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	06/28/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on clinical record review, observation, and staff and resident interviews, it was determined that the facility failed to reasonably accommodate a resident's need and preferences for comfortable seating for one resident (Resident 26) out of 12 residents sampled. Findings incudes: Clinical record review revealed that Resident 26 was admitted to the facility on [DATE], with diagnoses to include, cerebral infarction (stroke) with left sided hemiplegia/hemiparesis (inability to move one side of the body) and mild dementia. A review of a quarterly minimum data set assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated November 18, 2023, revealed that the resident had a BIMS score of 11, indicating that the resident was moderately cognitively impaired. The resident required maximum staff assistance for activities of daily living including ambulation, transfers and toileting. According to the resident's clinical records, the resident had a fall from her power recliner chair (in her room) during which the resident sustained a fractured ankle on January 19, 2024. She was hospitalized and returned to the facility on [DATE]. The resident received therapy services upon the resident's return to the facility after her hospitalization . The therapy discharge summary dated March 27, 2024, revealed that Resident 26 was without complaints of pain. A Cam boot (A controlled ankle motion walking boot, is an orthopedic device prescribed for the treatment and stabilization of severe sprains,[1] fractures, and tendon or ligament tears in the ankle or foot) was in place. Therapy noted that Emphasis today on safety with the use of the power recliner chair and reacher in place to retrieve items while seated. Resident demonstrated safety with precautions prevent future falls from the recliner chair. She verbalized movement related safety plan with active participation in strategy to prevent future falls. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on June 25, 2024 at 1 PM Resident 26 stated that after her fall in January the facility staff will no longer assist her to sit in the recliner chair. She stated that staff get her up in the morning and put her in her wheelchair. She goes to breakfast, activities and lunch seated in the wheelchair. Staff puts her back to bed in the afternoon after lunch and she is not allowed to sit in the recliner, which she prefers. She stated that her left ankle still hurts and if she could recline and elevate her legs it would help. She stated that nursing staff will not put her in the recliner, even though she wants to sit in the recliner chair. She stated that she knows how to operate the chair safely and received therapy after the fall. An interview June 26, 2024 at approximately 1:30 P.M., with the director of therapy revealed that Resident 26 received therapy services after her fall with fracture and confirmed that the resident was assessed for the use of the power recliner chair and there was no reason that she could not utilize the recliner chair for her seating comfort. 28 Pa Code 211.12 (c)(d)(3)(5) Nursing services

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	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** 21738 Based on review of clinical records and facility-initiated transfer notices and a staff interview, it was determined that the facility failed to failed to provide copies of written notices of facility-initiated hospital transfers of residents to a representative of the Office of the State Ombudsman for three out of 12 residents reviewed (Residents 9, 15, and 32). Findings include: Regulatory requirements indicate that before a facility transfers or discharges a resident, the facility must notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to the resident and/or resident's representative and to a representative of the Office of the State Long-Term Care Ombudsman. A review of the clinical record revealed that Resident 9 was transferred to the hospital on August 3, 2023, and returned to the facility on [DATE]. A review of the clinical record revealed that Resident 15 was transferred to the hospital on May 17, 2024, and was readmitted to the facility on [DATE]. A review of the clinical record revealed that Resident 32 was transferred to the hospital on May 3, 2024, and was readmitted to the facility on [DATE]. Although written notices were provided to the residents and resident representatives of the facility-initiated transfers, there was no documented evidence the facility sent copies of written notices of these facility-initiated transfers to the representative of the Office of the State Long-Term Care Ombudsman. An interview with the Nursing Home Administrator (NHA) on June 27, 2023, at approximately 1:00 PM, failed to provide documented evidence that copies of the facility-initiated transfers were sent to a representative of the Office of the State Long-Term Care Ombudsman. The NHA further confirmed that there was no evidence that copies were sent to a representative of the Office of the State Long-Term Care Ombudsman since March 15, 2023. 28 Pa. Code 201.14(a) Responsibility of Licensee

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on clinical record review and staff interview, it was determined that the facility failed to accurately complete the PASRR (Preadmission Screening and Resident Review) for one of 12 residents reviewed related to PASRR assessments (Resident 89). Findings include: The Pennsylvania Department of Human Service Office of the Long-Term Living Bulletin issued March 1, 2024, and effective March 1, 2024, issued a revised Pennsylvania Preadmission Screening Resident Review (PASRR) Level I identification form (PASRR Level I). The revised PASRR Level I form (MA 376 3/24) replaces the PASRR Level I Form (MA 376 11/18). Beginning March 1, 2024 the revised PASRR Level I form must be completed, prior to or no later than the day of admission, for individuals seeking admission to an MA certified nursing facility, regardless of the individual's payment source. If the applicant/resident is unable to answer the questions, another person who is knowledgeable about the applicant's/resident's medical condition and history (for example: family member, legal representative, or member of the health care team) may help to complete the form. Nursing facilities are responsible for assuring the accuracy of information reported on the PASRR Level I form. For a new resident entering the nursing facility, the nursing facility must make corrections to the PASRR Level I form on the resident's chart when new or missed information becomes available (for example, information provided by the family or doctor). Do not complete a new PASRR Level I for residents readmitted from a short-term acute care hospital stay that were in the nursing facility prior to the hospital stay. For these individuals, just update the PASRR Level I that was used in the nursing facility prior to the hospital stay. If the individual has a change in condition that affects program office criteria as found on the PASRR Level I form, a PASRR Level II evaluation form will need to be completed. Nursing facilities will communicate the need to have a PASRR Level II form done by notifying the department's Office of Long-Term Living, Division of Nursing Facility Field Operations Team via the MA 408 form. Nursing facilities are to advise applicants/residents regarding their rights to know how the PASRR process will be used, how to obtain a copy of this form, and the procedure to appeal the results of a decision by the departments program office. If the applicant meets program office criteria and is not an Exceptional Admission, as defined on page 6 of the PASRR Level I form, the individual's PASRR Level I form, along with other required documents, must be forwarded to Aging Well, who will complete a PASRR Level II evaluation and will also determine the level of care the individual needs prior to an individual's admission to the nursing facility. Failure to complete the most current version of the PASRR Level I and, when applicable, the PASRR Level II, prior to admission or on the day of admission will result in forfeiture of MA reimbursement to the nursing facility during the period of noncompliance in accordance with Federal PASRR Regulations at 42 CFR S 483. 122. The revised PASRR Level I form (MA 376 3/24) will be required for admissions on March 1, 2024 and thereafter. Previous versions of the PASRR Level I form are not acceptable for new admissions on March 1, 2024, and thereafter. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record revealed that Resident 89 was admitted to the facility on [DATE], with diagnoses which included COPD (chronic obstructive pulmonary disease- a group of lung diseases that block airflow and make it difficult to breathe). Review of Resident 89's Level I PASRR dated June 8, 2024, indicated the review was completed using the PASRR Identification Form dated September 1, 2018 (MA 376 11/18). Interview with the social services consultant on June 27, 2024, at approximately 11:00 AM confirmed that the facility was not yet using the revised PASRR Level I form (MA 376 3/24). Interview with the administrator on June 27, 2024, at 11:30 AM confirmed that the facility failed to timely implement the revised PASRR Level I form (MA 376 3/24). 28 Pa. Code 201.14 (a) Responsibility of Licensee

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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** 26142 Based on observation, review of clinical records, and staff interview, it was determined that the facility failed to maintain and store oxygen in a safe and sanitary manner and failed to provide supplemental oxygen administration as ordered for one of 12 residents reviewed (Resident 15). Findings include: An observation June 25, 2024, at 8:45 A.M and again at 1:30 P.M., revealed a partially full oxygen tank on the floor at the nurses station. The tank was free standing and not secured. An interview June 25, 2024, at 1:30 P.M., the interim Director of Nursing confirmed that oxygen should be secured and stored in an appropriate location. A review of Resident 15's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included heart failure. A physician order dated April 19, 2024 noted an order for oxygen at 3 liters per minute continuous via nasal cannula for a diagnosis of shortness of breath. An observation on June 26, 2024, at 8:45 AM revealed the filter on the back of the concentrator was dust covered. An observation on June 28, 2024, at 10:20 AM revealed the filter on the back of the concentrator was dust covered. The oxygen was set at 2 liters per minute and not the 3 liters per minute ordered by the physician. Interview with employee 2 (LPN) at this confirmed that the filter was dusty and in need of cleaning. Employee 2 (LPN) confirmed that the oxygen was to be set at 3 liters per minute as per physician order. An interview with the interim director of nursing on June 28, 2024, at 11:30 AM confirmed the facility failed to provide Resident 15's supplemental oxygen as ordered by the physician. The interim director of nursing confirmed that oxygen concentrator filters were to be cleaned weekly and as needed and that oxygen equipment was to be maintained in a sanitary manner. 28 Pa Code 211.12 (d)(5) Nursing services

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on clinical record review and staff interview, it was determined that the facility failed to ensure the physician wrote a progress note with each visit and that rubber stamp physician signature authorization is maintained by the facility for four of 12 sampled residents (Residents 14, 29, 9, and 15). Findings include: According to regulatory guidance at 483.30 (b) the physician must write, sign, and date progress notes at each visit and when rubber stamp signatures are authorized by the facility's management, the individual whose signature the stamp represents shall place in the administrative offices of the facility a signed statement to the effect that he/she is the only one who has the stamp and uses it. A list of computer codes, identification numbers and/or written signatures must be readily available and maintained under adequate safeguards. Adequate safeguards may include, but are not limited to, locked in a drawer; locked in a location that is accessible only by appropriate staff as defined by the facility; or available on a protected electronic site accessible by appropriate staff as defined by the facility. Clinical record review revealed that Resident 14 was admitted to the facility on [DATE], with a diagnosis of Parkinson's disease. Resident 14's clinical record revealed that on February 28, 2024, and March 29, 2024,the physician examined the resident and wrote a corresponding progress note. Employee 1 (physician) documentation dated February 28, 2024, and March 29, 2024, were stamped with rubber stamp signature. Nurses notes dated April 29, 2024, May 29, 2024 and June 19, 2024 indicated that the attending physician was in to see the resident, no new orders noted. However, there were no physician progress notes in the resident's clinical record to correspond with the noted physician visits on these dates. Resident 29 was admitted to the facility on [DATE], with diagnoses of atrial fibrillation (irregular and often very rapid heart rhythm). Clinical record revealed physicians progress notes written for Resident 29 dated October 30, 2023, November 29, 2023, December 27, 2023, January 29, 2024, and February 28, 2024 which indicated that the Physician examined the resident and wrote a corresponding progress note .Employee 1 (physician) progress notes dated October 30, 2023, November 29, 2023, December 27, 2023, January 29, 2024, and February 28, 2024, were stamped with a a rubber stamp signature. Nurses notes dated April 29, 2024, and June 19, 2024 indicated that the attending physician was in to see the resident but there were no physician progress notes in the resident's clinical record corresponding to April 29, 2024, and June 19, 2024, visits. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clinical record review revealed that Resident 9 was admitted to the facility on [DATE], with diagnosis to include dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders personality changes, and impaired reasoning). Physician documentation in Resident 9's clinical record dated June 22, 2023, August 30, 2023, October 23, 2023, and December 27, 2023, indicated that the physician examined the resident and wrote a corresponding progress note. Employee 1 (physician)'s progress notes dated June 22, 2023, August 30, 2023, October 23, 2023, and December 27, 2023, were stamped with a rubber stamp signature. Nurses notes dated February 28, 2024, April 29, 2024, and June 19, 2024 indicated that the attending physician was in to see the resident but there were no physician progress notes in the resident's clinical record corresponding to visits on February 28, 2024, April 29, 2024, and June 19, 2024. Clinical record review revealed that Resident 15 was admitted to the facility on [DATE], with diagnosis to include heart failure. Nurses notes dated April 29, 2024, May 29, 2024, and June 19, 2024, indicated that the attending Physician was in to see the resident but there were no physician progress notes in the resident's clinical record corresponding to April 29, 2024, May 29, 2024, and June 19, 2024, physician visits. There was no evidence at the time of the survey ending June 28, 2024, that the facility maintained safeguards regarding rubber stamped signatures. During an interview June 27, 2024, at 2:00 PM the interim Director of Nursing confirmed that a physician progress note was not written at each visit for Residents 14, 29, 9, and 15 and that rubber stamp signature safeguards were not in place at the time of the survey. 28 Pa. Code 211.2 (d)(8) Medical director 28 Pa. Code 211.5(f) Clinical records.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 26142 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 (Resident 37). Finding include: Review of facility policy entitled, Disposal of Medications and Medication Related Supplies, date revised January 25, 2002, 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. During an observation of the facility's medication room on June 25, 2024, at approximately 9 AM accompanied by the interim Director of Nursing (DON) an unopened box of single use ampules of Albuterol nebulizer solution 0.83% with the pharmacy label indicating that they had been dispensed for Resident 37. Resident 37 had a physician order dated March 12, 2024, for Albuterol Nebulizer solution 0.83% 1 ampule via nebulizer 4 times a day as needed for shortness of breath/wheezing In the medication refrigerator there was an open, unlabeled, multiple dose vial, of the antibiotic Ceftazidime, 1 gram vial. There was no open date. There were 3 unopened boxes containing a single dose of flu vaccine with an expiration date of May 22, 2024. An interview with the interim DON on June 25, 2024, at approximately 9:30 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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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 21738 Based on staff interview and a review of personnel files and employee credentials, it was determined that the facility failed to employ a full-time qualified dietary services supervisor in the absence of a full-time qualified dietitian. Findings include: Prior to beginning the initial tour of the food and nutrition services on June 25, 2024, at 9:00 AM the interim director of nursing stated that the facility did not currently have a full-time qualified dietary services supervisor or a full-time qualified dietitian. During initial tour of the food and nutrition services department on June 25, 2024, at 9:00 AM Employee 3 (cook/assistant food services supervisor) confirmed that the facility did not currently have a full-time qualified dietary services supervisor. Employee 3 (cook/assistant food services supervisor) stated that the full-time qualified dietary services supervisor had recently resigned. Employee 3 (cook/assistant food services supervisor) stated that in the absence of the full-time qualified dietary supervisor her responsibilities included oversight of food preparation, service, and storage of food. Employee 3 (cook/assistant food services supervisor) stated that the qualified dietitian provided oversight, but was not employed full-time at the facility. Interview with the interim director of nursing (DON) on June 27, 2024, at 11:00 AM confirmed the facility has been without a full-time qualified dietary services supervisor in the absence of a full- time qualified dietitian since June 5, 2024. 28 Pa Code 201.18(e)(1)(6) Management.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on observation and staff interview, it was determined that the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in the food and nutrition services department. Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). Initial tour of the food and nutrition services department in the presence of Employee 3 (cook/assistant food services supervisor) on June 25, 2024, at 9:00 AM revealed the following sanitation concerns with the potential to introduce contaminants into food and increase the potential for food-borne illness: Observation of the spice storage shelf revealed a 24-ounce container of dried basil which was opened but not dated when opened. Observation of the janitor closet located in the food and nutrition services department revealed a garbage can which was filled with empty #10 fruit and vegetable cans. There was no lid on the garbage can and four fruit flies were flying above the garbage can. There was a mop being stored in direct contact with the floor basin of the janitor closet. The floor in the janitor closet was visibly soiled. Observation of the lunch meal on June 25, 2024, at approximately 12:00 PM revealed staff passing trays for residents who resided in rooms 10 through 19 who desired to eat lunch in their rooms. The food cart was placed in the hall outside Resident room [ROOM NUMBER]. Further observation revealed that the dessert (cake) on the residents' trays were not covered when distributed to resident rooms throughout the hall. Interview with Employee 3 (cook/assistant food services supervisor) on June 28, 2024, at 11:30 AM confirmed that acceptable practices for food storage were to be followed and all food storage areas were to be maintained in a sanitary manner. 28 Pa. Code 211.6 (f) Dietary services. 28 Pa. Code 201.18 (e)(2.1) Management

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on review of select facility policy, clinical records, documentation, and staff interviews, it was determined that the facility failed to demonstrate the implementation of ongoing QAPI programs, to include the use of systems for investigating and analyzing the root cause of adverse events as evidenced by one resident out of 12 sampled (Resident 26). Findings include: Review of the facility policy entitled QAPI plan for the facility last reviewed January , 2024 revealed, the purpose of QAPI in our organization is to take a proactive approach to constantly work at improving the way we care for and engage with our residents. The objectives of the QAPI program are to: - Our organization will use quality assurance and performance improvement to make decisions and guide our day to day operations. -Our organization makes decisions based on data, which includes the input and experience of caregivers, residents, healthcare practioners, families and other stakeholders. -Our staff will utilize data from current industry based clinical guidelines and evidenced practices to benchmark performance improvement, whenever possible, to achieve high quality care. The facility owner leadership and QAPI steering committee have the responsibility for planning, designing, implementing and coordinating consumer care and service and selecting QAPI activities to meet the needs of residents and families. Compliance will be monitored formally through incident reports and staff satisfaction and informally through discussions, staff meetings, brainstorming activities and PDSA (plan-do-study-act) cycles. The facility will use data at every QAPI steering committee meeting to ensure performance measures are meeting QAPI goals. Root cause analysis will be completed in response to any unintended consequences identified through data sources. Clinical record review revealed that Resident 26 was admitted to the facility on [DATE], with diagnoses to include, cerebral infarction (stroke) with left sided hemiplegia/hemiparesis (inability to move one side of the body) and mild dementia. A review of a quarterly minimum data set assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated November 18, 2023, revealed that the resident had a BIMS score of 11, indicating that the resident was moderately cognitively impaired. The resident required maximum staff assistance for activities of daily living including ambulation, transfers and toileting. (continued on next page)

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	395716	A. Building B. Wing	06/28/2024

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's care plan, initiated November 8, 2022, revealed that Resident 26 had left sided hemiplegia and memory deficit following her stroke impaired cognitive function related to cerebral Infarction (stroke) with moderate, cognitive function. According to the resident's care plan the resident was at risk for falls related to her stroke. The resident had a history of falls to including on December 16, 2022, the resident had an unwitnessed fall. She was found on the floor in her room in front of her recliner chair. The care plan indicated that the recliner chair was noted to be in the highest position. A review of nursing documentation and a facility investigation report dated January 19, 2024 at 4:30 P.M., revealed that Resident 26 was seated in her recliner chair in her room. A nurse aide responded to the call bell and found the resident on the floor in front of her recliner chair. The recliner chair was noted to be in the elevated upright position. The resident was complaining of left ankle pain. The nurse aide called for the RN. The RN assessed the resident and Resident 26's left foot had an open fracture with bloody drainage. The resident was awake and oriented at that time. She denied hitting her head. The physician was contacted and the resident was sent to the hospital for evaluation and treatment. A review of hospital documentation revealed the resident had a CT scan of the left ankle. A displaced and comminuted [NAME] C distal fibular, medial, and posterior malleolus fracture. Lateral shift of the Talus at the tibiotalar joint. The resident was admitted to the hospital and had surgical repair of the fractures on January 20, 2024. She was readmitted to the facility on [DATE]. Further review of the facility investigation revealed the description of the event as full slide out of the recliner. Investigation of immediate environment at the time of the incident: recliner chair upright. Potential contributing factors: CVA(stroke) with left sided weakness Review of concerns related to statements written from staff. (attach written statements): -Resident dropped TV remote control- reached down to get it and her arm rested on the recliner remote, raising the chair. When the resident realized, it was too late and the resident slid out of the chair. Tentative conclusion: Isolated incident-Resident aware of incident Changes/corrective actions: will reassess on readmission to the facility. However, the only witness statement available at the time of the survey was written by the Director of Nursing, who was noted to have been called to the resident's room after the incident to assess the resident. The statement was dated January 19, 2024 at 4:30 P.M., noting that the Nurse aide walked in the resident's room. Resident 26 was on the floor in front of her recliner. This RN was called and assessed the resident. Fracture of the left lower extremity. The Physician was contacted. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An additional summary of the event dated January 19, 2024 at 4:30 P.M. indicated that, Resident 26 was in her recliner in her room. Nurse aide responded to call bell and found Resident 26 on the floor in front of the recliner chair. The recliner chair was noted to be in the elevated, upright position. The resident complained of left ankle pain. The nurse aide called the RN. The physician and emergency transport were called. The resident was medicated with Tramadol (a narcotic pain medication), sent to the hospital and admitted for treatment. The noted follow-up was that Resident 26 is alert and oriented and was able to recall the event. Stated she dropped her TV remote control and was trying to pick it up. She was inadvertently hitting the up button on her recliner when bending down and came out of the chair. She was able to reach her call bell to call for help. There was no date or time for this summary of event when reviewed during the survey ending June 28, 2024. There were no employee witness statement or resident witness statement noted with the investigation. No identification of the nurse aide involved noted in the summary. An interview June 25, 2024, at 12 PM, Resident 26 was awake and alert. She stated that she still had pain in her left ankle area. She stated that prior to the fall on January 19, 2024, she was seated in her recliner chair. She stated that she dropped her TV remote on the floor. She stated that she did not know where her call bell was at that time and she was impatient at the time, wanting her TV remote so she took the chair controller out of the seat pocket and raised the chair a little. She stated that she did not put the controller back into the seat pocket, but dropped it into the seat. As she was lifted up in the chair, the weight of her body pressed on the controller with the chair ending in the upright position and her falling to the floor. She again stated that she could not find her call bell to alert staff to her needs. During an interview June 27, 2024 at approximately 2 P.M., the interim DON stated that there were no witness statements available at the time of the survey to demonstrate that the facility had fully investigated this adverse event that resulted in serious injury to the resident to identify the potential root cause, and if the resident did have ready availability of her call bell. At the time of the survey ending June 28, 2024, the facility had not fully investigated this adverse event, and Resident 26's fall with major injury. There was no evidence that the facility had identified the underlying cause or contributing factors to this incident and was able to provide the surveyor with a factual and accurate representation of the events surrounding Resident 26's fall with change in condition necessitating hospital transfer. There was no evidence at the time of the survey that the facility demonstrated an effective QAPI program to include outcomes of quality of care and quality of life by investigating alleged incidents and thorough documentation to support their analysis of the data collected and any corrective actions developed and implemented. 28 Pa. Code 201.18 (b)(1)(3)(e)(1)(4) Management 28 Pa. Code 211.12 (c) 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. 26142 Based on review of select facility policies and the facility's infection control tracking log, and staff interview, it was determined that the facility failed to maintain and implement a comprehensive program to monitor and prevent infections in the facility, including protocols and provisions for Enhanced barrier precautions and their implementation. Findings include: A review of the facility's current infection control policy dated as reviewed by the facility January 2024, revealed that it is the policy of this facility to maintain an infection control program designed to provide a safe environment and to help prevent the development and transmission of infections within the residential population. The procedure to include: All infections will be identified, monitored and tracked be the appointed infection control nurse on a needs basis utilizing an infection control report flow sheet that clearly states the residents name, diagnosis, treatment modalities, signs and symptoms, isolation precautions and organism(when applicable). A review of MEMO FROM THE Center for Clinical Standards and Quality/Quality, Safety & Oversight Group, Ref: QSO-24-08-NH, CDC, Centers for disease control, dated March 20, 2024 regarding, Enhanced Barrier Precautions in Nursing Homes to Prevent Spread of disease revealed, CMS is issuing new guidance for State Survey Agencies and long term care (LTC) facilities on the use of enhanced barrier precautions (EBP) to align with nationally accepted standards. EBP recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. A review of the facility's infection control data provided at the time of the survey ending June 28, 2024, revealed that the facility's infection control program failed to reflect an operational system to monitor and investigate causes of infection and manner of spread. There was no evidence of a functional system, which enabled the facility to analyze clusters, changes in prevalent organisms, or increases in the rate of infection in a timely manner. A review of infection control logs revealed the following: - January 2024 Urinary Tract Infections (UTI)-3 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	eye infections-1 Sepsis-1 -February 2024 UTI, 6 -eye infections, 3 sepsis, 2 -March 2024 UTI, 7 eye infections, 4 -April 2024 UTI, 7 eye infections. 4 -May 2024 UTI, 6 eye infections, 2 A review of facility infection control logs for June 2024, as of June 14, 2024, revealed that the facility had not yet started tracking infections for the month of June as of the time of the survey ending June 28, 2024. There was no documentation of any staff or resident education provided in response to the continued urinary and eye infections in the facility noted on the line listings. There was no documentation of any evaluation or interventions designed to prevent the spread of the infections in response to the continued infections that occurred. There was also no documented evidence that the facility tracked and trended these infections to identify the potential need for intervention with staff and residents to deter similar infections. There was no indication that the limited data that was compiled was then evaluated to determine what could be done to prevent the spread or recurrence 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	Clinical record review revealed that there were 5 residents with indwelling urinary catheters, 2 residents with enteral feeding tubes and 5 residents with wounds. The Physician was contected and an antibiotic medication was ordered. There was no clinical documentation regarding the laboratory recommendation regarding isolating the resident due to this infection. Observations during the initial environmental tour June 25, 2024 at 9 A.M and again June 26, and June 27, 2024, at 10 AM there was no evidence of EBP for any of the above noted residents in the facility. Interview with the interim Director of nursing on June 27, 2024, at 1 PM confirmed that the facility infection control tracking logs were incomplete and that the facility was unable to demonstrate a fully functioning comprehensive program to monitor and prevent infections. She further confirmed that there were no EBP implemented for any resident in the facility at the time of the survey despite meeting the above criteria. 28 Pa. Code 211.12 (c)(d)(5) Nursing services. 28 Pa. Code 211.10(a)(d) Resident care policies