STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395682	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Health & Rehab Center	900 Third Ave Beaver Falls, PA 15010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41984 Based on review of facility policy, closed clinical records, resident fund account statements and staff interview it was determined that the facility failed to convey resident funds in accordance with State law and closed accounts upon death in a timely manner for one of four closed resident records (Closed Resident Records CR1). Findings include: The facility Admission Assessment policy dated last reviewed 6/1/24, indicated that available funds in the account will be distributed within 60 days of death. Review of Closed Resident Records CR1's admission record indicated she was admitted on [DATE], with diagnoses that included congestive heart failure, gastro-esophageal reflux disease, and constipation. Review of Closed Resident Records CR1's MDS assessment (Minimum Data Set--MDS assessment: a periodic assessment of resident care needs) dated 4/26/24, indicated that the diagnoses were the most recent upon review. Review of Closed Resident Records CR1's nurse progress notes dated 5/12/24, indicated that staff was called to her room at 5:35 p.m. resident noted to have no spontaneous respirations, no auscultated or palpable heart rate, no palpated or auscultated heart rate, x 60 seconds, no response to verbal or tactile stimuli, resident has CTB, family aware, hospice notified. Review of resident account indicated that Closed Resident Records CR1 had a balance of $8480. During an interview on 9/11/24, at 9:15 a.m. the Business Office Manager Employee E9 was asked about Closed Resident Records CR1's account and why it was still open It has to go to corporate for approval and that was new, in the position about 3 months. During an interview on 9/11/24, at 11:45 a.m. the Business Office Manager Employee E9 confirmed that the facility failed to convey resident funds in accordance with State law and closed accounts upon death in a timely manner as required. 28 Pa. Code 211.5(d) Clinical records. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395682	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code: 201.18(e)(1) Management.

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to notify a medical provider of a change in condition for one out of four residents (Resident R111). Findings include: Review of facility policy Change in Condition dated 6/1/24, indicated the Physician/Provider and Resident/Family/Responsible Party will be notified when there has been an accident or incident involving the resident. Review of the admission record indicated Resident R111 was admitted to the facility on [DATE]. Review of Resident R111's Minimum Data Set (MDS- a periodic assessment of care needs) dated 8/13/24, indicated the diagnoses of dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), stroke (damage to the brain from an interruption of blood supply), and high blood pressure. Review of Resident R111's event report dated 8/23/24, at 12:46 p.m. indicated on 8/22/24, medications from 7:00 a.m. were found at the resident's bedside in a medicine cup. Meds not taken. The daughter of the resident found the medications at the bedside to include five pills, Lopressor (heart pill), Plavix (blood thinner), Lexapro (antidepressant), Norvasc (blood pressure pill), and a pink pill. Attending faxed: No. Physician Notified: No. Resident representative notified: No. Review of Resident R111's progress notes failed to include an entry relating to notification of the physician regarding the incident of a medication error. Interview on 9/13/24, at 11:00 a.m. the Director of Nursing confirmed the facility failed to notify a medical provider of a change in condition for one out of four residents (Resident R111). 28 Pa. Code: 201.29(j) Resident rights. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(3)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395682	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
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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. 45577 Based on a review of facility admission documents and staff interview, it was determined that the facility failed to ensure resident rights to make informed decisions and choices about important aspects of residents' health, safety and welfare by making certain residents understand the Notice of Medicare Non-Coverage (NOMNC) form and failed to ensure the agreement is explained to the resident and his or her representative in a form and manner that he or she understands for one of three residents (Resident R14). Findings include: Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019 indicated that a Brief Interview for Mental Status (BIMS), is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of Resident R14's admission record indicated the resident was admitted to the facility 3/20/24. Review of Resident R14's demographic information available in the electronic medical record indicated that Resident R14's son was the emergency and primary financial contact. Review of facility document, Observation Detail Report: Brief Interview for Mental Status (BIMS) 2023, dated 4/1/24, indicated BIMS summary score of 10, moderately impaired. Review of the Minimum Data Set (MDS - periodic assessment of care needs) dated 4/5/24, included diagnoses of colon cancer, and heart failure (a progressive heart disease that affects pumping action of the heart muscles). Review of Section C: Cognitive Patterns, Questions C0500 BIMS Summary Score revealed Resident R14's score to be 10, moderately impairment. Review of Resident R14's clinical progress note date 4/19/24, indicated that Resident R14 was alert with confusion. Review of Resident R14's clinical progress note dated 4/22/24, recorded as a late entry on 4/23/24, indicated that Resident R14 stated that she feels she is in need of more therapy and that she would like to appeal but to call her son and have him do it and signed the NOMNC. Note further stated that a call was placed to the responsible party (son) and left a message about the details on the NOMNC, and a phone number to appeal by 4/23/24, at noon. Review of the NOMNC form dated 4/22/24, revealed that it was signed by Resident R14. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/13/24, at 9:54 a.m., the Nursing Home Administrator (NHA) confirmed the facility failed to ensure the NOMNC is explained to the resident and his or her representative in a form and manner that he or she understands for one of four residents (Resident R14). 28 Pa. Code 201.24 (b) Admission Policy. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(2) Management. 28 Pa. Code 201.29(a) 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of facility policies, job descriptions, documents, clinical records, and staff interviews, it was determined that the facility failed to protect residents from verbal abuse and mental anguish for one of five residents reviewed (Resident CR2), and failed to provide necessary services of medication administration for 29 of 29 residents on the Memory Impaired Unit (Residents R16, R27, R29, R30, R32, R54, R55, R60, R71, R72, R73, R75, R76, R83, R84, R89, R90, R91, R93, R97, R100, R101, R103, R107, R110, R116, R117, R118, and R121. Findings include: Review of facility policy entitled Pennsylvania Resident Abuse, dated 6/1/24, indicated that the facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone. It is the facilities policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, intimidation, exploitation of residents, misappropriation of resident property and injuries of unknown source. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of facility policy entitled Medication-Related Errors, dated 6/1/24, indicated an example of dispensing error includes omission error - facility fails to administer an ordered dose to the resident. Review of the facility policy Medication Administration dated 6/1/24, indicated facility staff should not leave medications or chemicals unattended. Review of the facility Registered Nurse Supervisor job description dated 6/1/24, indicated essential functions to include accurately administer medications and treatment to residents per Physician orders. Follows all required protocols, policies, and regulations related to medication administration. Review of the admission record indicated Resident CR2 was admitted to the facility on [DATE]. Review of Resident CR2's Minimum Data Set (MDS- a periodic assessment of care needs) dated 4/11/24, indicated the diagnoses of atrial fibrillation (irregular heart rhythm), heart failure (heart doesn't pump blood as well as it should), and high blood pressure. Section GG indicated resident is dependent for toileting needs. Review of CR2's care plan dated 4/21/24, indicated resident experiences bladder incontinence related to diuretic (water pill) use. Provide assistance for toileting upon request. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility provided documentation dated 4/9/24, indicated Nurse Aide (NA) Employee E10 has been verbally abusive over the course of the last two days. Resident CR2 indicated she needed to use the restroom, when NA Employee E10 entered her room and criticized me, that I peed myself. NA Employee E10 told the resident You should know when you have to go to the bathroom. I don't know how your daughter can stand taking care of you. Your daughter fights your battles. Resident indicated NA Employee E10 has always had a smart mouth and is short and curt with her responses. Resident is tearful, during interview. Reports feeling ashamed having experienced incontinence and being spoken to in this manner. Review of Registered Nurse (RN) Employee E11's statement dated 4/9/24, indicated During interview with NA Employee E10 regarding a witness statement, NA responded, at one point that I know I was not kind to her. I was not pleasant, in reference to allegations of verbal abuse. Review of NA Employee E10's disciplinary action form dated 4/9/24, indicated termination of employment regarding substantiated allegation of abuse, Critical Offence #1. Physical or verbal abuse of residents. This includes neglect of responsibilities or duties which result in physical or psychological harm to residents. Review of facility provided documentation dated 8/6/24, indicated it was reported to the Nursing Home Administrator and the Director of Nursing that medications from the previous evening shift of 8/5/24, were found at the bedside in multiple rooms by the 11:00 p.m. to 7:00 a.m. nurse, not administered to the residents residing on the 3A hallway of the Memory Impaired Unit which included rooms 301 - 315. Registered Nurse (RN) Employee E12's witness statement dated 8/7/24, indicated she was the only nurse for 45 residents and was not able to stop and watch each resident take their medications, sometimes one pill at a time. Interview on 9/13/24, at 12:00 p.m. the Nursing Home Administrator confirmed that the facility failed to protect residents from verbal abuse and mental anguish for one of five residents reviewed (Resident CR2), and failed to provide necessary services of medication administration for 29 of 29 residents on the Memory Impaired Unit (Residents R16, R27, R29, R30, R32, R54, R55, R60, R71, R72, R73, R75, R76, R83, R84, R89, R90, R91, R93, R97, R100, R101, R103, R107, R110, R116, R117, R118, and R121). 28 Pa Code: 201.14(a) Responsibility of licensee 28 Pa Code:201.18(a)(3) Management 28 Pa. Code: 201.29(j) Resident rights. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(3)(5) Nursing services.

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Respond appropriately to all alleged violations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46336

Based on review of facility policy, clinical records, facility documents, and staff interview, it was determined that the facility failed to fully investigate alleged allegation of abuse/neglect for 30 of 30 residents (Residents R16, R20, R27, R29, R30, R32, R54, R55, R60, R71, R72, R73, R75, R76, R83, R84, R89, R90, R91, R93, R97, R100, R101, R103, R107, R110, R116, R117, R118, and R121).

Findings include:

Review of the facility policy Pennsylvania Resident Abuse, dated 6/1/24, indicated that the facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone. It is the facilities policy to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, intimidation, exploitation of residents, misappropriation of resident property and injuries of unknown source.

Review of the clinical record indicated Resident R20 was admitted to the facility on [DATE].

Review of Resident R20's MDS dated [DATE], indicated diagnoses of dementia (range of conditions that cause a loss of cognitive function, such as thinking, remembering, and reasoning, that interferes with daily life), diabetes, and

hypertension.

Review of clinical nurse notes dated 6/23/24, indicated Resident R20's leg got injured on the hoyer lift.

Interview with Director of Nursing on 9/12/24, at 12:43 p.m. revealed no investagation with the injury.

Review of facility provided documentation dated 8/6/24, indicated it was reported to the Nursing Home Administrator and the Director of Nursing that medications from the previous evening shift of 8/5/24, were found at the bedside in multiple rooms by the 11:00 p.m. to 7:00 a.m. nurse, not administered to the residents residing on the 3A hallway of the Memory Impaired Unit which included rooms 301 - 315.

Registered Nurse (RN) Employee E12's witness statement dated 8/6/24, indicated she was the only nurse for 45 residents and was not able to stop and watch each resident take their medications, sometimes one pill at a time.

Further review of the facility provided documentation failed to include witness statements from the Nurse Aide who found the medications at bedside. Failed to document which medications were found at which resident's bedside. How long the medications were unattended prior to discovery and whether the medications were held or re-administered once discovered and physician was notified.

(continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Nursing on 9/12/24, at 12:10 p.m. indicated there was not a thorough investigation completed, and the only witness statements obtained were from staff involved at the time, that the facility failed to fully investigate (interviewing all potential witnesses and to interview other staff members who had contact with residents), alleged allegation of abuse/neglect for 30 of 30 residents (Residents R16, R20, R27, R29, R30, R32, R54, R55, R60, R71, R72, R73, R75, R76, R83, R84, R89, R90, R91, R93, R97, R100, R101, R103, R107, R110, R116, R117, R118, and R121). 28 Pa Code: 201.14(a) Responsibility of licensee 28 Pa Code:201.18(a)(3) Management 28 Pa. Code: 201.29(j) Resident rights. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(3)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for five of six residents sampled with facility-initiated transfers (Residents R7, R9, R21, R56 and R58). Findings include: Review of facility policy Resident Discharge/Transfer Letter Policy dated 6/1/24, indicated the designee will complete the appropriate forms. Review of the clinical record indicated Resident R7 was admitted to the facility on [DATE]. Review of Resident R7's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 8/6/24, indicated diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and major depressive disorder. Review of the clinical record indicated Resident R7 was transferred to the hospital on 5/13/24, and returned to the facility on [DATE]. Review of Resident R7's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE]. Review of Resident R9's MDS dated [DATE], indicated diagnoses of myelodysplastic syndrome (group of disorders caused when something disrupts the production of blood cells), acute respiratory failure with hypoxia and hypertension. Review of the clinical record indicated Resident R9 was transferred to the hospital on 6/20/24 and returned to the facility on [DATE] and also 7/8/24 and returned to the facility on [DATE]. Review of Resident R9's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R21 was admitted to the facility on [DATE]. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R21's MDS dated [DATE], indicated diagnoses of depression, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), severe protein-calorie malnutrition and cerebral infarction . Review of the clinical record indicated Resident R21 was transferred to the hospital on 4/2/24 and returned to the facility on [DATE]. Review of Resident R21's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R56 was admitted to the facility on [DATE]. Review of Resident R56's MDS dated [DATE], indicated diagnoses of cerebral palsy (group of disorders that affect a person's ability to move and maintain balance and posture), aphasia (language disorder that affects communication), and epilepsy (disorder of the brain characterized by repeated seizures). Review of the clinical record indicated Resident R56 was transferred to the hospital on 11/23/23, and returned to the facility on [DATE]. Review of Resident R56's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R58 was admitted to the facility on [DATE]. Review of Resident R58's MDS dated [DATE], indicated diagnoses of depression, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and end stage renal disease (ESRD, an inability of the kidneys to filter the blood). Review of the clinical record indicated Resident R58 was transferred to the hospital on 6/3/24, and returned to the facility on [DATE]. Review of Resident R58's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. During an interview on 9/11/24, at 10:59 a.m. the Director of Nursing confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for five of six residents sampled with facility-initiated transfers (Residents R7, R9, R21, R56 and R58). (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.29 (a) (c.3) (2) Resident rights.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075 Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for five of six residents (Residents R7, R9, R21, R56, and R58). Findings include: Review of facility policy Resident Discharge-Transfer Letter Policy dated 6/1/24, indicated staff designee will assure original discharge-transfer letter is given to resident or guardian. Copies will be sent to Ombudsman Office and scanned into the electronic chart. For emergency transfers, one list can be sent to the Ombudsman at the end of the month. Review of the clinical record indicated Resident R7 was admitted to the facility on [DATE]. Review of Resident R7's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 8/6/24, indicated diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and major depressive disorder. Review of the clinical record indicated Resident R7 was transferred to the hospital on 5/13/24, and returned to the facility on [DATE]. Review of Resident R7's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE]. Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE]. Review of Resident R9's MDS dated [DATE], indicated diagnoses of myelodysplastic syndrome (group of disorders caused when something disrupts the production of blood cells), acute respiratory failure with hypoxia, and hypertension. Review of the clinical record indicated Resident R9 was transferred to the hospital on 6/20/24, and returned to the facility on [DATE], and also 7/8/24, and returned to the facility on [DATE]. Review of Resident R9's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE], and 7/8/24. Review of the clinical record indicated Resident R21 was admitted to the facility on [DATE]. Review of Resident R21's MDS dated [DATE], indicated diagnoses of depression, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), severe protein-calorie malnutrition, and cerebral infarction . (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record indicated Resident R21 was transferred to the hospital on 4/2/24, and returned to the facility on [DATE]. Review of Resident R21's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE]. Review of the clinical record indicated Resident R56 was admitted to the facility on [DATE]. Review of Resident R56's MDS dated [DATE], indicated diagnoses of cerebral palsy (group of disorders that affect a person's ability to move and maintain balance and posture), aphasia (language disorder that affects communication), and epilepsy (disorder of the brain characterized by repeated seizures). Review of the clinical record indicated Resident R56 was transferred to the hospital on 11/23/23, and returned to the facility on [DATE]. Review of Resident R56's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE]. Review of the clinical record indicated Resident R58 was admitted to the facility on [DATE]. Review of Resident R58's MDS dated [DATE], indicated diagnoses of depression, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and end stage renal disease (ESRD, an inability of the kidneys to filter the blood). Review of the clinical record indicated Resident R58 was transferred to the hospital on 6/3/24, and returned to the facility on [DATE]. Review of Resident R58's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE]. During an interview on 9/11/24, at 10:59 a.m. the Director of Nursing confirmed that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for five of six residents (Residents R7, R9, R21,R56 and R58). 28 Pa. Code 201.29 (a) (c.3) (2) Resident rights.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075 Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for five of six resident hospital transfers (Resident R7, R9, R21, R56, and R58). Findings Include: Review of facility policy Resident Discharge-Transfer Letter Policy dated 6/1/24, indicated the resident or responsible party will receive a bed hold notice along with the discharge-transfer letter. Bed hold notices can be found in the electronic records. Review of the clinical record indicated Resident R7 was admitted to the facility on [DATE]. Review of Resident R7's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 8/6/24, indicated diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and major depressive disorder. Review of the clinical record indicated Resident R7 was transferred to the hospital on 5/13/24, and returned to the facility on [DATE]. Review of Resident R7s clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 5/13/24. Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE]. Review of Resident R9's MDS dated [DATE], indicated diagnoses of myelodysplastic syndrome (group of disorders caused when something disrupts the production of blood cells), acute respiratory failure with hypoxia and hypertension. Review of the clinical record indicated Resident R9 was transferred to the hospital on 6/20/24, and returned to the facility on [DATE] and also 7/8/24 and returned to the facility on [DATE]. Review of Resident R9's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 6/20/24 and 7/8/24. Review of the clinical record indicated Resident R21 was admitted to the facility on [DATE]. Review of Resident R21's MDS dated [DATE], indicated diagnoses of depression, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), severe protein-calorie malnutrition and cerebral infarction . (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record indicated Resident R21 was transferred to the hospital on 4/2/24, and returned to the facility on [DATE]. Review of Resident R21's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 4/2/24. Review of the clinical record indicated Resident R56 was admitted to the facility on [DATE]. Review of Resident R56's MDS dated [DATE], indicated diagnoses of cerebral palsy (group of disorders that affect a person's ability to move and maintain balance and posture), aphasia (language disorder that affects communication), and epilepsy (disorder of the brain characterized by repeated seizures). Review of the clinical record indicated Resident R56 was transferred to the hospital on 11/23/23, and returned to the facility on [DATE]. Review of Resident R56's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 11/23/23. Review of the clinical record indicated Resident R58 was admitted to the facility on [DATE]. Review of Resident R58's MDS dated [DATE], indicated diagnoses of depression, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and end stage renal disease (ESRD, an inability of the kidneys to filter the blood). Review of the clinical record indicated Resident R58 was transferred to the hospital on 6/3/24 and returned to the facility on [DATE]. Review of Resident R58's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 11/23/23. During an interview on 9/11/24, at 10:59 a.m. the Director of Nursing confirmed that the facility failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for five of six resident hospital transfers (Resident R7, R9, R21, R56, and R58). 28 Pa. Code: 201.29(b)(d)(j) Resident rights.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on a review of the RAI (Resident Assessment Instrument), clinical records, and staff interviews it was determined that the facility failed to make certain that resident assessments were accurate for two of twelve residents (Residents R52, and R111). Findings include: The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (periodic assessments of resident care needs), dated September 2024, indicated the following: Section I Active Diagnoses in the last seven days - Check all that apply. Section O Special Treatments, Procedures and Programs. While a resident of this facility and within the last 14 days. C1. Oxygen therapy. Review of the admission record indicated Resident R52 admitted to the facility on [DATE]. Review of Resident R52's MDS dated [DATE], indicated the diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), heart failure (heart doesn't pump blood as well as it should), and respiratory failure (a serious condition that makes it difficult to breathe on your own). Review of Resident R52's physician orders dated 6/28/24, indicated oxygen at five liters per minute (lpm) continuously. Review of Resident R52's care plan dated 7/31/24, indicated Oxygen at 5 lpm continuously. Review of Resident R52's Administration Record for July 2024, indicated oxygen was in use every shift for the entire month. Review of the MDS dated [DATE], Section O Special treatments failed to reflect the use of oxygen for Resident R52. Review of the admission record indicated Resident R111 admitted to the facility on [DATE], with the diagnoses of dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), anxiety, depression, cerebral infarction, unspecified mental disorder, reflux disease, epilepsy, cluster headaches, high blood pressure, coronary artery disease and atrial fibrillation. Review of Resident R111's MDS, Section I dated 8/13/24, indicated the diagnoses of non-traumatic brain dysfunction. All other diagnoses were not coded as indicated. Interview with Registered Nurse (RN) Employee E11 on 9/12/24, at 10:17 a.m., confirmed the omissions on Resident R52's and R111's MDS assessments. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Nursing Home Administrator (NHA) on 9/13/24, at 1:30 p.m., confirmed the facility failed to make certain that resident assessments were accurate for two of twelve residents (Residents R52, and R111). 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing Services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on review of facility policy, clinical records, and staff interview, it was determined the facility failed to update a care plan for four of eighteen residents (Residents R63, R66, R98, and R111) to accurately reflect the current status of the resident and care needs. Findings include: Review of the facility policy Comprehensive Care Planning Policy indicates the facility must develop a comprehensive Person-Centered Care Plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental/psychosocial needs. Review of the admission record indicated Resident R63 admitted to the facility on [DATE], with the diagnoses of type 2 diabetes mellitus, chronic kidney disease, and major depressive disorder. Review of Resident R63's MDS (Minimum Data Set (MDS) assessments - periodic assessments of resident care needs), Section I dated 6/18/24, indicated the diagnoses were current. Review of Resident R63's physician orders indicated wander guard bracelet for safety. Review of Resident R63's current care plan on 6/4/24, failed to include wanderguard. Review of admission record indicated Resident R66 admitted to facility 6/26/24, with the diagnoses of cerebral infarction (also called ischemic stroke, occurs when the blood supply to part of the brain is blocked or reduced), aphasia (disorder resulting from damage to the language area of the brain, usually from a stroke), and dysphagia (condition with difficulty in swallowing food or liquid). Review of Resident R66's MDS, Section I dated 8/14/24, indicated the diagnoses were current. Review of Resident R66's physician orders indicated Regular, Mech (Mechanical) Soft, Special Instructions: Low Fiber, GI (Gastrointestinal) Soft; Full Feed diet, initiated 8/21/24. Further review of physician orders also indicated supplement: Pro-Stat (protein modular oral nutritional supplement), Special Instructions: Administer Pro-Stat 30 cc (cubic centimeters) 2 times per day. Review of Resident R66's current care plan, failed to indicate that the nutritional plan of care was updated to include Resident R66's current diet order and use of protein modular supplement. During an interview on 9/11/24, at 10:25 a.m., Registered Dietitian (RD) Employee E17 confirmed that Resident R66's current nutritional plan of care did not reflect current physician orders for diet and nutritional supplement use as interventions to meet resident's current care needs. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R66's clinical wound and vascular progress note dated 9/5/24, indicated a right plantar foot has a chronic callus, not healed, measuring 0.6 cm (centimeter) length by 0.7 cm width. Noted to have no change in wound progression. Continued review indicated that Resident R66 also has a left second toe abrasion, not healed, measuring 0.4 cm length, by 0.2 width. Noted that wound is improving. Review of Resident R66's current care plan on 9/11/24, at 1:50 p.m., failed to include a plan of care for current impaired skin integrity to meet the care needs for right plantar foot and left second toe abrasion. During an interview on 9/11/24, at 1:52 p.m., Resident Nurse Assessment Coordinator (RNAC) Employee E5 confirmed that the current care plan did not include a plan of care for current impaired skin integrity for Resident R66's right plantar foot and left second toe abrasion. Review of the admission record indicated Resident R98 admitted to the facility on [DATE], with the diagnoses of type 2 diabetes mellitus, cerebral infarction (when the blood supply to part of the brain is blocked or reduced), and vitamin B12 deficiency. Review of Resident R98's MDS, Section I dated 8/9/24, indicated the diagnoses were current. Review of Resident R98's physician orders indicated 1.5L (liter) fluid restriction. Review of Resident R98's current care plan on 6/5/24, failed to include fluid restriction. Review of the admission record indicated Resident R111 admitted to the facility on [DATE], with the diagnoses of dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), anxiety, depression, cerebral infarction, unspecified mental disorder, reflux disease, epilepsy, cluster headaches, high blood pressure, coronary artery disease and atrial fibrillation. Review of Resident R111's MDS, Section I dated 8/13/24, indicated the diagnoses of non-traumatic brain dysfunction. Review of Resident R111's physician orders indicated the following cardiac medications were in use: amlodipine and metoprolol (blood pressure), Plavix (blood thinner), and rosuvastatin (cholesterol). Review of Resident R111's current care plan on 9/13/24, at 9:00 a.m., failed to include a cardiac care plan and management of medications. Interview on 9/13/24, at 11:00 a.m. the Director of Nursing (DON) confirmed the facility failed to update a care plan relating to cardiac care and management for Resident R111. Interview on 9/13/24, at 1:30 p.m., the Director of Nursing (DON) confirmed the facility failed to update a care plan for four of eighteen residents (Residents R63, R66, R98, and R111) to accurately reflect the current status of the resident and care needs. 28 Pa. Code: 211.10(d) Resident care policies. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.11(d) Resident Care Plan. 28 Pa. Code: 211.12(d)(3)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41984 Based on observation, clinical record review, and staff interviews, it was determined that the facility failed to notify a physician of abnormal glucose readings as per physician's order for one out of three sampled residents (Resident R21), and failed to make certain that residents were provided appropriate treatment and service for non-pressure wound dressing orders for one of twelve residents (Resident R66). Findings include: Review of Resident R21's admission record indicated he was admitted on [DATE], with diagnoses that included diabetes (metabolic disorder impacting organ function related to glucose levels in the human body), Hemiplegia and hemiparesis following other cerebrovascular disease, and protein-calorie malnutrition. Review of Resident R21's quarterly MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 8/21/24 , indicated that the diagnoses were current upon review. Review of Resident R21's care plan indicated to administer medication as per medical provider order and to monitor for signs and symptoms of hypoglycemia and hyperglycemia. Review of Resident R21's physician order's dated 7/28/24, indicated to Lantus Solostar U-100 Insulin(insulin glargine) Special Instructions: Hold dose if blood glucose <75. Notify MD if glucose is less than 70 or greater than 400. Review of Resident R21's blood glucose monitoring documentation from July 2024 to September 2024, indicated the following abnormal glucose levels: 7/4/24 low, off scale 7/14/24 low, off scale 7/22/24 high, off scale 8/25/24 low, off scale 9/3/24 55 Review of Resident R21's clinical nurse notes, physician notes, and Certified Registered Nurse Practitioner (CRNP) documentation did not include a notification to the physician about the abnormal glucose levels on 7/4/24, 7/14/24, 7/22/24, 8/25/24 and 9/3/24. During an interview on 9/10/24, at 2:25 p.m., the Director of Nursing (DON) confirmed that the failed to notify a physician of Resident R21's abnormal glucose readings as per physician's order. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of admission record indicated Resident R66 admitted to facility 6/26/24, with the diagnoses of cerebral infarction (also called ischemic stroke, occurs when the blood supply to part of the brain is blocked or reduced), aphasia (disorder resulting from damage to the language area of the brain, usually from a stroke), and dysphagia (condition with difficulty in swallowing food or liquid). Review of Resident R66's MDS, Section I dated 8/14/24, indicated the diagnoses were current upon review. Review of Resident R66's clinical wound and vascular progress note dated 9/5/24, indicated a right plantar foot has a chronic callus, not healed, measuring 0.6 cm (centimeter) length by 0.7 cm width. Noted to have no change in wound progression. Continued review indicated that Resident R66 also has a left second toe abrasion, not healed, measuring 0.4 cm length, by 0.2 cm width. Noted that wound is improving. Further review of Resident R66's clinical wound and vascular progress note dated 9/5/24, indicated wound orders: left second toe, cleanse/protect wound, Cleanse wound with warm soap and water - pat dry, apply betadine daily and PRN (as needed). Leave open to air. Review of Resident R66's clinical wound and vascular progress note dated 8/29/24, indicated wound orders: left second toe, cleanse/protect wound, Cleanse wound with warm soap and water - pat dry, apply betadine daily and PRN (as needed). Leave open to air. Review of Resident R66's current physician orders on 9/11/24, at 1:45 p.m., failed to indicate an order to treat resident's left second toe abrasion. Review of Resident R66's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for September 2024, failed to indicate that a wound treatment was provided for resident's left second toe abrasion from 9/1/24, through 9/10/24. During an interview on 9/11/24, at 1:52 p.m., Resident Nursing Assessment Coordinator (RNAC) Employee E5 confirmed that the facility failed to provide appropriate treatment and service for non-pressure wound orders for one of twelve residents (Resident R66). 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075 Based on a review of Resident Assessment Instrument (RAI) User's Manual, clinical records, and staff interviews, it was determined that the facility failed to ensure that MDS assessments accurately reflected the resident's status and failed to ensure that a comprehensive resident care plan was developed related to pressure wounds for one of four residents (Residents R2). Findings include: The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, indicated the following instructions: -Section M: Skin Conditions, Document the risk, presence, appearance, and change of pressure ulcer as well as other skin ulcers, wounds, or lesions. Also includes treatment categories related to skin injury or avoiding injury. Review of the clinical record revealed that Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 8/5/24, indicated diagnoses of high blood pressure, anxiety, and Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior). Review of Resident R2's clinical record revealed resident has a current pressure ulcer and is being followed by Hospice and Wound management. Review of Resident R2's physician orders dated 8/29/24, indicated to cleanse wound with normal saline (a mixture of sodium chloride and water), pat dry, apply Medi honey (a wound gel) to wound bed, cover with foam dressing every day. Review of Resident R2's MDS dated [DATE], did not include current pressure ulcer. Review of Resident R2's care plan failed to include current pressure ulcer and the plan of care for treatment. During an interview on 9/11/24, at 1:28 p.m., Registered Nurse Assessment Coordinator (RNAC) Employee R5 stated, I don't see a care plan for Resident R2's pressure ulcer, and I don't see it captured on the MDS. During an interview on 9/11/24, at 1:40 p.m. Director of Nursing (DON) confirmed that the facility failed to ensure that MDS assessments accurately reflected the resident's status and failed to ensure that a comprehensive resident care plan was developed related to pressure wounds for one of four residents (Residents R2). 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing Services. (continued on next page)

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	395682	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Health & Rehab Center	900 Third Ave Beaver Falls, PA 15010

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code: 211.11(a) Resident care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395682	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46336 Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to provide necessary supervision and monitoring of potential resident accidents for 29 of 29 residents on the Memory Impaired Unit (Residents R16, R27, R29, R30, R32, R54, R55, R60, R71, R72, R73, R75, R76, R83, R84, R89, R90, R91, R93, R97, R100, R101, R103, R107, R110, R116, R117, R118, and R121), and failed to assess and implement interventions to prevent the potential for elopement for one of two resident (Resident R233) reviewed. Findings include: Review of the facility policy Incident/Accident Policy dated 6/1/24, indicated an incident/accident is any occurrence which is not consistent with the routine care of a particular resident. Review of facility policy Elopement/Unauthorized Absence Policy dated 6/1/24, indicated that the facility will identify residents with the potential and/or actual risk factors for elopement and protect the resident through development and implementation of safety interventions. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2023, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of facility provided documentation dated 8/6/24, indicated it was reported to the Nursing Home Administrator and the Director of Nursing that medications from the previous evening shift of 8/5/24, were found at the bedside in multiple rooms by the 11:00 p.m. to 7:00 a.m. nurse, not administered to the residents residing on the 3A hallway of the Memory Impaired Unit which included rooms 301 - 315. Review of clinical records dated 8/6/24, indicated medications were found at the bedside in multiple rooms by the 11:00 p.m. to 7:00 a.m. nurse, not administered to the residents residing on the 3A hallway of the Memory Impaired Unit which included rooms 301 - 315. Daily observations of the Memory Impaired Unit (MIU) indicated residents freely wandering about the unit. Several residents noted to unknowingly be lying in another resident's bed. Residents observed grabbing items off the tables and trays at lunchtime. Clinical Record review indicated that the BIMS scores on the unit ranged from 0-9. Indicating severe cognitive impairment to moderate cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 9/10/24, Nurse Aide (NA) Employee E13 indicated The residents on this unit wander aimlessly about. They go in and out of each other's rooms, take each other's clothing, and take any item they believe is theirs. We have to protect them because they can get into anything. Interview with the Nursing Home Administrator on 9/12/24, at 10:00 a.m., confirmed the medications were left at bedside and the facility failed to provide necessary supervision and monitoring of potential resident accidents for 29 of 29 residents on the Memory Impaired Unit (Residents R16, R27, R29, R30, R32, R54, R55, R60, R71, R72, R73, R75, R76, R83, R84, R89, R90, R91, R93, R97, R100, R101, R103, R107, R110, R116, R117, R118, and R121). Review of Resident R233's admission record indicated that she was admitted to the facility 9/3/24, with the diagnoses left hip joint disorder, muscle weakness, and age-related cognitive decline. Review of Resident R233's clinical progress note dated 9/3/24, at 10:18 p.m., revealed resident kept wandering, multiple attempts to get resident to stay in room. Wander guard was placed on left wrist and pt was moved to room [ROOM NUMBER] bed A to be directly across from nurse's station. Patient has been pleasant, but very confused. During an observation made on 9/12/24, at 1:21 p.m., with the Director of Nursing (DON), who confirmed that Resident R233 had a wander guard bracelet on her left wrist, which was functioning properly. Review of Resident R233's clinical record failed to indicate that she was assessed for elopement risk on admission. Review of Resident R233's current physician orders failed to indicate an order for a wander guard. Review of Resident R233's plan of care failed to indicate goals or interventions to identify risk and/or prevent elopement. During an interview on 9/12/24, at 2:50 p.m., the DON confirmed that the facility failed to assess and implement interventions to prevent the potential for elopement for one of two residents (Resident 233) reviewed. 28 Pa Code: 201.14(a) Responsibility of licensee 28 Pa Code:201.18(a)(3) Management 28 Pa. Code: 201.29(j) Resident rights. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(3)(5) Nursing services.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on facility policy, clinical record review, and interview, the facility failed to ensure that appropriate treatment and services were provided for two of three residents with an indwelling urinary catheter (Residents R49 and R107). Findings include: Review of facility policy Indwelling Urinary Catheter Care Procedure dated 6/1/24, indicated to check drainage tubing and bag to ensure that the catheter is draining properly, and no kinks are present. The urinary drainage bag must be placed below the bladder level but not on the floor. Ensure drainage bag is covered with privacy/dignity cover. Resident R49 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/17/24, indicated diagnoses of obstructive uropathy (structural hindrance of normal urine flow), diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and heart failure (heart doesn't pump blood as well as it should). Section H indicated an indwelling catheter was present. Review of Resident R49's physician order dated 7/13/24, indicated to provide a privacy cover for drainage bag. Review of Resident R49's care plan dated 8/14/24, indicated to store collection bag inside a protective dignity pouch. During an observation on 9/10/24, at 8:45 a.m., Resident R49 was out of bed in the wheelchair with the drainage bag attached to the bottom of the chair without a protective dignity pouch. Interview on 9/10/24, at 8:46 a.m., Licensed Practical Nurse (LPN) Employee E14 confirmed the drainage bag was not covered as required. Resident R107 was admitted to the facility on [DATE], with the diagnoses of obstructive uropathy, Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), and sepsis (a life-threatening complication of an infection). Review of Resident R107's physician order dated 7/13/24, indicated to provide a privacy cover for drainage bag. Review of Resident R107's care plan dated 6/29/24, indicated resident requires an indwelling urinary catheter. During an observation on 9/9/24, at 12:12 p.m., Resident R107 was in bed. The catheter drainage bag was on the floor under the bed and did not have a protective dignity pouch. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 9/9/24, at 12:12 p.m., Nurse Aide (NA) Employee E15 confirmed the drainage bag was on the floor and not covered as required. Interview with the Director of Nursing on 9/13/24, at 1:30 p.m., confirmed the facility failed to ensure that appropriate treatment and services were provided for two of three residents with an indwelling urinary catheter (Residents R49 and R107). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 201.20(a)(b)(c)(d) Staff development. 28 Pa. Code: 201.29(j) Resident rights. 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336 Based on observation, clinical record review and interview, the facility failed to provide specialized care needs for the provision of respiratory care in accordance with professional standards of practice for three of four residents (Residents R52, R60, and R101). Findings include: Review of facility policy Oxygen Administration (all routes) Policy dated 6/1/24, indicated the staff are to change tubing, mask, cannula (small tubes in nose to administer oxygen) weekly and document according to facility policy. When oxygen not in use, store dry oxygen tubing, nasal cannula, or mask in a plastic bag. Review of admission record indicated Resident R52 was admitted to the facility on [DATE]. Review of Resident R52's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/19/24, indicated the diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), heart failure (heart doesn't pump blood as well as it should), and respiratory failure (a serious condition that makes it difficult to breathe on your own). Section O-oxygen usage failed to indicate oxygen was in use as required. Review of Resident R52's physician order dated 6/28/24, indicated oxygen at five lpm (liters per minute) continuously every shift. Review of Resident R52's care plan dated 7/31/24, indicated oxygen at 5 lpm continuously every shift. Observation on 9/10/24, at 1:33 p.m., Resident R52's oxygen cannula was not attached to the concentrator, was on the floor, the filter tube was not connected to the concentrator, and the cannula was dated 9/2/24. Interview on 9/10/24, at 1:34 p.m., Licensed Practical Nurse (LPN) Employee E16 confirmed Resident R52's oxygen cannula was not attached to the concentrator, was on the floor, the filter tube was not connected to the concentrator and that the cannula was outdated at 9/2/24. Review of the admission record indicated Resident R60 was admitted to the facility on [DATE]. Review of Resident R60's MDS dated [DATE], indicated the diagnoses of high blood pressure, Non-Alzheimer's Dementia (dementia caused by other diseases with symptoms forgetfulness, limited social skills, and impaired thinking abilities that interfere with daily functioning), and anxiety (intense, excessive, and persistent worry and fear about everyday situations). Review of Resident R60's physician order dated 8/27/24, indicated oxygen at 2 lpm via nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 9/11/24, at 12:45 p.m., Resident R60's oxygen concentrator was noted to have the cannula laying on top of the machine, not in a plastic bag, and without a date. Interview on 9/11/24, at 12:45 p.m., Nurse Aide (NA) Employee E13 confirmed the cannula was not bagged and that it did not have a date as required. Review of the admission record indicated Resident R101 was admitted to the facility on [DATE]. Review of Resident R101's MDS dated [DATE], indicated the diagnoses of high blood pressure, Alzheimer's Dementia, and respiratory failure. Review of Resident R101's physician order dated 5/2/24, indicated albuterol solution (breathing medication) for nebulization (a small machine that turns liquid medication into a mist that can be easily inhaled) twice daily. Observation on 9/11/24, at 12:50 p.m., Resident R101's nebulizer tubing and mask were sitting on top of the machine, not in a bag, and without a date. Interview on 9/11/24, at 12:50 p.m., Nurse Aide (NA) Employee E13 confirmed the nebulizer tubing was not bagged and that it did not have a date as required. Interview on 9/13/24, at 1:30 p.m. the Nursing Home Administrator (NHA) confirmed the facility failed to provide specialized care needs for the provision of respiratory care in accordance with professional standards of practice for three of four residents (Residents R52, R60, and R101). 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 211.10(d) Resident care policies.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 46336 Based on observations, clinical record review, resident and staff interviews, it was determined that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of 29 of 29 residents on the Memory Impaired Unit (Residents R16, R27, R29, R30, R32, R54, R55, R60, R71, R72, R73, R75, R76, R83, R84, R89, R90, R91, R93, R97, R100, R101, R103, R107, R110, R116, R117, R118, and R121). Findings Include: Review of the facility policy Dayforce Scheduling Policy dated 6/1/24, indicated Administrators, department leaders and all staff members are to be proficient in the use of Dayforce and use all its scheduling capabilities to ensure adequate staffing levels are maintained. Review of the facility Registered Nurse Supervisor job description dated 6/1/24, indicated essential functions to include accurately administer medications and treatment to residents per Physician orders. Follows all required protocols, policies, and regulations related to medication administration. Review of facility provided documentation dated 8/6/24, indicated it was reported to the Nursing Home Administrator and the Director of Nursing that medications from the previous evening shift of 8/5/24, were found at the bedside in multiple rooms by the 11:00 p.m. to 7:00 a.m. nurse, not administered to the residents residing on the 3A hallway of the Memory Impaired Unit which included rooms 301 - 315. Review of Registered Nurse (RN) Employee E12's statement dated 8/7/24, indicated I do recall the mixture of crushed meds and 2Cal for the residents who were not available in their room during med pass. My assignment consists of 45 patients, and I did not have time to look for the residents and still be able to finish when my shift ended. I have to also wait for them to take their pills (one at a time sometimes) and accommodate any questions or concerns. I was the only nurse on the floor. Staffing made my mob almost impossible to adequately provide safe and quality care. Interview on 9/12/24, at 11:30 a.m., Nurse Aide (NA) Employee E18 indicated we only had three aides for 45 residents this morning, until about an hour ago, and since 10:00 a.m., we only have one nurse on the floor. I wasn't able to get to my heavy showers today. We were rushing through trying to feed everyone and pass trays. Interview on 9/12/24, at 1:03 p.m., NA Employee E15 indicated I still have two people to take care of, I mean they're dry, but they aren't washed up for the day yet. Interview on 9/12/24, at 1:12 p.m., NA Employee E19 indicated I still have care to give on my assignment and we're still trying to feed lunch and collect trays. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 9/12/24, at 1:18 p.m., RN Employee E20 indicated we had two nurses this morning until 10:00 a.m. now there is just me for 45 residents. Interview on 9/13/24, at 1:30 p.m., the Director of Nursing confirmed the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of 29 of 29 residents on the Memory Impaired Unit (Residents R16, R27, R29, R30, R32, R54, R55, R60, R71, R72, R73, R75, R76, R83, R84, R89, R90, R91, R93, R97, R100, R101, R103, R107, R110, R116, R117, R118, and R121). 28 Pa Code: 201.14(a) Responsibility of licensee 28 Pa Code:201.18(a)(3) Management 28 Pa. Code: 201.29(j) Resident rights. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(3)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46336 Based on review of facility policy, observations and staff interview it was determined that the facility failed to date opened medications and properly store medications in one of three medication carts observed (Cart 2A and 2C). Findings include: Review of facility policy Storage and Expiration Dating of Medications and Biologicals dated 6/1/24, indicated once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened. Observation on 9/9/24, at 11:02 a.m. the medication cart for 2A and 2C indicated the following medications stored in the drawer without a date and time indicating date opened as required: -Resident R120's Lantus Pen (prefilled pen to inject long-acting insulin under the skin) and Lispro Pen (a short acting, manmade version of human insulin) , -Resident R231's Lispro Pen, -Resident R8's timolol eye drops (glaucoma medication) two bottles, latanoprost eye drops (glaucoma medication) two bottles, -Resident R77's latanoprost eye drops. Interview on 9/9/24, at 11:02 a.m., Registered Nurse (RN) Employee E21 verified the findings noted above. Interview on 9/9/24, at 12:09 p.m. the Director of Nursing confirmed that the facility failed to date opened medications and properly store medications in one of three medication carts observed (Cart 2A and 2C). 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services. 28. Pa. Code: 211.10(a)(c)(d) Resident care policies.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 45577 Based on review of facility documents and staff interview, it was determined that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all of the required committee members for three of four quarterly meetings (October 2023, February 2024, and April 2024). Findings include: Review of the CFR (Code of Federal Regulations) S483.75(g) Quality assessment and assurance. S483.75(g) Quality assessment and assurance. S483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection Preventionist. Review of Quality Assurance and Performance Improvement (QAPI) sign-in sheets and attendance records for quarterly meetings held 10/20/23, 2/22/23, and 4/25/24, did not indicate that the facility's Medical Director attended these quarterly meetings. During an interview on 9/13/24, at 12:10 p.m., the Nursing Home Administrator (NHA) confirmed that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all of the required committee members as required. 28 Pa Code: 201.18(e)(1)(2)(3) Management.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075 Based on facility policies, clinical record review, observation, and staff interview, it was determined the facility failed to implement measures to prevent the potential for cross contamination during a dressing change for one of two residents (Resident R12), failed to track Enhanced Barrier Precaution (EBP, a type of precautions used to take care of residents) for four of four residents (R53, R64, R81, and R109), failed to follow proper use of personal protective equipment (PPE) for one of three units (Unit one), failed to implement an infection control program that included a system of surveillance to identify possible communicable diseases or infections for ten of ten months (November 2023 - August 2024), and failed to ensure that a comprehensive resident care plan was developed related to infection precautions for 5 of 5 residents (R2, R56, R58, R64, and R81). Findings include: Review of facility policy Clean Dressing Change Policy dated 6/1/24, indicated wounds will be dressed using clean technique which avoids direct contamination of material and supplies. Review of Title 42 Code of Federal Regulations (CFR) S483.80 - Infection Control defines hand hygiene as hand washing with soap and water and/or alcohol-based hand rub (ABHR). Staff involved in direct resident contact must perform hand hygiene (even if gloves are used): - Before and after contact with the resident - Before performing an aseptic (preventing infection) task - After contact with blood, body fluids, visibly contaminated surfaces or after contact with objects in the resident's room - After removing personal protective equipment (PPE - e.g., gloves, gown, facemask) Appropriate use of PPE includes, but is not limited to, the following: - Gloves worn before and removed after contact with blood or body fluid, mucous membranes, or non-intact skin - Gloves changed and hand hygiene performed before moving from a contaminated-body site to a clean-body site during resident care The facility must prevent infections through indirect contact transmission. This requires the decontamination (i.e., cleaning and/or disinfecting an object to render it safe for handling) of resident equipment, medical devices, and the environment. Equipment or items in the resident environment likely to have been contaminated with infectious fluids or other potentially infectious matter must be handled in a manner so as to prevent transmission of infectious agents (e.g., wear gloves for handling soiled equipment and properly clean and disinfect or sterilize reusable equipment before use on another resident). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy Infection Prevention and Control Program Policy dated 6/1/24, indicated it is facility policy to maintain an organized, effective facility-wide program designed to systematically prevent, identify, control, and reduce the risk of acquiring and transmitting infections; to conduct surveillance of communicable disease and infectious outbreaks. Particular focus of the program will be conducting risk assessments, surveillance, reducing healthcare associated infections, limiting transmission of disease, promoting antibiotic stewardship, and report as necessary. Review of facility policy Comprehensive Care Planning Policy dated 6/1/24, indicated a plan of care will be established for every resident and updated on an as needed basis. Review of the clinical record indicated that Resident R12 was admitted to the facility on [DATE]. Review of Resident R12's MDS (MDS - a periodic assessment of care needs) dated 7/11/24, indicated diagnoses of anemia (too little iron in the body causing fatigue), gastroesophageal reflux disease (a digestive disease in which stomach acid irritates the food pipe lining), and artificial left hip joint. Review of a physician order dated 9/11/24, indicated to cleanse sacral (a triangular shaped bone at the base of the spine) wound with wound wash, pat dry, loosely fill wound depth and undermining (tunneling underneath the skin) with moistened gauze, cover with foam dressing twice a day. Review of physician order dated 9/4/24, indicated resident was on contact precaution (use of gowns and gloves required prior to entering room). During an observation of a dressing change on 9/11/24, at 11:30 a.m., Licensed Practical Nurse (LPN) Employee E4 entered Resident R12's room without donning (putting on) isolation equipment prior to entering room. Once in room, LPN Employee E4 touched objects without gloves on. She then washed her hands, put on a gown and a pair of gloves. Observation of Resident R12 revealed the resident to be lying in bed and incontinence care needed prior to dressing change. LPN Employee E4 provided care, removed gloves, washed hands, and put on another pair of gloves. LPN Employee E4 set supplies for the dressing change on Resident R12's bedside table without cleaning the surface. She then laid a clean chux (a pad) down on the bedside table, opened and prepared the supplies, and dated the dressing. LPN Employee E4 cleansed the wound with the physician ordered wound cleanser and disposed of dirty supplies. LPN Employee E4 failed to change her gloves after cleaning the wound. LPN Employee E4 used a cotton tip applicator to assist in inserting moistened gauze into the wound, and then covered with foam gauze. LPN Employee E4 then disposed of all the dirty supplies, took off her gloves, washed her hands, and took off her gown. She then pushed the bedside table in front of Resident R12 without cleaning the table or with gloves on. LPN Employee E4 then washed hands. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Providence Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 900 Third Ave Beaver Falls, PA 15010	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/11/24, at 12:00 p.m. LPN Employee E4 confirmed the above observations during the dressing change for Resident R12 and that the facility failed to implement measures to prevent the potential for cross contamination during a dressing change. Review of the clinical record indicated that Resident R53 was admitted to the facility on [DATE]. Review of Resident R53's MDS dated [DATE], indicated diagnoses of high blood pressure, cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain), and coronary artery disease (damage or disease in the heart's major blood vessels). During an observation on 9/10/24, at 12:05 p.m. Resident R53 had personal protective equipment (PPE) hanging on the door with signage for EBP. During review of facility provided isolation-precaution list on 9/10/24, at 2:03 p.m., Resident R53 was not listed on the tracking list. Review of the clinical record indicated that Resident R64 was admitted to the facility on [DATE]. Review of Resident R64's MDS dated [DATE], indicated diagnoses of high blood pressure, depression, and cancer (abnormal cells grow and spread uncontrollably in the body). During an observation on 9/10/24, at 12:09 p. m., Resident R64 had personal protective equipment (PPE) hanging on door with signage for EBP. During review of facility provided isolation-precaution list on 9/10/24, at 2:03 p.m. Resident R64 was not listed on the tracking list. Review of the clinical record indicated that Resident R81 was admitted to the facility on [DATE]. Review of Resident R81's MDS dated [DATE], indicated diagnoses of high blood pressure, coronary artery disease (damage or disease in the heart's major blood vessels), and chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness). During an observation on 9/10/24, at 12:14 p. m., Resident R81 had personal protective equipment (PPE) hanging on door with signage for EBP. During review of facility provided isolation-precaution list on 9/10/24, at 2:03 p.m. Resident R81 was not listed on the tracking list. Review of the clinical record indicated that Resident R109 was admitted to the facility on [DATE]. Review of Resident R109's MDS dated [DATE], indicated diagnoses of high blood pressure, Alzheimer' disease (a type of brain disorder that causes problems with memory, thinking and behavior), and anemia (too little iron in the body causing fatigue). During an observation on 9/10/24, at 12:20pm. Resident R109 had personal protective equipment (PPE) hanging on door with signage for EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During review of facility provided isolation-precaution list on 9/10/24, at 2:03 p.m. Resident R109 was not listed on the tracking list. During an interview on 9/10/24, at 2:15 p.m. Infection Preventionist (IP) Employee E9 confirmed that the facility failed to track R53, R64, R81, and R109 precautions on the facilities infection line list. During an observation on 9/10/24, at 8:37 a.m., there were blue isolation gowns hanging on three resident doorways that appeared to be used on unit one. During an interview on 9/10/24, at 8:40 a.m., Nurse Aide (NA) Employee E7 stated I took resident to the bathroom and hung up the gown to reuse it later. During an interview on 9/10/24, at 8:45 a.m., NA Employee E6 stated The gowns are used, we were told by the nurse to reuse them this morning. During an interview on 9/10/24, at 8:49 a.m., LPN Employee E4 stated It's my fault. I remember during the covid pandemic we could reuse them. I guess they shouldn't now. During an interview on 9/10/24, at 8:53 a.m., Registered Nurse (RN) Employee E1 stated The gowns are contaminated and should be thrown away after each use. We have plenty of supplies. During an interview on 9/10/24, at 12:05 p.m., Director of Nursing (DON) confirmed that the facility failed to follow proper use of PPE for one of three units (Unit one). Review of infection control documentation for the previous ten months (November 2023 through August 2024) failed to reveal surveillance for tracking infections for residents and staff ten of ten months (November 2023 - August 2024). During an interview on 9/12/24, at 9:01 a.m., Infection Preventionist (IP) Employee E9 stated I am new to this role and haven't plotted out infections monthly to see if infections spread or stayed together. I will start to do that. During an interview on 9/12/24, at 9:15 a.m., the IP Employee E9 confirmed that the facility failed to implement an effective infection control plan as required for the months of November 2023 through August 2024. Review of the clinical record indicated that Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's MDS dated [DATE], indicated diagnoses of high blood pressure, anxiety, and Alzheimer's disease. Review of Resident R2's plan of care revealed that no care plan was developed to address Resident R2's contact isolation. Review of the clinical record indicated Resident R56 was admitted to the facility on [DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R56's MDS dated [DATE], indicated diagnoses of cerebral palsy (group of disorders that affect a person's ability to move and maintain balance and posture), aphasia (language disorder that affects communication), and epilepsy (disorder of the brain characterized by repeated seizures). Review of Resident R56's plan of care revealed that no care plan was developed to address Resident R56's EBP's. Review of the clinical record indicated Resident R58 was admitted to the facility on [DATE]. Review of Resident R58's MDS dated [DATE], indicated diagnoses of depression, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and end stage renal disease (ESRD, an inability of the kidneys to filter the blood). Review of Resident R58's plan of care revealed that no care plan was developed to address Resident R58's EBP's. Review of the clinical record indicated that Resident R64 was admitted to the facility on [DATE]. Review of Resident R64's MDS dated [DATE], indicated diagnoses of high blood pressure, depression, and cancer (abnormal cells grow and spread uncontrollably in the body). Review of Resident R64's plan of care revealed that no care plan was developed to address Resident R64's EBP's. Review of the clinical record indicated that Resident R81 was admitted to the facility on [DATE]. Review of Resident R81's MDS dated [DATE], indicated diagnoses of high blood pressure, coronary artery disease (damage or disease in the heart's major blood vessels), and chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness). Review of Resident R81's plan of care revealed that no care plan was developed to address Resident R81's EBP's. During an interview on 9/11/24, at 1:28 p.m., Registered Nurse (RN) Employee E5 stated she did not see care plans for isolation precautions for Resident R2, R56, R58, R64, and R81. During an interview on 9/11/24, at 1:49 p.m., the Director of Nursing (DON) confirmed that the facility failed to ensure that a comprehensive resident care plan was developed related to infection precautions for 5 of 5 residents (R2, R56, R58, R64, and R81). 28 Pa. code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b) (1) (e) (1) Management. 28 Pa. Code: 211.10 (d) Resident care policies. 28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code: 211.11(a) Resident care plan.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 50075 Based on review of the facility's infection control policies and procedures and staff interview, it was determined that the facility failed to implement an antibiotic stewardship program for ten of ten months (November 2023 through August 2024). Findings include: Review of facility policy Antimicrobial Stewardship Program Policy dated 6/1/24, indicated antimicrobial stewardship will focus on improving antibiotic/antimicrobial use by avoiding unnecessary or inappropriate antibiotics. The antimicrobial stewardship program will be reviewed annually and as needed. The antimicrobial stewardship process will be overseen and managed by the Infection Preventionist (IP) who works collaboratively with the medical director, consulting pharmacist, nursing, and administrative leadership. Review of the facility's Infection Control surveillance for November 2023 through August 2024, failed to include documentation to indicate that antibiotic monitoring was completed. During an interview on 9/12/24, at 9:30 a.m., the IP Employee E9 was unable to locate and provide documentation to indicate that antibiotic monitoring was completed and stated, I am new in this role, I'm pretty sure we work with the pharmacist. During an interview on 9/12/24, at 10:05 a.m., Director of Nursing (DON) confirmed that the facility failed to implement an antibiotic stewardship program for ten of ten months (November 2023 through August 2024). 28 Pa. Code: 211.10(c)(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.