STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395716	A. Building B. Wing	03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smith Health Care Ltd	453 South Main Road Mountain Top, PA 18707

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 39235 Based on observations, review of clinical records and facility documentation and staff and resident interview, it was determined that the facility failed to afford residents the opportunity to select their preferred method of bathing and incorporate those preferences into the residents' personal care routine as evidenced by three of 34 sampled residents (Resident 7, 9 and 19). Findings include: A review of a facility documentation entitled Men's Side tasks revealed that all male residents in the facility receive either a bed bath or a tub bath, and no evidence that male residents are offered or provided a shower if preferred. A review of facility documentation entitled Female Side tasks revealed that all female residents in the facility receive either a bed bath or a tub bath, and there was no evidence that the facility provided or offered showers to the residents. Observations conducted during a tour of the facility on March 19, 2024, revealed that the facility has both a tub and shower in their common central bathing area. A review of the clinical record revealed that Resident 19 was cognitively intact and dependent on staff for assistance with bathing. Interview conducted on March 19, 2024, at 12:44 PM with Resident 19 revealed that the resident stated that the facility had not offered him the choice of a tub bath or a shower. The resident stated that he could not take a shower if he had to stand because he's unsteady on his feet, but stated that I love to take a shower. The resident, when asked during interview, was unaware that long term facilities use shower chairs or shower beds to shower residents who are unable to stand for a shower. The resident stated that he was unaware that those types of options were available. The resident confirmed that since the facility did not offer him a shower, he has been receiving only bed baths. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the clinical record of Resident 7 revealed that the resident was cognitively intact and required staff assistance with bathing. Interview on March 19, 2024, at 12:47 PM with Resident 7 revealed that the resident stated that the facility provided him a tub bath once during his stay and it was awful so now he just washes up himself. The resident stated, I need some help, so I can't get {myself} a shower, I can wash up myself. The resident stated that the facility did not offer him the choice to be showered, instead of a tub bath. The resident stated that the facility provides him what he needs to give himself a bed bath, since he doesn't like the tub bath and was not offered the choice for staff to assist him with a shower. A review of the clinical record revealed that Resident 9 was cognitively intact and required staff assistance with bathing. Interview on March 19, 2024, at 2:48 PM with Resident 9 revealed that he receives tub baths, because showers were not offered. The resident stated I need help from staff for bathing and showering. Interview with the Director of Nursing (DON) on March 19, 2024, at 2:30 PM, confirmed that there was no evidence that the facility offered residents the choice to receive a tub bath or a shower. 28 Pa. Code 211.12 (d)(5) Nursing services 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on observations and staff interviews, it was determined that the facility failed to provide maintenance services to maintain a safe and orderly environment in the resident shower room and one resident room (room [ROOM NUMBER]). Findings included: An observation on March 19, 2024, at 5:19 AM of the common tub/shower room located on the south side of the facility revealed broken and missing tiles on the wall exposing the underlying plaster. An observation on March 19, 2024, at 8:54 AM of Resident room [ROOM NUMBER] revealed an unsecured, loose electrical outlet located next to resident's bed that was separated from the wall exposing the outlet box and connecting electrical wires. During interview on March 19, 2024, at approximately 4:15 PM the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that the facility's environment should be kept in good repair and maintained in a safe and homelike manner. 28 Pa Code 201.18(e)(2.1) 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 39235 Based on a review of clinical records, the facility's abuse prohibition policy and select facility reports and staff interviews, it was determined that the facility failed to ensure that one resident was free from abuse by physically restraining the resident to most readily control the resident's behavior for one resident out of 34 sampled (Resident 3). Findings included: A review of the current facility policy titled Abuse (7 step process), last reviewed by the facility January 2024, revealed that it is the responsibility of this facility to assure services necessary to protect the health, safety and welfare of it's residents are implemented and delivered. Each resident has the right to be free from mistreatment, neglect, misappropriation of property, and exploitation. The policy defines abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Physical abuse is defined as the use of force, hitting, slapping, pinching kicking and controlling behavior through corporal punishment. Mistreatment was defined as to treat badly, or abusively. The facility's Restraints policy, last reviewed by the facility January 2024, indicated that each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that may warrant the use of restraints, or needs protection from harm for him/herself or others and all other alternatives have been exhausted. Current resident - new restraint, it must be demonstrated and documented that there is a specific medical symptom that requires the use of restraint's and how the use of restraints would treat the cause of the symptom and assist the resident in reaching his/her highest level of physical and psychosocial well-being. Appropriate alternative interventions and the responses to them must be documented prior to restraint use and to evaluate the residents behavior with specific emphasis on mood, behavior, incontinence pattern, skin condition, cognitive function, communication ability, interaction with staff, mobility, and history of falls. Appropriate alternative interventions and the responses to them must be documented prior to restraint use. A review of Resident 3's clinical record revealed admission to the facility on [DATE], with diagnoses of dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), aphasia, depression, and pain. A quarterly Minimum Data Set Assessment (MDS - federally mandated standardized assessment process conducted periodically to plan resident care) dated December 5, 2023, indicated that the resident was severely cognitively impaired with a BIMS (brief interview for mental status - a tool to assess cognitive status) of 1. The resident was dependent on staff for activities of daily living. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted with a facility employee, who did not wish to be identified for fear of retaliation, on March 19, 2024, at approximately 7:35 AM, the employee stated that a few weeks ago, a facility nurse tied the resident to a chair to restrain the resident because of the resident's behaviors. Further review of the resident's clinical record, including nursing progress notes during the survey ending March 19, 2024, revealed no documented evidence of the incident referenced by the anonymous employee when Resident 3 was tied to a chair and restrained to control the resident's behavior. Interview with the Director of Nursing (DON) on March 19, 2024, at approximately 7:45 AM, however, revealed that the facility's administration was aware of the alleged abuse, wrongful restraint use, and conducted an investigation into the allegation. The DON confirmed that the incident, and the facility's response, was not documented in the resident's clinical record. Review of facility provided document entitled Injury/Incident Report dated February 27, 2024, at 1:00 PM, indicating a that a witnessed incident had occurred. Employee 2, a nurse aide, responded to a safety alarm, and entered Resident 3's room, and witnessed Employee 1, a Licensed Practical Nurse, with resident {Resident 3} and saw a sweatshirt around {the resident's} waist in wheelchair. See investigation, no injury. Family and MD aware. A review of facility provided document entitled Investigation Statement written by Employee 2, nurse aide, dated February 27, 2024, revealed that on February 27, 2024, while doing AM care I heard an alarm going off, I entered the room and found {Resident 3} in wheelchair with a sweatshirt tied around her waist holding her in the chair and the nurse from 11 PM - 7 AM, {Employee 1, LPN}, was with her. I asked {Employee 1} who tied her in the chair and she replied {that} she did. I left the room and finished helping with a transfer and told the other nurse aide {Employee 3} what I walked in and witnessed, and she {Employee 3} walked down the hall with me and saw the exact same thing. {Employee 1, LPN} then walked out of the resident's {Resident 3} room with the resident the same way {tied to the chair}. We reported it directly to our boss. An undated facility document entitled Investigation Statement written by Employee 3, nurse aide, indicated that on February 27, 2024, while walking down the hall I witnessed {Employee 1, LPN}, with the medication cart and {Resident 3} in a wheelchair. I observed {Resident 3} tied into the wheelchair with a sweatshirt. I asked {Employee 1, LPN} why the resident was tied to the chair and {Employee 1, LPN}, replied 'she didn't have time for this {Resident 3's behaviors}, she had to get her medications done.' When my DON came in that day I reported this incident directly. An undated facility document entitled Investigation Statement, with Resident 3's name on it, no author identified, but identified by the DON at the time of the survey ending March 19, 2024, as written by Employee 1, LPN, noted that the resident was awake, alert, agitated mood. A wheelchair was used to keep resident with nurse for the resident's safety. Employee 1 observed Resident 3 repeating I'm leaving while in her room. The resident's behavior had exacerbated, so used a soft blanket to assist as safety measure. Call light on, awaiting for assistance. Employee 1 indicated that Resident 3 was flailing in the wheelchair. Sitting on edge of seat. High risk for fall or injury by foot pedals. Unable to remove peddles or retract resident myself. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility provided document entitled interview with Employee 1 (Licensed Practical Nurse - LPN, alleged perpetrator), indicated that on February 27, 2024, {Employee 1} was passing medications in the women's hall around 6:35 AM, when an alarm sounded and responded to find {Resident 3} standing stating I'm leaving, redirection attempted, {resident} repeated I'm leaving. Offered bathroom, food, water, music the Beatles. Resident back in recliner chair with alarm, appeared settled. Returned to med cart, alarm sounded again, this happened 3 times. On the 3rd time, {Employee 1, LPN} put resident in W/C to provide 1:1 monitoring. While in {Resident 3's} room, her behaviors increased with agitation and aggression. {Employee 1 LPN}, thought {Resident 3} was going to hurt self, so in response, {Employee 1, LPN} grabbed a dark blue lap blanket and applied around waist to prevent injury, and activated the call light. Blanket remained around waist - untied- pushed resident to day room. Resident was restrained for safety for approximately 5 minutes, Employee 1, LPN with resident at all times providing safe environment. A facility provided document entitled Conclusion of Investigation, dated as initiated February 27, 2024, and concluded March 4, 2024, revealed that the DON concluded Employee 1, LPN, made several attempts to address {Resident 3'} behaviors with different interventions. {Employee 1, LPN} then put {Resident 3} in WC for 1:1 monitoring /safety, resident then became increasingly agitated with a high risk for injury. LPN called for help and restrained resident with dark blue lap blanket around waist to prevent injury. Stayed with resident at all times. Resident restrained for approximately 5-7 minutes. DON presented all investigation findings to Nursing Home Administrator (NHA). After thorough review of all documentation, the NHA and DON found incident free of abuse/neglect. Employee 1, LPN acted quickly to prevent injury to resident, remained present during behaviors or time restrained, soft restraint ended up calming resident. No harm to resident, accident/injury prevented. Continued interview with the DON March 19, 2024, at approximately 8:50 AM, revealed that the DON acknowledged that Employee 1 tied Resident 3 to the wheelchair with a soft blanket, but that it was for a short period of time (5-7 minutes). The DON stated that when the resident calmed down Employee 1 LPN untied the blanket and took the resident to the day room. The DON also acknowledged the incident of physically restraining the resident is not common practice and should only be used as a last resort after exhausting all other means to assure the resident safety. The DON also verified, that at the time of the survey ending March 19, 2024, there was no documentation in the resident's clinical records or the witness statements obtained from other staff members of Resident 3's increased and continuous unsafe behaviors, which necessitated Employee 1 to tie the resident to the wheelchair for the resident's safety. There was no documentation in the nursing progress notes, indicating the resident was displaying increased unsafe behavior, a nursing assessment of the resident's current status, or the interventions attempted to alleviate or reduce the resident's behaviors. The DON stated that only Employee 1's statement, which is not part of the clinical record, noted attempts at alternative interventions. She further acknowledged that during the course of the investigation, from February 27, 2024, concluding March 4, 2024, Employee 1, remained on the schedule and continued to work with residents, which was also confirmed during an interview with Employee 7, Registered Nurse, on March 19, 2024, at approximately 10:50 AM. During an interview with the DON on March 19, 2024, at approximately 12:50 PM, confirmed the incident on February 27, 2024, which resulted in Resident 3 being physically restrained. She also acknowledged there is no documentation in the nursing progress notes at the time of, or following the incident. The DON further confirmed the facility failed to follow its abuse and restraint policies. Refer F 842, F 943, F 726 and F 745 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.18 (e)(1)(3) Management 28 Pa. Code 201.29 (a)(c) Resident Rights 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing Services 28 Pa. Code 211.8 (c.1)(2)(d)(e) Restraints

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on observations, a review of clinical records, select facility reports, and employee personnel files and interviews with facility staff, it was determined that the facility failed to provide nursing staff with the necessary competencies and skills to ensure a resident was assessed following an incident for one resident (Resident 3) and the results documented in the clinical record, and to administer prescribed medications, according to professional standards of nursing practice to residents for 33 out of 35 residents residing in the facility. (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, and 34). Findings include: According to the American Nurses Association the Standards of Practice describe a competent level of nursing care as demonstrated by the critical thinking model known as the nursing process. The nursing process includes the components of assessment, diagnosis, out- comes identification, planning, implementation, and evaluation. Nurses' responsibility for medication administration includes ensuring that the right medication is properly drawn up in the correct dose and administered at the right time through the right route to the right patient. The facility's medication administration policy entitled Medication Administration - General Guidelines dated August 6, 2001, indicated that medications are administered at the time they are prepared. Medications are not pre-poured. During an observation on March 19, 2024, at approximately 4:55 AM, upon entering the medication room, multiple stacks of disposable waxed coated paper cups, labeled with resident names were observed on the top of the med cart and on the counter in the med room. The cups contained pre-sealed plastic sleeves, on which a preprinted label of the medication, dosage, and quantity were noted, along with individual, perforated, plastic, foiled medications in the cups with preprinted label of the medication, dosage, and quantity. However, these cups of pre-poured resident medications, packaged in plastic sleeves or foil packs, lacked resident names on the labels of the medications assembled in these cups. According interview with Employee 1, LPN, at that time, the cups observed on the top of the medication cart and the counter in the medication room were the medications prepared for the morning med pass. Employee 1, LPN stated she had already pre-poured the medications (pre-pouring medications is the process of preparing medications in advance and then storing them until administering to the patient), and that it's ok (to pre-pour the meds), they are still sealed in protective coverings despite the lack of resident names on the labels. A follow-up interview with Employee 1, LPN on March 19, 2024, at approximately 7:10 AM, revealed that she had pre-poured the medications for all the residents for the 6 AM and 8 AM medication pass. Employee 1 stated that she pre-poured the medications because she is slower and needs more time and had other things to do. When asked if she was aware the standard of nursing practice and facility policy, and increased risk for errors by taking the short-cut of pre-pouring medications, Employee 1 said yes. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the personnel file for Employee 1, LPN, revealed that she was hired in June 1995. A medication administration observation audit, checklist, for medication administration was signed as completed with the employee most recently on March 12, 2009. Interview on March 19, 2024, at approximately 7:20 AM, with the Director of Nursing (DON) confirmed that pre-pouring medication was not consistent with facility policy and standards of nursing practice. According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's health record) to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care: Assessments Clinical problems Communications with other health care professionals regarding the patient Communication with and education of the patient, family, and the patient ' s designated support person and other third parties. A review of Resident 3's clinical record revealed admission to the facility on [DATE], with diagnoses of dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), aphasia, depression, and pain. A quarterly Minimum Data Set Assessment (MDS - federally mandated standardized assessment process conducted periodically to plan resident care) dated December 5, 2023, indicated that the resident was severely cognitively impaired with a BIMS (brief interview for mental status - a tool to assess cognitive status) of 1. The resident was dependent on staff for activities of daily living. During an interview conducted with a facility employee, who did not wish to be identified for fear of retaliation, on March 19, 2024, at approximately 7:35 AM, the employee stated that a few weeks ago, a facility nurse tied the resident to a chair to restrain the resident because of the resident's behaviors. Further review of the resident's clinical record, including nursing progress notes, during the survey ending March 19, 2024, revealed no documented evidence of the incident referenced by the anonymous employee when Resident 3 was tied to a chair and restrained to control the resident's behavior. Interview with the Director of Nursing (DON) on March 19, 2024, at approximately 7:45 AM, however, revealed that the facility's administration was aware of the alleged abuse, wrongful restraint use, and conducted an investigation into the allegation. The DON confirmed that the incident, and the facility's response to the occurrence, was not documented in the resident's clinical record. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A facility provided document entitled Conclusion of Investigation, dated as initiated February 27, 2024, and concluded March 4, 2024, revealed that the DON concluded Employee 1, LPN, made several attempts to address {Resident 3'} behaviors with different interventions. {Employee 1, LPN} then put {Resident 3} in WC for 1:1 monitoring /safety, resident then became increasingly agitated with a high risk for injury. LPN called for help and restrained resident with dark blue lap blanket around waist to prevent injury. Stayed with resident at all times. Resident restrained for approximately 5-7 minutes. DON presented all investigation findings to Nursing Home Administrator (NHA). After thorough review of all documentation, the NHA and DON found incident free of abuse/neglect. Employee 1, LPN acted quickly to prevent injury to resident, remained present during behaviors or time restrained, soft restraint ended up calming resident. No harm to resident, accident/injury prevented. Continued interview with the DON March 19, 2024, at approximately 8:50 AM, revealed that the DON acknowledged that Employee 1 tied Resident 3 to the wheelchair with a soft blanket, but that it was for a short period of time (5-7 minutes). The DON stated that when the resident calmed down Employee 1 LPN untied the blanket and took the resident to the day room. The DON also acknowledged the incident of physically restraining the resident is not common practice and should only be used as a last resort after exhausting all other means to assure the resident safety. The DON also verified, that at the time of the survey ending March 19, 2024, there was no documentation in the resident's clinical records or the witness statements obtained from other staff members of Resident 3's increased and continuous unsafe behaviors, which necessitated Employee 1 to tie the resident to the wheelchair for the resident's safety. There was no documentation in the nursing progress notes in the resident's clinical record, indicating the resident was displaying increased unsafe behavior, a nursing assessment of the resident's current status, or the interventions attempted to alleviate or reduce the resident's behaviors. The DON stated that only Employee 1's statement, which is not part of the clinical record, noted attempts at alternative interventions. During an interview with the DON on March 19, 2024, at approximately 12:50 PM, the DON confirmed that there was no documented evidence in the resident's clinical record that licensed nursing staff had assessed the resident after the resident had been physically restrained and had monitored the resident following the occurrence for any changes in status, mood, or functioning. Refer F842 28 Pa. Code 201.20 (a) Staff development 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services 28 Pa. Code 211.10 (a)(d) Resident Care policies 28 Pa. Code 211.5 (f) Medical records

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on review of clinical records, facility investigative reports and staff interview, it was revealed that the facility failed to provide medically-related social services to promote the mental and psychosocial well-being of one resident out of 34 sampled (Resident 3) Findings include: Regulatory guidance under S483.40(d) indicates that examples of medically-related social services include, but are not limited to advocating for residents and assisting them in the assertion of their rights within the facility in accordance with S483.10, Resident Rights, S483.12, Freedom from Abuse, Neglect, and Exploitation. Situations in which the facility should provide social services or obtain needed services from outside entities include expressions or indications of distress that affect the resident's mental and psychosocial well-being, resulting from depression, chronic diseases, such as Alzheimer's disease and other dementia related diseases), abuse of any kind and the need for emotional support. A review of Resident 3's clinical record revealed admission to the facility on [DATE], with diagnoses of dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), aphasia, depression, and pain. A quarterly Minimum Data Set Assessment (MDS - federally mandated standardized assessment process conducted periodically to plan resident care) dated December 5, 2023, indicated that the resident was severely cognitively impaired with a BIMS (brief interview for mental status - a tool to assess cognitive status) of 1. The resident was dependent on staff for activities of daily living. During an interview conducted with a facility employee, who did not wish to be identified for fear of retaliation, on March 19, 2024, at approximately 7:35 AM, the employee stated that a few weeks ago, a facility nurse tied the resident to a chair to restrain the resident because of the resident's behaviors. Further review of the resident's clinical record, including nursing progress notes, during the survey ending March 19, 2024, revealed no documented evidence of the incident referenced by the anonymous employee when Resident 3 was tied to a chair and restrained to control the resident's behavior. Interview with the Director of Nursing (DON) on March 19, 2024, at approximately 7:45 AM, however, revealed that the facility's administration was aware of the alleged abuse, wrongful restraint use, and conducted an investigation into the allegation. The DON confirmed that the incident, and the facility's response to the occurrence, was not documented in the resident's clinical record. (continued on next page)

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	395716	A. Building B. Wing	03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility provided document entitled Conclusion of Investigation, dated as initiated February 27, 2024, and concluded March 4, 2024, revealed that the DON concluded Employee 1, LPN, made several attempts to address {Resident 3'} behaviors with different interventions. {Employee 1, LPN} then put {Resident 3} in WC for 1:1 monitoring /safety, resident then became increasingly agitated with a high risk for injury. LPN called for help and restrained resident with dark blue lap blanket around waist to prevent injury. Stayed with resident at all times. Resident restrained for approximately 5-7 minutes. DON presented all investigation findings to Nursing Home Administrator (NHA). After thorough review of all documentation, the NHA and DON found incident free of abuse/neglect. Employee 1, LPN acted quickly to prevent injury to resident, remained present during behaviors or time restrained, soft restraint ended up calming resident. No harm to resident, accident/injury prevented. Continued interview with the DON March 19, 2024, at approximately 8:50 AM, revealed that the DON acknowledged that Employee 1 tied Resident 3 to the wheelchair with a soft blanket, but that it was for a short period of time (5-7 minutes). The DON stated that when the resident calmed down Employee 1 LPN untied the blanket and took the resident to the day room. The DON also acknowledged the incident of physically restraining the resident is not common practice and should only be used as a last resort after exhausting all other means to assure the resident safety. The DON also verified, that at the time of the survey ending March 19, 2024, there was no documentation in the resident's clinical records or the witness statements obtained from other staff members of Resident 3's increased and continuous unsafe behaviors, which necessitated Employee 1 to tie the resident to the wheelchair for the resident's safety. There was no documentation in the nursing progress notes in the resident's clinical record, indicating the resident was displaying increased unsafe behavior, a nursing assessment of the resident's current status, or the interventions attempted to alleviate or reduce the resident's behaviors. The DON stated that only Employee 1's statement, which is not part of the clinical record, noted attempts at alternative interventions. A review of the resident's clinical record conducted during the survey ending March 19, 2024, revealed no documented evidence that social services had assessed the resident following the adverse event of physical abuse to identify any therapeutic social services that may be required to assist the resident in attaining or maintaining their mental and psychosocial health and that social services had monitored the resident for any changes in mood, behaviors or affect, which was confirmed during interview with the DON on March 19, 2024, at approximately 1 PM. During an interview with the DON on March 19, 2024, at approximately 12:50 PM, was unable to provide evidence that the facility provided the required social services to support the resident's psychosocial well-being. Refer F600 28 Pa. Code 201.29 (a) Resident rights.

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	395716	A. Building B. Wing	03/19/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on observations, review of select facility policy, and clinical records, and staff interview, it was determined that the facility failed to implement a system to assure timely disposition of resident medications (the process of returning and/or destroying unused medications) to prevent loss and potential drug diversion and failed to periodically review pharmacy procedures for continued appropriateness, effectiveness and compatability with current regulatory requirements for drugs awaiting final disposition. Finding include: Review of facility policy entitled, Disposal of Medications and Medication Related Supplies, date revised [DATE], revealed that when medications are discontinued by physician order, a resident transferred, or discharged and does not take medications with him/her, or in the event of resident's death, the medications are marked as discontinued, or if the packages are unopened, returned to the issuing pharmacy. Medications awaiting disposal or return, are stored in a locked, secure area designed for that purpose until destroyed or picked up by pharmacy. The facility pharmacy policies provided during the survey ending [DATE], entitled Disposal of Medications and Medication Related Supplies, Controlled Medications - Disposal were dated as reviewed most recently [DATE], and the policy entitled Disposal of Medications and Medication Related Supplies Discharge Medications was dated [DATE], and revised [DATE], and the policy entitled Preparation for Medication Administration Medication Administration - General Guidelines, was dated [DATE]. There was no documented evidence that these pharmacy policies and procedures had been reviewed or revised in over [AGE] years. During an observation of the facility's medication room on [DATE], at approximately 4:55 AM accompanied by Employee 1 (Licensed Practical Nurse - LPN) two plastic drawers filled with medications were observed. These medications were in a pre-sealed plastic sleeve with preprinted label of the medication, dosage, and quantity. However, these sleeves of medications lacked labels with residents' names. The medications in these drawers, without resident names, included antibiotics such as Bactrim DS, Azithromycin, Levoflox, Cefdinir, Cefuroxime, Clindamycin, Levofloxacin, Doxycycline, and Ciprofloxacin. Diuretics such as furosemide, steroid - Prednisone, a thyroid medication - Levothyroxine (expired February 28, 2024), and an antidepressant - Sertraline (expired [DATE]). There were multiple boxes of eye drops, ointments, dispensed for current residents of the facility with pharmacy labels, preprinted of the medication, dosage, quantity, and resident names stored along with these unlabeled medications. These included the following medications, which had been prescribed to current residents in the last two years, but no longer current physician orders at the time of the survey: Resident 34 had a physician order dated [DATE], for Tobradex eye drops x 10 days. Resident 32 had a physician order dated [DATE], for Tobradex eye drops x 5 days. (continued on next page)

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	395716	A. Building B. Wing	03/19/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 26 had a physician order dated [DATE], for Systane Zaditor eye drops, every 8 hours as needed. Resident 11 had a physician order dated [DATE], to perform the following eyelid treatment for 1 week prior to your cataract consultation on [DATE], which included Artificial tears, 4 x daily. Resident 17 had a physician order dated February 24, 2024, for Maxitrol eye drops x 5 days. Resident 24 had a physician order dated [DATE], for Tobradex eye drops x 10 days. Resident 23 had a physician order dated [DATE], for Tobradex eye drops x 5 days. Resident 16 had a physician order dated [DATE], for Tobramycin eye drops x 5 days. Resident 6, had a physician order dated [DATE], for Tobradex eye ointment x 5 days, and February 8, 2023, for Erthromycin eye ointment x 7 days. Employee 1, LPN, stated during interview on [DATE], at approximately 5:05 AM, stated the medications observed stored in the facilities medication room are supplies of discontinued medications that the facility stores for potential future use. She also confirmed that the facility maintains no inventory of these medications or documents to account for the medications. Employee 1 stated that the pharmacy comes to the facility multiple times a week, but the medications have not been returned or disposed of, and that nursing staff should have given these medications to the pharmacy for disposition and not remain in the facility in storage. " During an interview with the Director of Nursing (DON) on [DATE], at approximately 5:23 AM, revealed that all the discontinued medications should have been picked up by pharmacy or destroyed per the facility policy and not stockpiled in the nursing medication room. She further confirmed the facility failed to implement procedures to promote the timely disposition of resident medications and failed to timely revise their pharmacy policies and procedures. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services. 28 Pa Code 211.9 (a)(1)(d)(j.1)(1)(2)(3)(4)(5)(k) Pharmacy services

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	395716	A. Building B. Wing	03/19/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on clinical record review and staff interviews it was determined that the pharmacist failed to identify drug irregularities in the drug regimen of two of 34 residents sampled (Resident 4 and Resident 33) including duplicate drug therapy for anxiety and agitation, and PRN psychoactive drug orders exceeding 14 days without re-evaluation of continued necessity. Findings include: A review of Resident 4's clinical record revealed admission to the facility on [DATE], with diagnoses to include dementia (a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities) and history of falling. A review of an admission Minimum Data Set Assessment (MDS - federally mandated standardized assessment conducted periodically to plan resident care) dated January 20, 2024, revealed that Resident 4 was cognitively impaired. A physician order dated January 24, 2024, was noted for Clonazepam (antianxiety medication) 0.5 mg by mouth take one tablet twice daily as needed (PRN) for anxiety, restlessness, and agitation. At the time of the survey ending March 19, 2024, there was no physician documentation of the clinical necessity of initiating clonazepam for treatment of Resident 4. There was no physician documentation that the PRN Clonazepam was re-evaluated after the 14 days, as of the time of the survey ending March 19, 2024. Review of the resident's monthly behavior monitoring records dated February 2024 through March 19, 2024, revealed no behaviors documented to justify the use of this medication. The physician failed to document justification for the continued use PRN Clonazepam in the resident's clinical record as of the time of the survey ending March 19, 2024. During an interview with the Director of Nursing (DON), she was unable to provide resident-specific individualized documentation by the attending physician to clinically justify the use of the PRN Clonazepam. There was no documented evidence that the pharmacist had identified this irregularity during the monthly drug regimen review completed in February 2024. Clinical record review revealed that Resident 33 was admitted to the facility on [DATE], with diagnosis to include dementia, intracranial abscess (a pus-filled pocket of infected material in your brain or its membranes) and granuloma (a mass of granulation tissue, typically produced in response to infection, inflammation, or the presence of a foreign substance). A review of an admission MDS assessment dated [DATE], revealed that Resident 33 was severely cognitively impaired. (continued on next page)

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	395716	A. Building B. Wing	03/19/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone order dated February 15, 2024, revealed Alprazolam 0.25 (antianxiety) mg by mouth PRN twice a day for anxiety and restlessness. A telephone order dated March 7, 2024, revealed an increase in the frequency of the Alprazolam dosage of 0. 25 mg PRN to four times a day for anxiety. A telephone order dated March 12, 2024, (no time) revealed Ativan (anti-anxiety medication) 1 mg intramuscular now for severe agitation and Risperdal (antipsychotic medication) 1 mg by mouth twice daily for agitation. A telephone order dated March 11, 2024, revealed an increase in the dosage of Alprazolam to 0.5 mg three times a day PRN for nervousness and agitation. Review of the resident's monthly behavior monitoring records dated February 2024 through March 19, 2024, revealed no documented evidence of behaviors requiring treatment with these psychoactive medications, including the initiation of the antipsychotic drug for agitation. There was no physician documentation of the clinical necessity of the Alprazolam, Ativan or Risperdal to treat anxiety and agitation, including the duplicate antianxiety drugs, in the resident's clinical record at the time of the survey. There was no attending physician documentation that the PRN Alprazolam was re-evaluated after the 14 days. At the time of the survey ending March 19, 2024, the Alprazolam remained an active order without a stop date. The physician failed to document justification for the continued use use of as needed Alprazolam. During an interview with the Director of Nursing (DON), she was unable to provide resident-specific individualized documentation by the physician to clinically justify the use of the Alprazolam, Ativan, or Risperdal to treat anxiety and agitation. There was no documented evidence that the pharmacist identified these drug irregularities, duplicate drug therapy for treatment of anxiety and agitation, and use of PRN psychoactive meds without stop and re-evaluation dates during medication reviews. An interview with the DON on March 19, 2024, at 2:53 PM confirmed that the pharmacist had not identified the above noted irregularities in the residents' drug regimens. Refer F756 28 Pa. Code 211.2 (d)(3) Medical director 28 Pa. Code 211.5 (f) Medical records 28 Pa. Code 211.9 (a)(1)(k) Pharmacy services 28 Pa. Code 211.12 (d)(3)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395716	A. Building B. Wing	03/19/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on clinical record review and staff interviews, it was determined that the facility failed to clinically justify the use of as needed psychoactive drugs prescribed for two out of 34 sampled residents (Resident 4 and 33), failed to provide documentation by the attending physician or prescribing practitioner, that it is appropriate for the PRN order to continue beyond 14 days and failed to evaluate the resident for continued appropriateness of the medication before renewing the PRN order. Findings include: A review of Resident 4's clinical record revealed admission to the facility on [DATE], with diagnoses to include dementia (a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities) and history of falling. A review of an admission Minimum Data Set Assessment (MDS - federally mandated standardized assessment conducted periodically to plan resident care) dated January 20, 2024, revealed that Resident 4 was cognitively impaired. A physician order dated January 24, 2024, was noted for Clonazepam (antianxiety medication) 0.5 mg by mouth take one tablet twice daily as needed (PRN) for anxiety, restlessness, and agitation. At the time of the survey ending March 19, 2024, there was no physician documentation of the clinical necessity of initiating clonazepam for treatment of Resident 4. There was no physician documentation that the PRN Clonazepam was re-evaluated after the 14 days. At the time of the survey ending March 19, 2024. Review of the resident's monthly behavior monitoring records dated February 2024 through March 2024, revealed no behaviors documented to justify the use of this medication. The interventions identified in response to the resident's restlessness and agitation, of which no episodes were documented, were to provide 1:1, assess and meet the needs, and to give PRN Clonazepam (Klonopin) if no other interventions are effective. There were no other individualized non-pharmacological interventions identified. The physician failed to document justification for the continued use PRN Clonazepam. During an interview with the Director of Nursing (DON), she was unable to provide resident-specific individualized documentation by the attending physician to clinically justify the use of the PRN Clonazepam. Clinical record review revealed that Resident 33 was admitted to the facility on [DATE], with diagnosis to include dementia, intracranial abscess (a pus-filled pocket of infected material in your brain or its membranes) and granuloma (a mass of granulation tissue, typically produced in response to infection, inflammation, or the presence of a foreign substance). (continued on next page)

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	395716	A. Building B. Wing	03/19/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of an admission MDS assessment dated [DATE], revealed that Resident 33 was severely cognitively impaired. A telephone order dated February 15, 2024, revealed Alprazolam 0.25 (antianxiety) mg by mouth PRN twice a day for anxiety and restlessness. A telephone order dated March 7, 2024, revealed an increase in the frequency of the Alprazolam dosage of 0. 25 mg PRN to four times a day for anxiety. A telephone order dated March 12, 2024, (no time) revealed Ativan (anti-anxiety medication) 1 mg intramuscular now for severe agitation and Risperdal (antipsychotic medication) 1 mg by mouth twice daily for agitation. A telephone order dated March 11, 2024, revealed an increase in the dosage of Alprazolam to 0.5 mg three times a day PRN for nervousness and agitation. Further review of Resident 33's clinical record revealed that the above telephone orders for the psychoactive and antipsychotic drugs were not countersigned by the prescribing physician or the physician's delegee within 48 hours, and not signed at the end of the survey March 19, 2024. Review of the resident's monthly behavior monitoring records dated February 2024 through March 19, 2024, revealed no documented evidence of behaviors requiring treatment with these psychoactive medications, including the initiation of the antipsychotic drug for agitation. The interventions planned for restlessness and agitation included 1:1 assess and meet the needs, change scenery, and give PRN Alprazolam (Xanax) if no other interventions are effective. However, no other individualized non-pharmacological interventions were identified. There was no physician documentation of the clinical necessity of the Alprazolam, Ativan or Risperdal to treat any anxiety and agitation displayed by resident, including the duplicate drug therapy for treatment of anxiety and agitation at the time of the survey ending March 19, 2024. There was no attending physician documentation that the PRN Alprazolam was reevaluated after the 14 days. At the time of the survey ending March 19, 2024, the Alprazolam remained an active order without a stop date. The physician failed to document justification for the continued use use of as needed Alprazolam beyond 14 days. During an interview with the Director of Nursing (DON), she was unable to provide resident-specific individualized documentation by the physician to clinically justify the use of the Alprazolam, Ativan, or Risperdal to treat anxiety and agitation. An interview with the DON on March 19, 2024, at 2:53 PM confirmed the physician failed to justify and reevaluate the need for psychotropic medications prescribed on an as needed basis for more than 14 days for Resident 4 and 33. Refer F756 28 Pa. Code 211.2 (d)(3) Medical director (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395716	A. Building B. Wing	03/19/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.5 (f) Medical records 28 Pa. Code 211.9 (a)(1)(k) Pharmacy services 28 Pa. Code 211.12 (d)(3)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395716	A. Building B. Wing	03/19/2024

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. 39235 Based on a review of select facility policy, observation, resident, and staff interviews, it was determined that the facility failed to ensure fresh water was consistently readily accessible to residents to meet residents' preferences, and to promote personal comfort and adequate hydration. Findings include: Review of a facility policy entitled Hydration Management dated as reviewed January 2024, revealed that the facility was to provide residents with appropriate fluid intake to prevent dehydration, hypo/hypervolemia (occurs when you there is a low (hypo) or to high (hyper) amount of fluid volume circulating in your body). Observations conducted during a tour of resident rooms on March 19, 2024, at approximately 4:50 AM revealed that residents did not have access to fresh ice water at their bedsides at the time of the tour of all resident rooms. Observation of residents' rooms including Residents 5, 21, 25 and 28 at approximately 5:00 AM revealed no fresh ice water was present, but there was a drink observed at the foot of the residents' bed out of the residents' reach. The drinks observed, included a personal beverage container with a resident name, that was empty, an eight ounce can of warm soda that was half full without a date on it, and two small sized Styrofoam cups half full of warm water, without a resident name or date on the cups. Observation of Resident 32's room at 5:03 AM revealed that the resident had a small clear cup 3/4 inch filled with warm water at the bedside that was undated. Interview with Employee 4, a nurse aide, on March 19, 2024, at approximately 5:05 AM confirmed there were no water pitchers or fresh ice water available for residents whe observed at this time. Employee 4 stated that the direction she was provided upon hire, regarding water pass, was that at the start of her shift at 11:00 PM it was her responsibility to collect all cups at the bedside and bring the cups to utility to be cleaned. She was instructed not to pass water or drinks during the remainder of her shift, unless a resident requests a drink, and then she could bring a small clear plastic cup of water. Interviews and observations of Resident 13 and Resident 18 revealed no fresh ice water at the bedside when observed at 5:15 AM. The residents confirmed that the facility does not consistently provide fresh ice water at the residents' bedside and they do get thirsty. Resident 13 and 18 at this time requested water from the surveyor. Resident 13 stated I am so thirsty. Resident 18 stated my mouth is so dry; I need a drink. Interview with Resident 4, a cognitively intact resident, on March 19, 2024, at 12:47 PM confirmed that he did not have any water available at his bedside during the night, he said he would need to ask staff for water or another beverage and then staff would provide him a drink. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395716	A. Building B. Wing	03/19/2024

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an Interview with the Director of Nursing (DON) on March 19, 2024, at approximately 2:30 PM the DON confirmed that the facility does not provide residents ready access to fresh water during each shift of nursing duty. The DON stated that we have noticed that the residents respond better when there is 1:1 encouragement with fluids throughout the day. The residents are not provided fluids after bedtime unless they request it. Interview with the Nursing Home Administrator (NHA) and DON on March 19, 2024, at approximately 4:15 PM, also confirmed the facility does not provide routine distribution of fresh ice water throughout the day to provide resident with readily available access to water. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on review of select facility policy, clinical records, and facility reports, and staff interview, it was determined that the facility failed to maintain complete and accurate clinical records, according to professional standards of practice, by failing to document the actual experiences of a resident, the interventions used by the facility to treat a resident, the resident's response to those interventions, and assessment and monitoring of the resident following an adverse event for one resident out of 34 sampled (Resident 3). Findings include: According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient record to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of patient care: Assessments, Clinical problems, Communications with other health care professionals regarding the patient, Communication with and education of the patient, family, and the patient's designated support person and other third parties. Review of facility policy entitled Restraints last reviewed by the facility on January 2024, a current resident - new restraint, it must be demonstrated and documented that there is a specific medical symptom that requires the use of restraint's and how the use of restraints would treat the cause of the symptom and assist the resident in reaching his/her highest level of physical and psychosocial well-being. Appropriate alternative interventions and the responses to them must be documented prior to restraint use. And to evaluate the residents behavior with specific emphasis on mood, behavior, incontinence pattern, skin condition, cognitive function, communication ability, interaction with staff, mobility, and history of falls. Appropriate alternative interventions and the responses to them must be documented prior to restraint use as indicated in the facilities policy. A review of Resident 3's clinical record revealed admission to the facility on [DATE], with diagnoses of dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), aphasia, depression, and pain. A quarterly Minimum Data Set Assessment (MDS - federally mandated standardized assessment process conducted periodically to plan resident care) dated December 5, 2023, indicated that the resident was severely cognitively impaired with a BIMS (brief interview for mental status - a tool to assess cognitive status) of 1. The resident was dependent on staff for activities of daily living. During an interview conducted with a facility employee, who did not wish to be identified for fear of retaliation, on March 19, 2024, at approximately 7:35 AM, the employee stated that a few weeks ago, a facility nurse tied the resident to a chair to restrain the resident because of the resident's behaviors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395716	A. Building B. Wing	03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smith Health Care Ltd	453 South Main Road Mountain Top, PA 18707

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the resident's clinical record, including nursing progress notes, during the survey ending March 19, 2024, revealed no documented evidence of the incident referenced by the anonymous employee when Resident 3 was tied to a chair and restrained to control the resident's behavior. Interview with the Director of Nursing (DON) on March 19, 2024, at approximately 7:45 AM, however, revealed that the facility's administration was aware of the alleged abuse, wrongful restraint use, and conducted an investigation into the allegation. The DON confirmed that the incident, and the facility's response to the occurrence, was not documented in the resident's clinical record. A facility provided document entitled Conclusion of Investigation, dated as initiated February 27, 2024, and concluded March 4, 2024, revealed that the DON concluded Employee 1, LPN, made several attempts to address {Resident 3'} behaviors with different interventions. {Employee 1, LPN} then put {Resident 3} in WC for 1:1 monitoring /safety, resident then became increasingly agitated with a high risk for injury. LPN called for help and restrained resident with dark blue lap blanket around waist to prevent injury. Stayed with resident at all times. Resident restrained for approximately 5-7 minutes. DON presented all investigation findings to Nursing Home Administrator (NHA). After thorough review of all documentation, the NHA and DON found incident free of abuse/neglect. Employee 1, LPN acted quickly to prevent injury to resident, remained present during behaviors or time restrained, soft restraint ended up calming resident. No harm to resident, accident/injury prevented. Continued interview with the DON March 19, 2024, at approximately 8:50 AM, revealed that the DON acknowledged that Employee 1 tied Resident 3 to the wheelchair with a soft blanket, but that it was for a short period of time (5-7 minutes). The DON stated that when the resident calmed down Employee 1 LPN untied the blanket and took the resident to the day room. The DON also acknowledged the incident of physically restraining the resident is not common practice and should only be used as a last resort after exhausting all other means to assure the resident safety. The DON also verified, that at the time of the survey ending March 19, 2024, there was no documentation in the resident's clinical records or the witness statements obtained from other staff members of Resident 3's increased and continuous unsafe behaviors, which necessitated Employee 1 to tie the resident to the wheelchair for the resident's safety. There was no documentation in the nursing progress notes in the resident's clinical record, indicating the resident was displaying increased unsafe behavior, a nursing assessment of the resident's current status, or the interventions attempted to alleviate or reduce the resident's behaviors. The DON stated that only Employee 1's statement, which is not part of the clinical record, noted attempts at alternative interventions. During an interview with the DON on March 19, 2024, at approximately 12:50 PM, the DON confirmed that there was no documented evidence in the resident's clinical record of the resident's actual experience of being physically restrained, tied to the wheelchair with a blanket, to control the resident's behaviors. There was no documented evidence of the resident's behavioral symptoms necessitating restraining the resident for the resident's safety. There was no nursing documentation that the resident was physically assessed after the occurrence or of continuing monitoring following the event for any changes in the resident's condition. Refer F726 28 Pa. Code 211.5 (f) Medical records. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 39235 Based on select facility policy review, observation and staff interview it was determined that the facility failed to ensure the consistent implementation of infection control procedures designed to prevent the potential for the spread of infection. Findings include: Review of a facility policy entitled General Cleaning with a review date of January 2024, indicated that upon discharge the housekeeping department of the facility was to thoroughly disinfect all room furnishings including basins and bedpans, urinals will be discarded. Observation on March 19, 2024, at 5:16 AM revealed a collection of basins, bed pans and urinals located under the sink in bathroom in the south side hallway of the facility. The basins appeared to have been used as evidenced by a coating of a white residue covering. A bed pan, also appeared to have been used as it was coated with a yellow-urine like substance, which emanated a urine-like odor which was also stacked between other bed pans. Interview on March 19, 2024, at 5:20 AM with Employee 1 Licensed Practical Nurse (LPN) revealed that all of the above resident care items located under the sink in this bathroom were used, by previous residents, and being reused. Employee 1 LPN stated that these items were sterilized after resident use. When shown the basin and bed pan that appeared to be used, and obviously noted cleaned, as evidenced by the urine-like residue and white coated residue, Employee 1 LPN then stated that these particular items were not sterilized or cleaned. Interview on March 19, 2024, at 11:40 AM with Employee 5 Environmental Services Supervisor revealed that basins and bed pans were reused, it was the housekeeping department's responsibility to clean these items after use with a chemical called Sterigent. The facility was unable to provide documentation of an established procedure staff would use to sterilize or disinfect these used resident care items for reuse by other residents. Interview on March 19, 2024, at 3:00 PM with Employee 6 Registered Nurse (RN) confirmed that the facility reuses basins and bedpans. Employee 6 RN stated that the procedure she would use to disinfect these items was cavi-wipes (disinfectant wipe) and then let them air dry, which differed from the product Sterigent, that Employee 5 said was used to disinfect the resident care items. There was no documented evidence that the facility had developed and operationalized infection control procedures for the re-use of basins and bed pans by other residents to ensure consistent and effective sanitization and disinfection to prevent the potential spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on March 19, 2024, at 5:13 AM revealed a yellow disposable gown hanging on the door of a resident's room. Interview on March 19, 2024, at 5:27 AM with the Director of Nursing (DON) revealed the gown that was hanging on a resident's door was placed there as a precaution because the resident was just admitted and had an episode of diarrhea. However, there was no signage posted for transmission-based precaution (TBP) on the door or any other forms of PPE (personal protective equipment) available at the entrance of this resident's room. When the DON was asked about TBP she stated that the resident was not on any type TBP at this time. Interview on March 19, 2024, at 5:40 AM with Employee 1 LPN revealed that the resident was not on TBP and she did not know why the gown was hanging on the door. Interview with the DON and Nursing Home Administrator (NHA) on March 19, 2024, approximately 4:15 PM confirmed that the facility failed to ensure the consistent implementation of infection control procedures designed to prevent the potential for the spread of infection. 28 Pa Code 211.12(c)(d)(1)(3)(5) Nursing services 28 Pa. Code 211.10 (a)(d) Resident care policies