission Minimum Data Set assessment dated [DATE], revealed that the resident was moderately cognitively impaired with a BIMS score of 9. A review of the resident's primary insurance payer revealed Aetna Medicare Advantage Plan was the resident's insurance plan on admission. On February 1, 2024, the resident's Medicare Advantage plan was changed to traditional Medicare. A review of a facility form entitled Medicare Advantage Disenrollment Form dated January 31, 2024, revealed a request to disenroll the resident from the resident's Medicare Advantage plan so that the resident may be covered under original Medicare benefits. The form was sign by the resident despite being moderately cognitively disabled. A review of Resident CR5's clinical record revealed no documented evidence of the date or time the resident or his responsible party requested to be disenrolled from his Medicare Advantage Plan. Further there was no documentation the facility had assessed his cognitive function prior to having the resident sign the disenrollment form to identify the resident's ability to understand this type of information. As indicated above the resident was moderately cognitively impaired and there was no documentation that the resident's responsible party was made aware of this disenrollment and was explained the risks of disenrollment and agreed to the change in the resident's Medicare plan. A review of Resident CR6's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included muscle weakness and diabetes. An Admission Minimum Data Set assessment dated [DATE], revealed that the resident was cognitively intact with a BIMS score of 15. A review of the resident's primary insurance payer revealed [NAME] Gold Medicare Advantage Plan was the resident's insurance plan upon admission. On February 1, 2024, the resident's Medicare Advantage plan was changed to traditional Medicare. A review of a facility form entitled Medicare Advantage Disenrollment Form dated January 31, 2024, revealed a request to disenroll the resident from the resident's Medicare Advantage plan so that the resident may be covered under original Medicare benefits. A review of Resident CR6's clinical record revealed no documented evidence of the date or time the resident or his RP expressed their wish to disenroll from his Medicare Advantage Plan. (continued on next page)

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident CR7's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included respiratory failure and muscle weakness. An Admission Minimum Data Set assessment dated [DATE], revealed that the resident was moderately cognitively impaired with a BIMS score of 11. A review of the resident's primary insurance payer revealed [NAME] Gold Medicare Advantage Plan was the resident's insurance plan on admission. On February 1, 2024, the resident's Medicare Advantage plan was changed to traditional Medicare. A review of a facility form entitled Medicare Advantage Disenrollment Form dated January 31, 2024, revealed a request to disenroll the resident from the resident's Medicare Advantage plan so that the resident may be covered under original Medicare benefits. The form was not signed but instead the name of the resident's power of attorney (POA) was written in and indicated the POA gave verbal consent to make the change. A review of Resident CR7's clinical record revealed no documented evidence of the date or time the resident or his POA initiated their request to disenroll from his Medicare Advantage Plan. An interview with Employee 3 Business Office Manager on March 28, 2024, at 8:40 AM revealed that she initiates the conversations with the residents and their families about switching their Medicare advantage plans to straight traditional Medicare. A telephone interview was completed with Resident CR6's responsible party on March 28, 2024, at 9:25 AM. The resident's RP stated that he received a phone call from the facility telling him they need to switch his sister's insurance plan so she can have more days covered by therapy. The RP stated neither he nor Resident CR6 was concerned with her existing Medicare insurance or wanted to change plans prior to receiving the phone call from the facility telling them they needed to switch Medicare health plans. The RP stated that the facility did not explain the risks or potential that make affect his sister's ability to re-enroll into her original Medicare advantage plan or that her copays or available benefits and covered services might change. He stated that his sister was upset when they were working on her discharge with home health services because, as a result of the change to traditional Medicare, from her prior [NAME] Gold Medicare Advantage plan, she might have to pay more than before. The RP stated that the facility presented the change, in a manner, that made it seem like the resident had to switch her insurance plan to traditional Medicare to continue receive services in the facility. A telephone interview with Resident CR6 on March 28, 2024, at 9:34 AM revealed that the facility staff approached her during her stay and asked her to change her insurance coverage. The resident stated that she told the facility that she was happy with her [NAME] Medicare Advantage Plan. The resident stated the facility told her she would not get as much with her insurance as she would with traditional Medicare. The resident stated that the facility did not inform her that she might not be able to re-enroll back into her [NAME] Medicare advantage plan or that her copays might change, and her coverage, benefits and services might change. (continued on next page)

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A telephone with Resident CR7's POA was conducted on March 28, 2024, at 9:49 AM. The resident's POA stated that it was a hectic time when his father was admitted into the facility. He stated that the facility staff approached him about changing his father's Medicare advantage plan to traditional Medicare. The resident's POA stated he was confused by all the talk, and they never had a concern with his father's Medicare Advantage insurance plan. The POA stated the facility had a two minute conversation with him about switching insurances and was told this (making the change to traditional Medicare) is what will be best. The POA stated he never saw a form for disenrollment. The conversation between he and the facility staff happened over the phone. The POA further stated that the risks were not explained to him, and he was unaware that his father may not be able to re-enroll into his original Medicare advantage plan or that his copays and coverage might change. An interview with the Director of Nursing (DON) on March 28, 2024, at approximately 10:00 AM revealed that the facility does not have a policy on disenrolling residents from their Medicare Advantage plans but just followed the CMS guidance and handed this surveyor the CMS Medicare Disenrollment Memo. A telephone interview with Resident 12's RP on March 28, 2024, at 10:30 AM revealed that Employee 3, the facility's business office manager, initiated a conversation with her, about changing her grandmother's Medicare Advantage plan to traditional Medicare. The RP stated that the facility told her that traditional Medicare would be better for the resident. The RP stated they had no concerns with the resident's Medicare advantage plan prior to the facility approaching her about changing it to traditional Medicare. The RP stated the facility did not explain the risks of changing the plan and was not informed that the resident may not be able to re-enroll in her original Medicare advantage plan or that copays and coverage might change. A telephone interview was completed with Resident 11's RP on March 28, 2024, at 10:48 AM. The RP stated the facility approached her about changing her brother's Medicare advantage plan to traditional Medicare because it would be better for him. The RP stated they never had a problem with the resident's Medicare advantage plan. The RP stated that the facility told her that her brother would be able to re-enroll into his original Medicare advantage plan, but did not explain any risks, such as enrollment periods, potential penalties, or changes in benefits, services and copays. The RP stated she doesn't really understand much about it but the facility kept telling her that it would be better for the resident. An interview was conducted with the Nursing Home Administrator on March 28, 2024, at approximately 2:15 PM confirmed that the facility was unable to demonstrate that the facility had protected residents from unacceptable practices of disenrolling residents from the Medicare Advantage Plans, which were initiated by the facility, and not the residents or their representatives, and done without assesment of residents' cognitive abilities and full explanations of the potential risks of making these changes to their Medicare health plans. 28 Pa. Code 201.29 (a)(c) Resident rights 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (b)(2)(3)(e)(1) Management

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460 Based on observations and staff interview, it was determined that the facility failed to maintain a clean and orderly environment in resident areas on one of two resident care units. (first floor) Findings included: An observation on March 28, 2024, at approximately 8:30 AM of the first floor revealed peeling/chipped paint on the windowsills at the end of each hallway. Missing and peeling paint was observed on the multiple resident room doors on this unit. At end of the hallway on the first floor unit, floor tiles were missing and broken and a large area of molding was missing, exposing the drywall. An observation of resident room [ROOM NUMBER] revealed stained ceiling tiles. In resident room [ROOM NUMBER], laminate was missing on the surfaces of the drawers by the sink. Soiled linens were observed on the floor and draped over the wheelchair, in Resident room [ROOM NUMBER] Interview with the Director of Nursing on March 28, 2024, at approximately 1:45 PM confirmed that the facility is required to provide housekeeping and maintenance services to maintain a clean and orderly environment for its residents. 28 Pa. Code 201.18 (e)(2.1) Management

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that dependent residents were provided with the necessary services to maintain good personal hygiene, by failing to provide showers as scheduled for two of 20 residents sampled (Residents 3 and 12). Findings include: A review of the clinical record revealed that Resident 3 was admitted to the facility on [DATE], and had diagnoses, which included a need for assistance with personal care and other abnormalities of gait and mobility. A review of the resident's shower record revealed that the resident was to be showered on Tuesdays and Thursdays on the 7:00 AM to 3:00 PM shift. A review of the resident's shower schedule for the month of January 2024 and February 2024 revealed that the resident was showered once in two months and given a bed bath twice in these two months. There was no documented evidence in the resident's clinical record or care plan of any resident refusals or reasons for not showering this resident as scheduled. A review of Resident 12's clinical record was admitted to the facility on [DATE], with diagnoses which included muscle weakness and cirrhosis of the liver (a type of liver damage where healthy cells are replaced by scar tissue). A review of the resident's clinical record revealed the resident is supposed to receive a shower on 7 AM to 3 PM shift. A review of the resident's bathing record for February 2024 revealed the resident had only received one shower during the month on February 2, 2024. A review of the resident's bathing record for March 2024 revealed the resident had only received only one shower during the month on March 14, 2024. Interview with the Nursing Home Administrator on March 28, 2024, at approximately 2:15 PM confirmed the facility failed to provide adequate services for personal hygiene to meet the residents' needs. 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460 Based on review of clinical records, information submitted by the facility, and select facility reports and staff interviews, it was determined that the facility failed to provide necessary supervision and effective safety measures to monitor the whereabouts and activities of one resident at risk for elopement (Resident 2) and failed to implement appropriate interventions based on individual needs of a resident at increased risk for falls to promote resident safety and prevent falls for one resident (Resident 3) out of 20 sampled. Findings include: A review of the clinical record revealed that Resident 2 was originally admitted to the facility on [DATE], with diagnoses of Dementia (a group of symptoms that affects memory, thinking, and interferes with daily life). Review of Resident 2's plan of care, dated as initiated June 7, 2023, revealed that the resident was identified as a high risk for elopement due to exit seeking behavior with planned interventions to calmly redirect an divert resident's attention, promptly check when alarm system goes off to ensure resident is safe in the facility, wanderguard/alarming bracelet on wheelchair, monitor placement/function, and distract resident when wandering/insistent on leaving facility by offering pleasant diversion, structured activities, food, conversation, television, books, etc. A review of facility event investigation entitled Elopement dated February 22, 2024, at 8:41 AM, revealed that on February 20, 2024, at 6:15 PM, an LPN brought Resident 2 was brought to the nursing station. According to the nurse, she was in her car, when she saw a wheelchair coming out of the front door of the facility. She got out of her car because she thought it was a resident who usually went outside. When she looked closely, she observed that it was Resident 2. The nurse escorted Resident 2 back into the building and the resident was assessed with no injuries identified. According to the investigation, Resident 2 was placed on checks/observations every 15-minute. Review of the elopement by the interdisciplinary team determined that Resident 2 was within view of a facility employee when exiting the facility until returned into the building by the LPN who was outside the building in her car. The resident's wanderguard was checked and functioning. All wanderguard alarms were checked by the facility's maintenance department. The facility investigation did not include information leading up to Resident 2 being observed exiting the facility to the parking lot in her wheelchair. No additional witness statements were available for review at the time of the survey ending March 28, 2024. No information was available at the time of the survey, regarding Resident 2's behavior and activites prior to the elopement or staff observation of the resident prior to 6:15 PM on February 20, 2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nursing Home Administrator (NHA) on March 28, 2024, stated during interview at approximately 1:10 PM, that Resident 2 was not without facility staff observation, despite exiting the facility. The NHA further confirmed that had staff not been in the parking lot, there was no evidence facility staff were aware that Resident 2 had exited the facility unsupervised. A review of clinical record revealed that Resident 3 was admitted to the facility on [DATE], with diagnoses to include encephalopathy (disease that affects the brain structure or function and causes altered mental status), unsteadiness on feet, muscle weakness, lack of coordination, other abnormalities of gait (manner or style of walking) and mobility and need for assistance with personal care. A significant change Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) of Resident 3 dated March 12, 2024, indicated that the resident required extensive assistance from staff with activities of daily living (ADL). The resident had severe cognitive impairment with a BIMS (brief interview for mental status, a tool to assess the residents' attention, orientation, and ability to register and recall new information, a score of 13-15 indicates the resident is cognitive intact) score of two. A review of clinical record titled Admission/Readmission Evaluation dated January 5, 2024, at 11:20 AM revealed that the resident was at moderate risk for falling. A review of the resident's care plan dated January 5, 2024, revealed a goal to minimize risk for fall related injuries through next review with planned interventions including activity/group program, maintain a call light within reach and educate the resident to use it, maintain needed items within reach and every hour safety checks. A review of the clinical record revealed that the resident had falls on January 8, 26, 28, 29 and 31, 2024. A review of clinical record titled Fall Occurrence Note dated January 8, 2024, at 6:00 PM revealed that the resident had an unwitnessed fall and was observed on the floor laying on her left side, in front of her broad chair without injuries. The interventions that were in place at this time related to the resident's fall risk included an activity program group. There was no indication of the activity program group scheduled or occurring at that time, at 6 PM. There was no documentation that any other preventative interventions were initiated or implemented. A review of a facility incident report dated January 8, 2024, at 6:00 PM revealed the resident was found in the hallway by dietary staff lying on her left side in front of her wheelchair. The resident was assessed to have no injuries. A broad chair was then implemented, and a sensor alarm was to continue. The resident often bends forward to pick up things she sees on the floor, broad chairs are closer to the ground she will be able to do this without falling forward. The resident was unable to give a description of the event due to baseline confusion. A review of an employee witness statement January 8, 2024, 6:00 PM revealed, that Employee 2, Licensed Practical Nurse (LPN) stated the last time the resident was toileted was at 5:00 PM. The resident had a chair alarm and non-skid socks in place at the time of the incident. However, the chair alarm was not sounding at the time of the incident to alert staff to the resident's unsafe acts. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a progress note dated January 8, 2024, at 8:28 PM revealed that staff asked the resident if she hit her head and the resident stated no. The resident's alarm did not sound but when staff touched the alarm, it sounded. When the alarm was checked again it did not sound, it was replaced and was now functioning according to the entry. The physician and power of attorney (POA) were made aware. A review of clinical record titled Fall Occurrence Note dated January 26, 2024, at 4:45 AM revealed that the resident had an unwitnessed fall and was observed kneeling on the floor next to her bed without injuries. The interventions that were in place at this time related to the resident's fall risk included activity program group, despite the fall occurring at 4:45 AM and activities programming was not scheduled at that time. There was no documentation that any other preventative interventions were initiated or implemented. A review of a facility incident report dated January 26, 2024, at 4:45 AM revealed that the resident was observed to be kneeling on the floor with upper body on the side of the bed. When asked to explain what happened, the resident verbalized unintelligible sentences, usual confusion noted. The resident's call bell was not activated and bed was in the lowest position. The resident had no injuries or complaints, vital signs and neurological checks were within normal limits and the physician and resident representative were notified. The new intervention implemented was to have therapy screen the resident. The resident has a baseline of confusion, incontinence, impaired memory, gait imbalance and weakness. A review of an employee witness statement January 26, 2024, 4:45 AM revealed, that Employee 1 Certified Nurse Aide (CNA) stated that the resident was last seen at 4:30 AM sleeping, the call bell was within reach and was not activated. The resident was continent and last toileted on the evening (3:00 PM to 11:00 PM) shift. The resident had a bed and chair alarm in place and the alarms were not sounding at the time of the incident. Further review of the record revealed on January 26, 2024, the intervention of every hour safety checks was discontinued. A review of clinical record titled Fall Occurrence Note dated January 28, 2024, at 5:30 AM revealed that the resident had an unwitnessed fall and was observed to be lying on the floor beside bed on her left side. The interventions that were in place at this time related to the resident's fall risk included activity program group (despite the early AM hour) and fall mat to floor next to bed when occupied. There was no documentation that any other preventative interventions were initiated or implemented. A progress note dated January 28, 2024, at 5:33 AM revealed that the resident had removed her non-skid socks and the care plan was updated to include fall mat beside bed while occupied. A review of a facility incident report dated January 28, 2024, at 6:15 AM revealed that the resident was observed to be lying on the floor beside bed on left side. Vital signs and neurological checks were within normal limits there were no open areas or bruising noted and the resident did not have any complaints. Predisposing factors were that the resident had baseline confusion, gait imbalance and impaired memory. She was ambulating without assistance during a transfer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility incident report dated January 29, 2024, at 7:21 PM revealed that the resident fell on the floor and hit her head. Staff heard the alarm sound and turned to observe the resident sitting in an upright position and slid to the floor. The resident was alert no signs of injury or discomfort. The resident was assisted from the floor to her chair. Vital signs and neurological checks were within normal limits. The physician and representative were made aware. A review of clinical record titled Fall Occurrence Note dated January 29, 2024, at 7:21 PM revealed that the resident had a witnessed fall, chair alarm was under the resident and activated. The resident was near the nurse's station and the chair was in a low position. The interventions that were in place at this time related to the resident's fall risk again included activity program group, fall mat to floor next to bed when occupied, chair and bed alarm. There was no documentation that any other preventative interventions were initiated or implemented. A review of clinical record titled Fall Occurrence Note dated January 31, 2024, at 2:30 AM revealed that the resident had an unwitnessed fall she was found lying on her left side on the floor next to her bed. The resident stated that she was trying to turn the television on. Vital signs were within normal limits and no injury was observed. The interventions that were in place at this time related to the resident's fall risk included activity program group (fall at 2:30 AM), fall mat to floor next to bed when occupied, chair and bed alarm. There was no documentation that any other preventative interventions were initiated or implemented. A review of the Documentation Survey Report for January 2024 revealed no evidence that facility staff were completing the tasks of checking bed and chair alarms for proper placement and function, transfers, placement of fall mats on both sides of the bed, and ensuring that resident cannot be left alone in bathroom while toileting were performed. On January 29, 2024, checks for proper placement and function of the bed and chair alarms and placement of the floor mats were initiated, after the resident had four falls. Further review of the record revealed that on February 1, 2024, Dycem (helps stabilize objects, hold objects firmly in place, or to provide a better grip) for chair and to keep the remote in easy reach was initiated after most recent fall on January 29, 2024. A review of the Documentation Survey Report for February 2024 and March 2024 revealed no evidence that staff were completing the task of checking bed and chair alarms for proper placement and function, transfers, placement of fall mats on both sides of the bed, scheduled toileting every two hours, and resident cannot be left alone in bathroom while toileting. A review of the clinical record revealed that the resident had falls on February 22, 26, 27 and 28, 2024. After the resident's fall on February 26, 2024, the resident's care plan was updated to include toileting every two hours. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of care plan revised February 28, 2024, revealed that the resident was at risk for falls related to decreased mobility, poor safety awareness and confusion and planned interventions included maintain call light in reach, implement preventative fall interventions, toilet every two hours, mat to floor next to bed on both sides when occupied and bed and chair alarms. The resident's care plan for fall risk did not address the resident's need for staff supervision. A review of a facility incident report dated March 7, 2024, at 7:00 AM revealed that the resident was found on the floor mat lying on her right side next to her bed with an injury to the top of her scalp. The predisposing factors to this incident were that the resident was incontinent, confused, gait imbalance and impaired memory. Vital signs and neurological checks were within normal limits. Reviewed by the interdisciplinary team (IDT) the patient is confused and unable to focus. The current interventions in place are bed alarm, fall mats, bed to floor position and bolsters. Bolsters were changed to roll control bolster that strap under the mattress. After the resident's fall on March 7, 2024, the resident's care plan was updated to include bolsters and to always remain with the resident in the bathroom (which had previously been noted on the resident's documentation survey report as planned tasks). The facility failed to ensure that the facility timely evaluated the effectiveness of the resident's fall prevention plans, based on the resident's individual risk factors, pattern of falls and unsafe behaviors, to prevent repeated falls increasing the risk for serious injuries. The resident fell on [DATE], 28, 29 and 31, 2024, February 22, 26, 27 and 28, 2024 and March 7, 2024, and the facility failed to evaluate those fall prevention measures that were ineffective, revise planned measures based on the resident's risk factors and needs and to ensure the inclusion of necessary staff supervision, at the level and frequency required, to prevent repeated falls. During an interview at the time of the survey ending February 7, 2024, the Director of Nursing (DON) and the Nursing Home Administrator (NHA) confirmed the facility failed to implement effective fall and safety measures for this resident with a known risk of falls and failed to provide adequate supervisory and monitoring interventions to prevent repeated falls. 28 Pa. Code 211.12 (d)(3)(5) Nursing services

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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. 41460 Based on observations and staff interview, it was determined that the facility failed to maintain infection control practices to prevent spread of infection for one of 20 sampled residents. (Resident 5) Findings include: Observation of Resident 5's room on March 28, 2024, at approximately 8:30 AM revealed that there were several unopened sterile 4 x 4 gauze packages on the resident's nightstand. An opened 1000 mL bottle of Sterile water and an uncovered 60 mL piston syringe used for irrigation, were also on the nightstand. Approximately 200 mL was remaining in the bottle and was not dated. Additional observation of Resident 5's room revealed an opened tube of silver antibacterial wound gel between the foot of the mattress and the footboard of the bed. During observation, Resident 5 stated that the nurse must have left it there after doing my leg. Resident 5's indwelling urinary catheter drainage bag was also observed hanging on the side of the bed, yet the catheter bag drainage tube was resting directly on the floor. During an interview with the Nursing Home Administrator and Director of Nursing on March 28, 2024, at 2 PM, it was confirmed that infection control practices were not followed for resident wound care supplies. The DON further confirmed that Resident 5's indwelling catheter was not maintained in a manner to prevent potential contamination. 28 Pa. Code 211.10 (a)(d) Resident care policies 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services.