STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395717	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linwood Nursing and Rehabilitation Center	100 Florida Avenue Scranton, PA 18505

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 0600 Level of Harm - 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** 43944 Based on a review of clinical records, select facility reports and the facility's abuse prohibition policy, and resident and staff interviews, it was determined that the facility failed to ensure that one resident was free from sexual abuse (Resident 48) and the facility neglected to provide the necessary care and services to prevent psychosocial and/or physical harm and physical discomfort for two residents out of 21 sampled (Residents 21 and 80). Findings include: A review of the current facility policy titled Abuse Policy, last reviewed by the facility on May 10, 2024, indicated that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in the regulation. Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends, or other individuals. Each resident has the right to be free from mistreatment, neglect, and misappropriation of property. This includes the facility's identification of residents whose personal histories render them at risk for abusing residents, the development of intervention strategies to prevent occurrences, monitoring for changes that would trigger abusive behavior, and reassessment of the interventions on a regular basis. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Sexual abuse is non-consensual sexual contact of any type with a resident, including sexual harassment, sexual coercion, or sexual assault. Sexual contact or assault that results from threats, force, or the inability of the person to give consent and involving a range of activities. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. A review of Resident 48's clinical record revealed admission to the facility on [DATE], with diagnoses that included Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking, and behavior and is a gradually progressive condition), cognitive communication deficit (occurs when someone has trouble with one or more cognitive processes involved in communication), and anxiety disorder (a group of mental illnesses that cause constant fear and worry and are characterized by sudden feelings of worry, fear, and restlessness). (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 0600 Level of Harm - Actual harm Residents Affected - Few	Resident 48's care plan, initiated on May 17, 2022, and revised on November 24, 2023, identified that the resident had impaired/declined cognitive function or impaired thought processes related to diagnosis of Alzheimer's dementia without behavioral disturbance diagnosis. A review of the resident's annual Minimum Data Set (MDS), a federally mandated standardized assessment conducted at specific intervals to plan resident care] assessment dated [DATE], indicated that the resident had severe cognitive impairment with a BIMS (brief interview for mental status - a tool to assess cognitive status) of 3. A review of Resident 8's clinical record revealed admission to the facility on [DATE], with diagnoses that included unspecified dementia and adjustment disorder (difficulty in managing stressful life changes such as coping with work-related problems, loss of loved ones, or relationship issues that leads to significant impairment in functioning) with mixed disturbance of emotions and conduct. The resident had severe cognitive impairment. A review of Resident 8's plan of care initiated June 25, 2023, and revised on March 26, 2024, indicated that the resident had the potential to demonstrate verbally abusive and sexually inappropriate behaviors related to dementia and poor impulse control, with the noted goal that the resident would verbalize understanding of the need to control verbally abusive behavior. Planned interventions were to conduct every fifteen-minute checks related to behaviors, analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document, monitor and document observed behavior and attempted interventions in behavior log, and intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later. Additionally, encourage seating next to males and/or leader during activities and meals or otherwise provide arm's length space or supervision and reminders of expected behavior. A progress note in Resident 8's clinical record completed by Employee 4, Social Services, dated October 16, 2023, at 5:13 p.m., indicated that it was called to this social workers attention that Resident 8 may become a little too handsy with some female residents and likes to hold and sometimes kiss female residents hands and was known as a ladies' man. According to the entry, it was explained to him the best way possible by myself {Employee 4} and his daughter. However, his BIMS score was 9 (moderate cognitive impairment) with his short-term memory impaired and resident needs reminders. The Activity Department was also made aware and will intentionally seat Resident 8 closer to men and all staff will continue to provide reminders. The progress note written by Employee 4 did not document details regarding the resident's behavior towards female residents and if the resident becoming too handsy was sexual abuse, sexual harassment, sexual coercion, or sexual assault and if abuse reporting and investigation was required, including identifying Resident 8's female resident victims. A progress note written by Employee 5, a licensed practical nurse (LPN), dated January 7, 2024, at 12:09 p. m., revealed that Resident 8 was observed multiple times the shift being sexually inappropriate with the female residents, rubbing their thighs up to their crotch. This was witnessed by this nurse {Employee 5} and by one of the CNAs. Resident 8 was placed in his room and told that he needs to be appropriate and to keep his hands to himself. This nurse {Employee 5} also called resident's daughter and explained the situation to her. Daughter seemed to be embarrassed and apologized. Daughter also stated that if it happened again, to give her a call and put him on the phone with her. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A nurse progress note completed by Employee 6, RN Supervisor, dated January 7, 2024, at 12:31 p.m., revealed that related to inappropriate sexual behavior, Resident 8 was redirected and placed on every 15-minute checks for behavioral observation. Resident made aware behaviors was inappropriate. Resident stated, I don't remember doing it. Daughter was in to visit and made aware of behavior and behavioral monitoring checks and was okay with same. Employee 6 failed to initiate an investigation into the sexual abuse perpetrated by Resident 8 and failed to identify the female resident victims. At the time of the survey ending June 28, 2024, the facility was unable to provide documented evidence that they attempted to identify and protect the female resident victims from sexual abuse perpetrated by Resident 8. The facility failed to prevent, report, investigate and protect female residents from sexual abuse by Resident 8 as indicated in the facility's abuse prohibition policy. Resident 8's clinical record revealed a progress note completed by Employee 7, RN/former DON, dated February 29, 2024, at 5:55 p.m., revealed that the resident's representative was made aware on February 28, 2024, that a female resident reported that on February 27, 2024, Resident 8 approached her in the lobby and rubbed her leg over her clothes and stated oh you like this, and when she responded that she did not like this, he proceeded to grab her left breast over her clothes. The female resident removed herself from the lobby. Resident's RP, daughter, was very apologetic and has spoken with her father regarding these behaviors. RP reported that Resident 8 had no recollection of these behaviors when they happened, and he was remorseful and tearful when they discuss his actions. The facility failed to report this sexual abuse of the female resident perpetrated by Resident 8 and failed to promptly implement their abuse prohibition policy. An interview with the DON on June 26, 2024, at 11:25 a.m., confirmed that the facility was unable to provide documented evidence that the facility had implemented their abuse prohibition policy for identifying, reporting, investigating and protecting residents from sexual abuse perpetrated by Resident 8. The facility failed to identify the female resident victim. A review of Resident 48's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking, and behavior and is a gradually progressive condition), cognitive communication deficit (occurs when someone has trouble with one or more cognitive processes involved in communication), and anxiety disorder (a group of mental illnesses that cause constant fear and worry and are characterized by sudden feelings of worry, fear, and restlessness). Resident 48's care plan, initiated on May 17, 2022, and revised on November 24, 2023, identified that the resident had impaired/declined in cognitive function or impaired thought processes related to diagnosis of Alzheimer's dementia without behavioral disturbance diagnosis. A review of the resident's annual Minimum Data Set assessment dated [DATE], indicated that the resident had severe cognitive impairment with a BIMS of 3. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An incident report, completed by Employee 1, a Registered Nurse (RN), dated June 6, 2024, at approximately 5:30 p.m., revealed that Employee 2, a nurse aide (NA), reported that while by nurses' station talking with the scheduler, she looked down the hall (300's hallway) and saw another resident {Resident 8} close to Resident 48. Employee 2 went to Resident 48 and observed that her right breast was exposed and a male resident {Resident 8} had his hand on the resident's bare breast. Residents were separated immediately and taken to their rooms. Resident 48 was assessed by this writer {Employee 1} and no signs or symptoms of distress and offered no complaints and was acting per usual, pleasantly confused. Vital signs were obtained, and skin check completed with no abnormalities or injuries noted. Voice message left for Resident 48's attending physician and responsible party (RP), son, were informed of incident. A review of a witness statement written by Employee 2, no date or time noted, described that at approximately 3:30 p.m., I was at the nurses' station talking to [scheduler] about staying tonight. I happened to look down the hall and saw Resident 8 feeling Resident 48's right exposed breast. I ran down the hall, separated them and I put her {Resident 48} in her room and Resident 8 in his room. Further review of the incident report indicated that Resident 8's attending physician and RP were notified of the incident and the facility immediately initiated one-to-one direct observation of Resident 8. A review of a physician's order dated June 6, 2024, at 8:28 p.m., revealed an order for one-to-one direct observation by staff at all times. There was no documented evidence that the facility consistently provided sufficient supervision of Resident 8 and monitored the resident every fifteen-minute checks as care planned as of March 26, 2024, to ensure the safety of other residents due to Resident 8's sexual behaviors towards female residents. A review of Resident 8's clinical record revealed a nurses' progress note Health Status Note completed by Employee 3, a licensed practical nurse (LPN), dated June 6, 2024, at 10:26 p.m., revealed this writer last saw resident at approximately 5:00 p.m., seated in his wheelchair by nurses' station sleeping intermittently. One-to-one supervision and one-to-one supervision followed post incident and continued with no further incident this shift. An interview with the Director of Nursing (DON) on June 26, 2024, at 2:05 p.m., revealed that that Resident 8 was known to have sexually inappropriate encounters/behaviors with female residents as noted in his clinical record by staff. The DON was unable to provide documented evidence that the incidents noted on October 16, 2023, January 7, 2024, and on February 29, 2024, were thoroughly investigated. The facility did not report these incidents to the State Survey Agency, there were no incident reports or PB-22s (state agency standardized format for completion of abuse investigations) completed. The DON was unable to state why the facility did not implement their abuse policy for reporting, investigating and protecting residents because this DON was not employed at the facility during the times of the noted incidents. The only incident reported and investigated was the abuse of Resident 48 on June 6, 2024. The DON confirmed that the facility could not provide documented evidence that every fifteen-minute checks were conducted to provide supervision of Resident 8 with known sexually inappropriate behaviors to prevent him from further sexually abusing other female residents. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility failed to protect and ensure that Resident 48 {victim} was free from sexual abuse perpetrated by Resident 8 who had a known documented history of sexual inappropriate behaviors. According to the Centers for Medicare and Medicaid Services psychosocial outcome guide, application of reasonable person concept, Resident 48 would have the expectation that she was safe in her home and treated with respect and dignity. When applying the reasonable person concept, Resident 48 would have suffered psychosocial harm and humiliation due to being sexually abused by Resident 8. An interview with the Nursing Home Administrator (NHA) on June 27, 2024, at 2:30 p.m., confirmed that the facility failed to protect Resident 48 from a resident {Resident 8} with known sexually inappropriate behaviors from sexual abuse. The NHA confirmed that the facility failed to ensure that each incident of sexual abuse towards other female residents was identified, by implementing their abuse policy in response and timely initiate an investigation to identify resident victims of sexual abuse perpetrated by Resident 8 and the protection of other female residents. A review of the facility's policy titled Bladder and Bowel Screening and Assessment, dated reviewed by the facility on May 10, 2024, revealed that incontinent management (check and change) is a technique for use with residents who are mostly incontinent, and staff will perform incontinent care on a check and change schedule. A clinical record review revealed that Resident 80 was admitted to the facility on [DATE], with diagnoses that included transient ischemic attack (a temporary blockage of blood flow to the brain) and cerebral infarction (brain damage that results from a lack of blood). The resident's care plan indicated that Resident 80 was at risk for decreased ability to perform activities of daily living in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting, initiated on May 16, 2024. An MDS assessment dated [DATE] revealed that Resident 80 was cognitively intact with a BIMS score of 14 (a score of 13-15 indicates cognition is intact), dependent on staff for toileting hygiene (the ability to maintain perineal hygiene and adjust clothes before and after voiding having a bowel movement) and required substantial or maximal assistance for lower body dressing, showering, bathing, and moving from a sitting position to a standing position or transferring to the toilet. Resident 80 was always incontinent of bowel and bladder according to this assessment. A facility investigation dated June 6, 2024, revealed that Employee 12, Nurse Aide (NA), checked Resident 80 for incontinence and changed her at 11:20 AM on June 5, 2024 . Employee 12, NA, indicated that the resident is incontinent of urine, every two hours, and {communicates to staff when she} needs to be changed. Employee 12, NA, explained that she recalls seeing Resident 80 at 1:30 PM or 2:00 PM {on that date}but stated that she did not check if Resident 80 was incontinent because she was multi-tasking and helping two other residents with moving rooms. A facility investigation, dated June 6, 2024, revealed that Employee 13, NA, indicated that she changed Resident 80 before therapy {on June 5, 2024} and responded to her call bell later in the day. Employee 13, NA, indicated that Resident 80 is normally incontinent, and it is frequent. Employee 13, NA, indicated that she last checked and changed Resident 80 prior to the resident's therapy session {at 11:30 AM} (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A witness statement, undated, revealed that Employee 14, Certified Occupational Therapy Aide, indicated that Resident 80 received therapy services and was returned to her room at approximately 12:00 PM {on June 5, 2024}. A facility investigation, dated June 6, 2024, revealed that Employee 15, NA, checked Resident 80 during her first set of rounds on the 3:00 PM to 11:00 PM shift on June 5, 2024. Employee 15, NA, explained that the resident was soiled through her clothes and had dried bowel movement on her at the time. Employee 15, NA, indicated that Resident 80 was upset because she asked to be changed after lunch, but no one changed her when requested. A witness statement provided by Resident 80 dated June 6, 2024, revealed that on June 5, 2024, Resident 80 indicated she rang her call bell between 1:00 PM and 2:00 PM on June 5, 2024, to be changed. Resident 80 explained that the nurse aide told her she would change her, then told her the next shift staff would provide her care and left without providing her care. A witness statement provided by Employee 11, Registered Nurse, dated June 6, 2024, revealed that she entered Resident 80 ' s room {on June 5, 2024,} at 5:20 PM and saw urine dripping to the floor from the resident's lift pad. Employee 11, RN, explained that Resident 80 looked at her with tear-filled eyes and said they {staff} said they would be back, but they didn't come. Employee 11, RN, promised the resident that she would take care of this, changed the resident's clothes and hoyer pad, then assisted the resident to bed. A progress note dated June 5, 2024, at 11:34 PM indicated that a skin check assessment was performed and no new skin injuries or wounds were identified. During an interview on June 27, 2024, at 10:30 AM, Resident 80 stated that she sometimes waits over 30 minutes or more for care from staff when she needs to be changed. The resident explained that she needs staff assistance because she is not able to care for herself. Resident 80 recalled that on June 5, 2024, staff came into her room and told her that they couldn't change her because they were assisting others and too busy to provide her care. She explained that they told her the next shift would have to take care of her. She stated that she waited in a soiled brief for hours that day. Resident 80 stated that she is upset, frustrated, and cries when she needs to wait for care after soiling her brief. Resident 80 stated that staff continue to check on her, turn her call bell light off, but leave her without providing care. During an interview on June 28, 2024, at approximately 10:30 AM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that that facility neglected to provide the care and services necessary to avoid psychosocial upset and physical discomfort for Resident 80 failing to assure the resident's physical, mental, and psychosocial well-being. The NHA and DON confirmed that the facility investigation identified that Resident 80 was left in a soiled brief from approximately 1:30 PM on June 5, 2024, until 5:20 PM. The NHA and DON stated that Employee 12, NA, was terminated for neglecting Resident 80's needs. A clinical record review revealed that Resident 21 was admitted to the facility on [DATE], with diagnoses that include cerebral infarction (brain damage that results from a lack of blood) and hemiplegia (paralysis on one side of the body). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of a quarterly MDS assessment dated [DATE] revealed that Resident 21 is cognitively intact with a BIMS score of 15 (a score of 13-15 indicates cognition is intact), and required substantial or maximal assistance for lower body dressing, showering, bathing, and moving from a sitting position to a standing position or transferring to the toilet. Resident 21's care plan indicated that the resident was at risk for urinary incontinence related to impaired mobility, physical limitations, and a history of hemiplegia initiated January 14, 2024, with a planned intervention to check the resident every two hours and as needed for incontinence also implemented on January 14, 2024. A facility investigation, dated May 23, 2024, revealed that Resident 21 reported that at night sometimes the {staff} comes in and tells me I'm not wet and leave my room. Resident 21 explained that in the middle of the night last {May 22, 2024}, she rang her call bell because she was wet. Resident 21 relayed that staff came in and told her she wasn't wet and would be back later but did not return to provide her care for about two hours. A statement dated May 24, 2024, at 11:00 AM, revealed that Employee 16, NA, stated that she changed Resident 21 at 3:00 AM on May 22, 2024. Employee 16 indicated that she responded to Resident 21's call bell for assistance at 4:30 AM. Employee 16, NA, stated that she did not check to see if Resident 21 was wet or provide Resident 21 with incontinence care because she assumed she was dry, despite the resident indicating she needed to be changed. Employee 16, NA, stated that she was trying to get caught up on documentation that night and went back to change the resident at 4:55 AM. Employee 16, NA, stated that her action in making the resident wait to be changed was wrong. A progress note dated May 24, 2024, at 9:01 PM indicated that Resident 21's skin was assessed and no new skin injuries or wounds were identified. During an interview on June 27, 2024, at 10:00 AM, Resident 21 stated that sometimes she waits a long time for care. She stated that she waits 20 minutes for staff to provide her care and longer when the facility is short on staff. Resident 21 stated that a few weeks ago, there was an incident where she rang her call bell for assistance to be changed, but staff told her she had to wait to be changed. Resident 21 stated that she felt disappointed because she was treated in that manner by staff. During an interview on June 28, 2024, at approximately 10:30 AM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that that facility neglected to provide the care and services necessary to avoid harm and to attain or maintain Resident 21's physical, mental, and psychosocial well-being. The NHA and DON confirmed that the facility investigation identified that Resident 21 rang her call bell because she soiled her brief but was not provided care timely because Employee 16, NA, was completing documentation. The NHA and DON stated that Employee 16, NA, was suspended, received a final level of discipline, and returned to work after completing abuse, neglect, and resident rights training. 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 201.29 (a) Resident Rights 28 Pa. Code 211.12 (d)(5) Nursing Services

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on a review of clinical records and the facility's abuse prohibition policy, and staff interviews, it was revealed that the facility failed to promptly report instances of resident abuse to the State Survey Agency, and submit completed abuse investigations to the State Survey Agency within five working days of the incident, for three out of four allegations of abuse reviewed. Findings include: A review of a policy entitled Abuse Prevention Program last reviewed by the facility on May 10, 2024, indicated that the facility will report alleged and substantiated incidents to the Pennsylvania Department of Health, additional state agencies and/or local authorities per federal and state requirements. The facility will analyze the occurrences to determine what changes are needed, of any, to policies and procedures to prevent further occurrences. Any report or allegations of abuse/neglect, misappropriation, or exploitation will be reported initially by the Administrator (NHA), Director of Nursing (DON), Assistant Director of Nursing (ADON), or delegated supervisor as follows: Within 24-hours of knowledge of the event to the Pennsylvania Department of Health through the electronic reporting system Immediately to the Area Agency on Aging Local police department The State Survey Agency, Pennsylvania Department of Health will be notified of the reports of abuse involving the following and will be reported by the Administrator (NHA), Director of Nursing (DON), Assistant Director of Nursing (ADON), or delegated supervisor as required to The Pennsylvania Department of Aging for the following reasons: Serious bodily injury Serious physical injury Sexual abuse, assault, rape Suspicious death The appropriate agencies listed above will be notified of the results and outcomes of the investigation by the NHA or his/her designee. The mandatory reporting form will be submitted to the local Area Agency on Aging (AAA) with 48-hours, the NHA will complete the PB-22 within five (5) working days of the incident and any supplemental information to the AAA. If abuse is substantiated, the NHA and/or designee will notify the appropriate agencies and/or licensing board(s). (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 8's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included unspecified dementia and adjustment disorder (difficulty in managing the stressful life changes such as coping with work-related problems, loss of loved ones, or relationship issues that leads to significant impairment in functioning) with mixed disturbance of emotions and conduct. The resident had severe cognitive impairment with a BIMS score of 4. A review of Resident 8's plan of care dated June 25, 2023, and revised on March 26, 2024, indicated that the resident had potential to demonstrate verbally abusive and sexually inappropriate behaviors related to dementia and poor impulse control and a noted goal that the resident would verbalize understanding of need to control verbally abusive behavior. Social service progress notes in Resident 8's clinical record completed by Employee 4, Social Services, dated October 16, 2023, at 5:13 p.m., Resident 8 may become a little too handsy with some female residents and likes to hold and sometimes kiss female residents hands and was known as a ladies man. The facility had not reported any instances of alleged sexual abuse or harassment of female residents, perpetrated by Resident 8 to State Survey Agency at that time, which was confirmed during interview with the DON on June 26, 2024, at 11:15 a.m A review of a progress note completed by Employee 5, a licensed practical nurse (LPN), on January 7, 2024, at 12:09 p.m., revealed that Resident 8 was observed multiple times this shift being sexually inappropriate with the female residents, rubbing their thighs up to their crotch. This was witnessed by this nurse {Employee 5} and by one of the CNA's. Resident 8 was placed in his room and told that he needs to be appropriate and to keep his hands to himself. The facility failed to report this observed incident of sexual abuse to the State Survey Agency, which was confirmed during interview with the DON on June 26, 2024, at 11:20 a.m., that this incident between Resident 8 and an unknown female resident was not reported to the State Agency Agency within 24 hours and the completed investigation submitted within 5 working days of the incident. Further review of Resident 8's clinical record revealed a progress note completed by Employee 7, RN/DON, dated February 29, 2024, at 5:55 p.m., revealed that the resident's RP was made aware on February 28, 2024, that a female resident reported that on February 27, 2024, Resident 8{Perpetrator} approached her in the lobby and rubbed her leg over her clothes and stated oh you like this, and when she responded that she did not like this, he proceeded to grab her left breast over her clothes, female resident removed herself from the lobby. Resident's RP, daughter, very apologetic and has spoken with her father regarding these behaviors. RP reported that Resident 8 had no recollection of these behaviors when they happened, and he was remorseful and tearful when they discuss his actions. Daughter aware of gradual dose reduction of Celexa (an antidepressant) and increase in Celexa from February 25, 2024, daughter in agreement with same and would continue to visit daily and provide support to her father regarding these behaviors. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linwood Nursing and Rehabilitation Center	100 Florida Avenue Scranton, PA 18505

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility did not report this sexual abuse to the State Survey Agency within 24 hours and submit a completed investigation within 5 working days of the incident, which was confirmed during interview with the DON on June 26, 2024, at 11:25 a.m. The Nursing Home Administrator (NHA) confirmed on June 27, 2024, at 11:35 a.m., that the above instances of sexual abuse perpetrated by Resident 8 should have been reported to the State Survey Agency within 24 hours and completed abuse investigations, PB22, within five working days of the incident. Refer F600 28 Pa. Code 201.14(c) Responsibility of licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a)(c) Resident Rights

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460 Based on a review of clinical records, the facility's abuse prohibition policy and information provided by the facility it was determined the facility failed to promptly conduct a thorough investigation into instances of sexual abuse, protect other female residents from the potential for further abuse during the investigation and submit the completed investigation to the State Survey Agency within five working days of the incident as evidenced by one of 14 residents reviewed (Resident 8) and failed to thoroughly investigate injuries of unknown origin, ankle fracture, to rule out abuse, neglect or mistreatment as the potential cause for one out of 21 sampled residents (Residents 48). Findings included: A review of the facility's Abuse Policy that was last reviewed by the facility on May 10, 2024, defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Sexual abuse is non-consensual sexual contact of any type with a resident, including sexual harassment, sexual coercion, or sexual assault. Sexual contact or assault that results from threats, force, or the inability of the person to give consent, and involving a range of activities. A facility policy entitled Allegation, Suspicion, or Witnessed Abuse, Neglect, Misapplication, or Exploitation Intervention and Reporting, last reviewed by the facility on May 10, 2024, indicated that any individual(s) observing an incident of abuse or suspects' abuse has the responsibility to intervene immediately so that the safety of the resident can be ensured. All management and staff are jointly and individually responsible to ensure that any compliant allegation or suspicion of abuse, or witnessed resident abuse is reported immediately to the supervisor of the area. Procedures include to assess and preserve the scene while taking action(s) to immediately separate and protect the residents from alleged abuse situation. Further assess resident for need of immediate first aid or care for any injuries inflicted by the alleged incident. This includes physical care as well as emotional support the resident and any others who may have witnessed the alleged incident. The individual(s) who witnessed the incident of abuse or suspected abuse will immediately report the incident to the Charge Nurse or immediate supervisor of the area. Upon receiving a report of abuse or alleged abuse, the Charge Nurse or supervisor or the area shall immediately notify the RN Supervisor, who will respond to the location, examine the resident, and begin the investigation. The following information should be included in the initial verbal and subsequent written report: name of the resident(s) involved, the date and time of the incident, the exact location of the incident, the name(s) of the alleged perpetrator and contact information, the name(s) of any witnesses to the incident and contact information, a statement will be obtained from the resident(s) if he/she are interviewable [The RN Supervisor and/or Social Service will interview the resident], a description of the incident as witnessed, and any other pertinent information which may be useful to the investigation. The RN Supervisor will notify the appropriate personnel of the incident and shall include, but no limited to the following: Director of Nursing (DON) or Assistant Director of Nursing (ADON) immediately, Administrator (NHA) immediately, attending physician or as directed by the NHA, DON, or ADON (e.g., nest A.M. if immediate notification is not warranted based upon the allegation, signs of injury, time, and type of allegation made), Resident Representation (RP) immediately or as directed by the NHA, DON, ADON (e.g., next A.M. if immediate notification is not warranted based upon the allegation, signs of injury, time, and type of allegation made). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additionally, the NHA, DON, or designee will inform resident and the resident's representative that there will be a complete investigation of the incident or allegation and that the resident will be safe and free of retaliation. The Director of Social Services immediately or as directed by the NHA, DON, or ADON (e.g., next A.M. if immediate notification is not warranted based upon the allegation, signs of injury, time, and type of allegation made). Follow-up emotional support will be provided by the Social Service Staff as needed. An incident report will be completed, documenting the alleged abuse, results of the physical examination and any physical injuries noted to the resident. Medical treatment will be provided as indicated and as directed by the Attending physician. Documentation of the alleged abuse, physical injuries noted, orders received from the physician, and all notifications will be made in the progress notes of the resident record by a licensed nurse. A review of Resident 8's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included unspecified dementia and adjustment disorder (difficulty in managing the stressful life changes such as coping with work-related problems, loss of loved ones, or relationship issues that leads to significant impairment in functioning) with mixed disturbance of emotions and conduct. The resident was severely cognitively impaired with a BIMS score of 4. Resident 8's care plan initiated June 25, 2023, and revised on March 26, 2024, indicated that the resident had potential to demonstrate verbally abusive and sexually inappropriate behaviors related to dementia and poor impulse control and a noted goal that the resident would verbalize understanding of need to control verbally abusive behavior. Employee 4, Social Services, documentation dated October 16, 2023, at 5:13 p.m., indicated that Resident 8 may become a little too handsy with some female residents and likes to hold and sometimes kiss female residents hands and was known as a ladies' man. Employee 4 failed to identify the female residents and the circumstances of these instances to determine if they met the definition of sexual abuse or harrassment to ensure that a complete investigation and to protect other female residents from potential sexual abuse. During an interview with the Director of Nursing (DON) on June 26, 2024, at 11:15 a.m., reported that Employee 4 should have reported the incident that was reported to her related to Resident 8's sexual behaviors toward other female residents and confirmed that the facility did not initiate an investigation into Resident 8's sexual behavior to the unidentified female residents. A review of a progress note completed by Employee 5, a licensed practical nurse (LPN), on January 7, 2024, at 12:09 p.m., revealed that Resident 8 was observed multiple times this shift being sexually inappropriate with the female residents, rubbing their thighs up to their crotch. This was witnessed by this nurse {Employee 5} and by one of the CNA's. Resident 8 was placed in his room and told that he needs to be appropriate and to keep his hands to himself. This nurse {Employee 5} also called resident's daughter and explained the situation to her. Daughter seemed to be embarrassed and apologized. Daughter also stated that if it happened again, to give her a call and put him on the phone with her. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing documentation by Employee 6, RN Supervisor, dated January 7, 2024, at 12:31 p.m., revealed that in response to Resident 8's observed inappropriate sexual behavior, Resident 8 was redirected and placed on every 15-minute checks for behavioral observation. Resident made aware behaviors was inappropriate. Resident stated, I don't remember doing it. Daughter was in to visit and made aware of behavior and behavioral monitoring checks and was okay with same. Employee 6 failed to initiate an investigation to the sexual abuse of the unidentified female residents. During an interview on June 26, 2024, at 11:20 a.m., the DON stated that Employee 6 should have initiated an investigation related to sexual abuse of the female residents by Resident 8. Resident 8's clinical record revealed a progress note completed by Employee 7, RN/former DON, dated February 29, 2024, at 5:55 p.m., revealed that the resident's RP was made aware on February 28, 2024, that a female resident reported that on February 27, 2024, Resident 8{Perpetrator} approached her in the lobby and rubbed her leg over her clothes and stated oh you like this, and when she responded that she did not like this, he proceeded to grab her left breast over her clothes, female resident removed herself from the lobby. Resident's RP, daughter, very apologetic and has spoken with her father regarding these behaviors. RP reported that Resident 8 had no recollection of these behaviors when they happened, and he was remorseful and tearful when they discuss his actions. The facility failed to investigate this sexual abuse and report the results to State Agency/Local Authority within five working days of the incident, which was confirmed during interview with the DON on June 26, 2024, at 11:25 a.m. An interview with the facility's Nursing Home Administrator (NHA) on June 27, 2024, revealed that she was not working in the facility when the above incidents occurred. However, she confirmed that the facility failed to investigate Resident 8's sexual abuse of multiple female residents and report the results of these investigations to the State Agency/Local Authority within five working days of the incidents. A review of the facility's policy entitled, Resident Abuse & Neglect Prevention Program, last reviewed on May 10, 2024, indicated that each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation as defined in the regulation. Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. According to the policy, bruises and/or injuries of unknown origin will have an investigation initiated to rule out the possibilities of abuse. Immediately upon discovery of an allegation of abuse or situation with the potential for abuse or harm, the facility will take all reasonable measures to separate the alleged perpetrator from access to the alleged victim. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Progress note dated February 21, 2024, at 3:47 PM, indicated that an order for an x-ray of the left ankle was ordered. Results of the x-ray revealed distal fibular fracture with mild angulation, comminution and relatively mild soft tissue swelling. Generalized osteopenia. Physician orders were obtained to apply an ace wrap to left ankle, elevate and ice to the area, and to see orthopedics for follow-up. Progress note date February 22, 2024, at 3:09 PM, indicated that Resident 48 was transferred to the hospital emergency room from the orthopedic office and was admitted to the hospital for further treatment of the left ankle fracture. Review of facility event report dated February 22, 2024, revealed that an investigation related to the resident sustaining a fractured ankle was initiated on February 22, 2024, at 3PM. According to the report, the resident was documented as not tolerating restorative programming well and discontinued, and that the mechanical lift used during transferring of the resident was used correctly. Review of progress note date February 22, 2024, at 9:36 AM, the resident's planned restorative passive range of motion program was for the right lower extremity. There was no program for the left lower extremity. Review of facility investigation of the injury of unknown injury failed to provide evidence that the investigation included observation and/or demonstration of the mechanical lift to evaluate that the lift was used correctly. Review of the clinical record further revealed that Resident 48 received a shower on February 2, 9, and 12, 2024, during the 3PM - 11PM shift. There was no evidence that the investigation included observation and/or demonstration that care was provided to Resident 48 according to her plan of care. There was no documented evidence that the facility had thoroughly investigated the potential origin of Resident 48's fracture to her left ankle to rule out abuse, neglect or mistreatment as the potential cause of the injury. During an interview with the Director of Nursing (DON) on June 28, 2024, at approximately 8:15AM, confirmed that there was no evidence that the facility had thoroughly investigated Resident 48's ankle fracture of unknown origin. Refer F697, F713 28 Pa. Code 201.29(a)(c)(d) Resident rights 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(e)(1) Management

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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** 43944 Based on a review of clinical records and facility-initiated transfer notices and a staff interview, it was determined that the facility failed to provide written notices of facility-initiated hospital transfers to the resident and their representative and failed to provide a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for six residents out of the 21 sampled (Resident 2, 7, 24, 53, 72, and 188). 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. A review of the clinical record revealed that Resident 2 was transferred to the hospital on January 13, 2024, and was readmitted to the facility on [DATE]. A review of the clinical record failed to find documented evidence that the facility provided the resident and resident representative with a written notice of the facility-initiated transfer and reason for the transfer on January 13, 2024. A review of the clinical record revealed that Resident 53 was transferred to the hospital on May 5, 2024, and was readmitted to the facility on [DATE]. A review of the clinical record failed to find documented evidence that the facility provided the resident and resident representative with a written notice of the facility-initiated transfer and reason for the transfer on May 5, 2024. A review of the clinical record revealed that Resident 7 was transferred to the hospital on May 15, 2024, and was readmitted to the facility on [DATE]. A review of the clinical record failed to find documented evidence that the facility provided the resident and resident representative with a written notice of the facility-initiated transfer and reason for the transfer on May 15, 2024. A review of the clinical record revealed that Resident 24 was transferred to the hospital on January 24, 2024, and was readmitted to the facility on [DATE]. A review of the clinical record failed to find documented evidence that the facility provided the resident and resident representative with a written notice of the facility-initiated transfer and reason for the transfer on January 31, 2024. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Review of the clinical record revealed that Resident 72 was transferred to the hospital on February 25, 2024, and returned to the facility on [DATE]. Resident 72 was again transferred to the hospital on April 1, 2024, and was readmitted on [DATE], and again on May 18, 2024, and returned to the facility on [DATE]. Review of the clinical record failed to provide evidence that the facility provided the resident and resident representative with a written notice of the facility-initiated transfer and reason for the transfers on February 25, April 1, and May 18, 2024. An interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on June 27, 2024, at approximately 1:30 PM confirmed that the facility failed to provide transfer information to Resident 2, 7, 24, 53, 72, and 188 and their representatives. The NHA and DON also confirmed that the facility was not currently providing information regarding the notification of facility-initiated resident transfers to a representative of the Office of the State Long-Term Care Ombudsman. 28 Pa. Code 201.29 (a)(c.3)(2) Resident rights

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records and select facility policy, staff, and resident interviews, it was determined that the facility failed to provide written notice of the facility's bed hold policy to a resident and the resident's representative upon the resident's transfer to the hospital for six residents out of the 21 sampled (Residents 2, 7, 24, 53, 72, and 188). Findings include: A review of the clinical record revealed that Resident 2 required transfer to the hospital on January 13, 2024, and was readmitted to the facility on [DATE]. Further clinical record review revealed no documentation that Resident 2 or Resident 2's representative were made aware of a facility's bed-hold and reserve bed payment policy upon transfer to the hospital. A review of the clinical record revealed that Resident 53 required transfer to the hospital on May 5, 2024, and was readmitted to the facility on [DATE]. Further clinical record review revealed no documentation that Resident 53 or Resident 53's representative were made aware of a facility's bed-hold and reserve bed payment policy upon transfer to the hospital. A review of the clinical record revealed that Resident 7 was required transfer to the hospital on May 15, 2024, and was readmitted to the facility on [DATE]. Further clinical record review revealed no documentation that Resident 7 or Resident 7's representative was made aware of a facility's bed-hold and reserve bed payment policy upon transfer to the hospital. A review of the clinical record revealed that Resident 24 was transferred to the hospital on January 24, 2024, and was readmitted to the facility on [DATE]. Further clinical record review revealed no documentation that Resident 24 and Resident 24's representative were made aware of a facility's bed-hold upon transfer to the hospital. Review of the clinical record revealed that Resident 72 was transferred to the hospital on February 25, 2024, and was readmitted to the facility on [DATE]. The resident again required transfer to the hospital on April 1, 2024, and returned on April 5, 2024, and again on May 18, 2024, with readmission to the facility on [DATE]. There was no evidence that Resident 72 and their representative were made aware of the facility's bed-hold and reserve bed payment policy with any of the facility-initiated transfers. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on June 27, 2024, at approximately 1:30 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) were unable to provide evidence that the facility made Residents 2, 7, 24, 53, 72, and 188 and their representatives, aware of a facility's bed-hold and reserve bed payment policy upon transfer to the hospital. 28 Pa Code 201.18 (e)(1) Management 28 Pa Code 201.29 (a) Resident rights

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460 Based on a review of clinical records and the Resident Assessment Instrument and staff interviews, it was determined that the facility failed to ensure that the Minimum Data Set Assessments (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) accurately reflected the status of one of 21 sampled residents (Resident 12). Findings include: According to the RAI User's Manual regarding Section N0410 for Medications Received, the facility would record the number of days a medication was received by the resident at any time during the 7-day look back period. A review of Resident 12's quarterly MDS assessment dated [DATE], Section N 410 indicated that the resident received an anticoagulant medication 7 days in the 7 day look back period. A review of the Resident 12's physician orders revealed that the resident did not have a physician order for an anticoagulant medication during the 7 day look back period. Review of the resident's May 2024 and June 2024 Medication Administration Records revealed that there were no anticoagulant medications administered to the resident during the 7-day look back period. Interview with the Registered Nurse Assessment Coordinator on June 28, 2024, at approximately 9:00 AM confirmed the quarterly MDS Assessment was inaccurate with respect to Medications Received.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41460 Based on observation and staff interview, it was determined that the facility failed to maintain an environment free of potential accident hazards on one of three resident care units (300 Hall). Findings include: Observations made during medication administration on June 28, 2024, at approximately 8:30 AM revealed an unattended, and unlocked, medication cart in the hallway of the resident unit. During observation of resident medication administration with Employee 10, licensed practical nurse, the medication cart was left unlocked and unattended when Employee 10 took medications into a resident room to administer to resident. The cart was left against the wall across from where the resident's room was located and out of the nurse's view. Further observation of the medication cart revealed that the keys to the cart, which allow access to both the medication cart and narcotic drawer within, were left unattended on top of the cart. Multiple residents were observed ambulating/self-propelling out in the hallway at the time of this observation. During an interview with the Director of Nursing on June 28, 2024, at 8:50 AM confirmed the potential accident hazard and the presence of independently mobile residents in the area at that time, creating the potential for unauthorized access to the med cart and its contents. 28 Pa. Code 211.12 (d)(5) Nursing Services.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on a review of clinical records, select facility policy and investigative reports and staff interviews it was determined that the facility failed to fully assess and implement individualized measures planned for the toileting needs of three residents out of 5 sampled for a decline in continence (Residents 51,15, and 2). Findings included: A review of a facility policy entitled Bladder and Bowel Screening and Assessment that was last reviewed by the facility May 10, 2024, indicated that a resident's bladder and bowel status will be evaluated and assessed at the time of admission/readmission and as needed with a change in bladder and bowel status. A plan of care is initiated based on the findings of the evaluation/assessment and/or voiding pattern diaries. The procedure included a minimum of three consecutive days (if appropriate), to identify the type of bladder/bowel incontinence and develop a bowel/bladder program as indicated. Upon completion of a bladder and bowel diary, the findings will be reviewed to determine a bowel and/or bladder program appropriate for the resident and the care plan would be updated to reflect the appropriate bowel and/or bladder programs. A review of Resident 51's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included sepsis (is a life-threatening medical emergency caused by the body's extreme reaction to an infection), urinary tract infection (UTI is an infection of any part of the urinary system, including kidneys, ureters, bladder, and urethra), metabolic encephalopathy (is a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), and dementia [is a general term that represents a group of diseases and illnesses that affect your thinking, memory, reasoning, personality, mood and behavior. The decline in mental function interferes with your daily life and activities]. A review of Resident 51's care plan, dated on January 13, 2024, identified that the resident was at risk for urinary incontinence related to history of falls, dementia, and diuretic use with panned interventions that included to check the resident every two hours and change required for incontinence, wash and rinse and dry perineum, change clothing PRN (as needed) after incontinence episodes. A review of Resident 51's hospital records dated June 3, 2024, at 8:55 p.m., revealed that the resident had changes in mental status and was more lethargic. Resident was diagnosed with sepsis and urinary tract infection (UTI). The resident was treated in the hospital with intravenous antibiotic therapies to manage infections. A review of the resident's survey documentation report (an electronic record that summarizes tasks for care performed by nursing staff that is specific to a resident's individual care needs) dated from January 14, 2024, through survey ending June 28, 2024, failed to reveal that staff were consistently checking and changing Resident 15 every two hours as planned. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility was unable to provide provide documented evidence that every two-hour check and changes were timely and consistently completed as planned in Resident 51's incontinence plan. An interview with the Director of Nursing (DON) on June 27, 2024, at 1:15 p.m., confirmed that the facility failed to ensure that nursing staff were consistently checking and changing Resident 51 every two hours as planned. A review of Resident 15's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included a compression fractures, heart failure (a term used to describe a heart that cannot keep up with its workload and the body may not get the oxygen it needs), frequent urinary tract infections (UTI), and a history of falls. Nursing progress dated November 9, 2023, at 11:13 a.m., revealed that a follow up to resident's incontinence was conducted and that Resident 15 would be placed on an every two-hour check and change. Nurse progress notes dated November 9, 2023, at 6:11 p.m., revealed that the resident's daughter was notified of the resident's incontinence and that the resident's plan of care would be updated to include every two-hour check and change due to the resident being identified as a heavy wetter related to diuretics (medications used to remove excess water build-up due to heart failure) and diagnosis of overactive bladder. A review of Resident 15's Medication Administration Record (MAR) dated March 2024, revealed that staff administered Keflex [(Cephalexin) is used to treat infections caused by bacteria, including upper respiratory infections, ear infections, skin infections, urinary tract infections and bone infections] oral capsule 500 milligrams (mg), give one (1) capsule by mouth two times a day for UTI for seven (7) days. A review of resident's survey documentation report (an electronic record that summarizes tasks for care performed by nursing staff that is specific to a resident's individual care needs) dated from November 12, 2023, through survey ending June 28, 2024, failed to reveal that staff were consistently checking and changing Resident 15 every two hours as planned. The facility failed to ensure that Resident 15's planned every two-hour check and change program was timely and consistently implemented. An interview with the Director of Nursing (DON) on June 27, 2024, at 1:25 p.m., confirmed that the facility failed to ensure that nursing staff were consistently checking and changing Resident 15 every two hours as planned. A review of Resident 2's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included urinary retention (is when the bladder doesn't completely empty upon urination) with need for Foley catheter [is a device that drains urine from your urinary bladder into a collection bag outside of your body when you can't pee on your own or for various medical reasons], history of chronic UTIs, and chronic kidney disease [(CKD) is a long-term condition where the kidneys do not work as well as they should]. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's quarterly Minimum Data Set (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) assessment dated [DATE], indicated that the resident cognitively intact impaired with a BIMS (brief interview for mental status - a tool to assess cognitive status) of 3 and had a Foley catheter present and was always continent of bowel. A quarterly MDS dated [DATE], revealed that the resident was occasionally incontinent of bowel (decline from the MDS completed March 4, 2024) and was not bowel retraining program. Resident 2's clinical record failed to reveal evidence that the facility had acted upon the resident's decline in bowel continence and evaluated the resident for potential bowel retraining or applicable management program to meet the resident's needs and prevent further decline in bowel continence. During an interview with the Director of Nursing on June 27, 2024, at 1:30 p.m., confirmed that the facility failed to timely identify and address the resident's decline in bowel continence. The Nursing Home Administrator (NHA) on June 27, 2024, at 1:50 p.m., confirmed that the failed to ensure that Residents 51, 15, and 2 toileting needs were fully assessed and plans to meet the resident's bowel and bladder needs were developed and consistently implemented. 28 Pa. Code 211.10 (a)(c)(d) Resident care policies 28 Pa. Code 211.12 (d)(3)(5) Nursing services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records and select facility policy, and staff interviews, it was determined that the facility failed to consistently and accurately monitor resident weights to timely identify changes in nutritional parameters for three residents out of 21 sampled (Residents 21, 7, and 53). Findings included: A review of facility policy titled Weighing of Residents, last reviewed by the facility on May 10, 2024, revealed the facility must monitor the resident's weight to detect significant weight loss or gain in order to ensure that the resident maintains acceptable parameters of nutritional status, taking into account the resident's clinical condition or other appropriate intervention when there is a nutritional problem. The policy indicates that if the resident exhibits a weight change of 5 pounds from the previous weight, the resident shall be re-weighed within 24 hours, and the re-weight shall be recorded. Furthermore, the policy indicates that if the weight change falls into the significant category (5% change in one month or 10% in six months), the registered dietician completes an assessment to investigate the cause of the weight change. Upon admission/readmission the resident is weighed weekly for one month and the dietitian will determine after one month if weekly weights should continue. A clinical record review revealed that Resident 21 was admitted to the facility on [DATE], with diagnoses that include cerebral infarction (brain damage that results from a lack of blood) and hemiplegia (paralysis on one side of the body). A review of Resident 21's care plan, initiated November 30, 2022, revealed that she was at nutritional risk with a potential for decreased intake with planned interventions for staff to monitor changes in nutritional status, such as unplanned weight loss or weight gain, and reporting to dietitian/physician as indicated. A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 11, 2024, revealed that Resident 21 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). Resident 21's current recorded weights revealed the following: April 23, 2024, at 12:50 PM: 176.0 pounds April 28, 2024, at 3:02 PM: 193.8 pounds (17.8 pounds weight gain in five days, or 10.1% change) May 3, 2024, at 2:47 PM: 229.0 pounds (35.2 pounds weight gain in five days, or 18.16% change) May 8, 2024, at 2:50 PM: 180.0 pounds (49.0 pounds weight loss in five days, or 21.4 % change) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A late-entry nutrition note dated May 13, 2024, indicated that Resident 21 had no significant change in weight per MDS parameters at one, three, or six months. Mild weight gain was noted over six months. The resident was noted to be overall stable at this time. Weight history was noted on April 10, 2024, at 179.6 pounds, on February 4, 2024, at 175.6 pounds, and on November 3, 2023, at 170.8 pounds. The registered dietitian made no recommendations or changes during this review period. Noting to continue the current plan of care, diet, and supplements. The resident will maintain weight without significant changes through the next review. There was no documented evidence that resident's significant weight changes, noted on April 28, 2024 (17.8 pounds weight gain in five days or 10.1% change), May 3, 2024 (35.2 pounds weight gain in five days or 18. 16% change), or May 8, 2024 (49.0 pounds weight loss in five days or 21.4% change), were evaluated for accuracy. In response to surveyor inquiry at the time of the survey ending June 28, 2024, Resident 21 was weighed on June 26, 2024, and weighed 175.8 pounds. During an interview on June 27, 2024, at approximately 1:30 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that the facility failed to identify that Resident 21's significant weight changes and timely re-weigh the resident to ensure accuracy. The DON and NHA were unable to explain why the registered dietitian failed to identify Resident 21's significant weight changes noted on April 28, 2024, May 3, 2024, or May 8, 2024, when assessing the resident's nutritional status and parameters. Resident 7 was admitted to the facility on [DATE], with diagnoses that include atrial fibrillation (a condition that causes the heart to beat irregularly and sometimes much faster than normal), cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body), and heart failure (a condition that develops when the heart doesn't pump enough blood to meet the body's needs). A review of a quarterly Minimum Data Set assessment dated [DATE], revealed that Resident 7 is cognitively intact with a BIMS score of 14. Resident 7's care plan revealed that she is at nutritional risk with a potential for decreased intake, initiated on July 29, 2021, with planned interventions for staff monitoring for changes in nutritional status, such as unplanned weight loss or weight gain, and reporting the dietitian/physician as indicated. Resident 7's current recorded weights revealed the following: May 26, 2024, at 1:09 PM: 189.6 pounds June 2, 2024, at 10:33 AM: 177.2 pounds (12.4 pounds weight loss in 7 days, or 6.54% change) June 2, 2024, at 1:53 PM: 177.2 pounds June 16, 2024, at 11:43 AM: 188.9 pounds (11.7 pounds weight gain in 14 days, or 6.60% change) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	June 18, 2024, at 3:23 PM: 189.9 pounds June 26, 2024, at 10:40 AM: 178.4 pounds (10.6 pounds weight loss in eight days, 5.58% change) A nutrition note dated June 4, 2024, at 12:47 PM indicated Resident 7's weight record was reviewed, with a noted weight loss of 12.4 pounds in the past week. The entry noted that It is difficult to justify weight loss without reweight. Intake was reviewed and noted at 75-100% per nursing documentation. Regular diet noted, with no tolerance issues reported. Diuretic therapy is noted with the resident accepting fluid at meals (240-540 ml) per nursing documentation. No pressure areas were reported. No appetite changes, no change in edema, or medication changes were noted to justify weight loss. Will re-evaluate reweight and follow weekly weights for trends. The nutrition note dated June 4, 2024, failed to identify that a re-weight occurred on June 2, 2024, at 1:53 PM, that confirmed Resident 7's significant weight loss. A nutrition note dated June 10, 2024, at 1:17 PM indicated that a re-weight was completed with verified weight changes for Resident 7. No changes were reported with the intake of foods or fluids (75-100% intake) per nursing documentation. No medication changes were noted or reported. [NAME] is on diuretic therapy, which may impact weight changes. Fluids are accepted with meals per nursing documentation (200-540 ml). Weight changes are likely related to fluid shifts. Follow weekly weights for trends. Continue with a regular diet and encourage the intake of fluids and meals. Further review of the clinical record revealed no evidence Resident 21 was evaluated after significant weight changes were noted on June 16, 2024 (11.7 pound weight gain in 14 days, or 6.60%) and if the gains were also related to fluid. Following surveyor inquiry during the survey ending June 28, 2024, Resident 7 was weighed on June 26, 2024, and weighed 178.4 pounds (10.6 pounds weight loss in eight days, 5.58% change). During an interview on June 27, 2024, at approximately 1:30 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that the registered dietitian failed to assess the resident's weight changes, of June 16, 2024, that was confirmed by a re-weight on June 18, 2024. A review of Resident 53's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included subarachnoid hemorrhage (is a type of bleeding stroke that happens between your brain and the membrane that surrounds it), cerebral aneurysm (bulging or ballooning of the artery due to weakness in the wall of the vessel that supplies blood to the brain), and seizure disorder. The resident had severe cognitive impairment. Additionally, the resident's profile indicated an allergy to lactose. A review of the resident's plan of care dated March 14, 2023, identified that Resident 53 was nutritionally at risk due to gradual weight loss, required a mechanically altered diet, and variable intakes with noted goals to prevent weight loss and for the resident to consume 50 - 75% of meals. Planned interventions were to honor food preferences within meal plan, monitor intakes at all meals, and offer alternate choices as needed, alert dietitian and physician to any decline in intakes. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 53's clinical record revealed that she was admitted to the hospital on May 5, 2024, and readmitted to the facility on [DATE], with a diagnosis transient ischemic attack [(TIA) is a short period of symptoms similar to those of a stroke and caused by a brief blockage of blood flow to the brain] and facial drooping. A nutrition evaluation completed by the facility's Registered Dietitian dated May 15, 2024, at 2:50 p.m., revealed that the resident was readmitted from the hospital on May 11, 2024, due to facial drooping, rule out stroke. Working with SLP (speech therapy) for swallowing, diet currently regular with dental soft textures and thin liquids per SLP. Consuming 75-100% of meals with supervision and assistance. Fluid intakes approximately 260-480 milliliters (ml) per meal. No ordered nutritional supplements. Skin is without pressure related breakdown. Current weight: 141.8-lbs., obtained 5/11 and weight history 1 month ago 4/10/24 - 143. 7-lbs., 3 months ago 2/16/24 - 147.4-lbs., 6 months ago 11/21/23 - 148.2-lbs. Weight does not trigger for a significant change however notably down 6.4-lbs. over 6 months. Gradual decline noted and was previously on Magic Cup (high calorie/high protein supplement) with meals and will request to reorder same to encourage good oral fluids. Will monitor weekly weight trend. Med review completed with no diuretic therapy noted. Will continue to follow weights, skin, and oral intakes. A review of physician's orders dated May 15, 2024, at 5:00 p.m., was noted for a Magic Cup supplement with breakfast, lunch, and dinner. A review of the Resident 53's weight record revealed the following recorded weights: May 11, 2024, at 4:27 p.m. - 141.8 - pounds (readmission weight) May 11, 2024, at 6:49 p.m. - 141.8-pounds (re-weight) May 18, 2024 - weekly weight not obtained or recorded. May 25, 2024 - weekly weight not obtained or recorded. May 31, 2024, at 2:19 p.m. - 142.6 - pounds June 2, 2024, at 12:35 p.m. - 140.2 -pounds June 9, 2024 - weekly weight not obtained or recorded. June 16, 2024 - weekly weight not obtained or recorded. June 23, 2024, at 12:10 p.m. - 138.0 - pounds The facility failed to complete weekly weight monitoring, as indicated in their Weighing of Residents policy, upon Resident 53's readmission to the facility. A review of Resident 53's survey documentation report for the month June 2024 (through survey ending June 28, 2024), revealed that staff failed to consistently document the percentage of meals consumed (18 opportunities to document meal intakes out 90 meals served, 20-percent missed intake entries) by Resident 53. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Meal observation on June 25, 2024, at 12:48 p.m., revealed that Resident 53's meal ticket noted that the resident was to receive a Magic Cup. Observation at that time revealed that the physician ordered supplement, Magic Cup, was not present on the resident's tray. A review of the resident's June MAR (medication administration record) dated June 25, 2024, revealed that staff noted that the percentage of the Magic Cup consumed could not be determined, noting a check mark. During an interview with the Director of Nursing (DON), and in the presence of the Nursing Home Administrator (NHA) on June 27, 2024, at 1:35 p.m., confirmed that the facility failed to ensure that weekly weights were obtained and failed to provide physician ordered nutritional supplementation. 28 Pa. Code 211.5 (f) Medical Records 28 Pa. Code 211.12 (d)(3)(5) Nursing services

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460 Based on review of clinical records and staff interviews it was determined that the facility failed to develop and implement individualized pain management program, consistent with professional standards of practice, to meet the pain management needs of one of 21 residents reviewed (Resident 48). Findings include: According to the US Department of Health and Human Services, Interagency Task Force, Executive Summary Report dated May 2021, for Pain Management Best Practices the development of an effective pain treatment plan after proper evaluation to establish a diagnosis with measurable outcomes that focus on improvements including quality of life (QOL), improved functionality, and Activities of Daily Living (ADLs). Achieving excellence in acute and chronic pain care depends on the following: An emphasis on an individualized patient-centered approach for diagnosis and treatment of pain is essential to establishing a therapeutic alliance between patient and clinician. Acute pain can be caused by a variety of different conditions such as trauma, burn, musculoskeletal injury, neural injury, as well as pain due to surgery/procedures in the perioperative period. A multi-modal approach that includes medications, nerve blocks, physical therapy and other modalities should be considered for acute pain conditions. A multidisciplinary approach for chronic pain across various disciplines, utilizing one or more treatment modalities, is encouraged when clinically indicated to improve outcomes. These include the following five broad treatment categories -Medications: Various classes of medications, including non-opioids and opioids, should be considered for use. The choice of medication should be based on the pain diagnosis, the mechanisms of pain, and related co-morbidities following a thorough history, physical exam, other relevant diagnostic procedures, and a risk-benefit assessment that demonstrates the benefits of a medication outweighs the risks. The goal is to limit adverse outcomes while ensuring that patients have access to medication-based treatment that can enable a better quality of life and function. Ensuring safe medication storage and appropriate disposal of excess medications is important to ensure best clinical outcomes and to protect the public health. o Restorative Therapies including those implemented by physical therapists and occupational therapists (e.g. , physiotherapy, therapeutic exercise, and other movement modalities) are valuable components of multidisciplinary, multimodal acute and chronic pain care. o Interventional Approaches including image-guided and minimally invasive procedures are available as diagnostic and therapeutic treatment modalities for acute, acute on chronic, and chronic pain when clinically indicated. A list of various types of procedures including trigger point injections, radiofrequency ablation, cryoneuroablation, neuro-modulation and other procedures are reviewed. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o Behavioral Health Approaches for psychological, cognitive, emotional, behavioral, and social aspects of pain can have a significant impact on treatment outcomes. Patients with pain and behavioral health comorbidities face challenges that can exacerbate painful conditions as well as function, QOL, and ADLs. o Complementary and Integrative Health, including treatment modalities such as acupuncture, massage, movement therapies (e.g., yoga, tai chi), spirituality, among others, should be considered when clinically indicated. Effective multidisciplinary management of the potentially complex aspects of acute and chronic pain should be based A review of Resident 48's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included rheumatoid arthritis (a chronic autoimmune disease that causes inflammation and damage to the body's joints and other tissues), Alzheimer's disease, age-related osteoporosis (a bone disease that causes bones to become fragile due to a decrease in bone mass and density), and was dependent on facility staff for all activities of daily living which included transfers, repositioning, and toileting. Further review of the resident's clinical record revealed that the resident had communication deficits due to Alzheimer's disease. The resident's plan of care initiated May 17, 2022, identified that Resident 48 was at risk for alterations in comfort related to chronic pain, musculoskeletal disorders, neuropathic pain, and rheumatoid arthritis. Planned interventions were to evaluate pain characteristics, quality, severity, location, precipitating/relieving factors, utilize pain scale, monitor for non-verbal signs/symptoms of pain (increase in agitation, grimace, resistance to care) and medicate as ordered. A physician order dated May 17, 2023, was noted for Acetaminophen (Tylenol) 650 mg by mouth every 4 hours as needed for mild pain 1-3 on 0-10 pain scale. Review of nurses note dated February 5, 2024, at 10:41 PM, the resident complained of left leg pain. Review of resident's Medication Administration Record dated February 2024, indicated that the resident had been medicated with Tylenol at 2:40 PM, for a pain level of 3 and it was effective. There was no evidence that the resident received Tylenol after 2:40 PM on February 5, 2024. Review of nurse's note dated February 8, 2024, at 1:32 PM, revealed that a call was placed to the resident's physician upon request of the family, requesting something stronger for pain due to increased leg pains. There was no documented evidence that staff administered any additional Tylenol for pain in response to the concerns expressed by family on February 8, 2024. Review of nurse's note dated February 9, 2024, at 10:52 revealed that Resident 48 continued to display signs/symptoms of pain and discomfort when transferring and repositioning. Resident will scream out occasionally. Noted facial grimacing when left leg moved. According to the February 2024 MAR, the resident was medicated with Tylenol for a pain level of 4 at 6:10 PM, outside the physician ordered parameter of pain rated 1-3. There was no evidence the resident was medicated for pain/discomfort at any other time on February 9, 2024. (continued on next page)

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Linwood Nursing and Rehabilitation Center	100 Florida Avenue Scranton, PA 18505

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of nurse's note dated February 10, 2024, at 12:44 PM revealed that the resident continued to experience pain and discomfort when transferring and repositioning, yet while resting in bed no signs/symptoms of pain or discomfort. Continue to monitor and medicate with pain meds as needed. Nurse's note dated February 10, 2024, at 7:01 PM indicated that Resident 48 exhibited signs/symptoms of pain during transfers and repositioning, was medicated with Tylenol with good effect and was cooperative with care. Review of MAR revealed that the resident was medicated with Tylenol at 5:42 PM for evidence of pain rated at a 3 on the pain scale. Further review of the MAR revealed that staff administered the prn Tylenol 650 mg on February 10, 2024, at 3:35 PM, February 12, 2024, at 7:15 PM, February 14, 2024, at 6:14 PM, February 16, 2024, at 6:46 PM, on February 17, 2024, at 2:12 PM, February 21, 2024, at 7:30 PM, and on February 22, 2024, at 6:09 AM. Review of Pharmacy Review Note dated February 19, 2024, at 4:49 PM revealed that the physician was made aware of request for pain management, no change. There was no evidence that the physician responded to the pharmacist's identified concern related to the management of Resident 48's pain. Review of the clinical record revealed that there was no evidence that the facility staff performed a Pain Evaluation for effectiveness of current pain medication regimen when a change in condition and increased pain was identified on February 5, 2024. Review of clinical record revealed that on February 17, 2024, swelling of the resident's left leg was identified by the resident's family which was subsequently identified as a left ankle fracture on February 21, 2024. An interview the Director of Nursing (DON) on June 28, 2024, at approximately 2:00 PM confirmed the facility failed to implement an effective pain management program designed to promote the resident's comfort and meet the goals for effective pain relief consistent with current standards of practice. Refer F610, F713 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services. 28 Pa. Code 211.10 (c)(d) Resident care policies

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F 0713 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or arrange emergency care by a doctor 24 hours a day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460 Based on a review of clinical records and staff interview, it was determined that the facility failed to ensure the provision of consistent and timely physician services for one of 21 sampled residents (Resident 48). Findings include: A review of Resident 48's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included rheumatoid arthritis (a chronic autoimmune disease that causes inflammation and damage to the body's joints and other tissues), Alzheimer's disease, age-related osteoporosis (a bone disease that causes bones to become fragile due to a decrease in bone mass and density). A nurse's note dated February 17, 2024, at 2:07 PM indicated that the resident's family approached the nurse, concerned over swelling of the resident's left leg and requested results of the x-ray that was performed on February 5, 2024. According to the note, a call was placed to the physician, and message left. Nurse's note dated February 18, 2024, at 1 PM indicated that a follow-up call placed to physician's answering service regarding swelling on resident's left ankle. Voicemail left with answering service requesting call back. Nurse's note dated February 21, 2024, at 1:33 PM indicated that another follow-up call placed to physician regarding family concern over swelling noted on left ankle. Message left with answering service. Review of nurse's note dated February 21, 2024, at 3:47 PM, revealed that orders were received from the physician, four days after initial concern identified. The physician ordered an x-ray of the left ankle. On February 21, 2024, at 7:52 PM, documentation indicated that Resident 48 had fracture(s) of the left ankle and orders were obtained to apply an Ace wrap, to the left ankle, elevate, apply ice to the area, and for resident to see orthopedics on February 22, 2024. There was no evidence that the facility attempted to reach an on-call physician or contact the facility's medical director in the absence of a timely response to Resident 48's change in condition. Nursing noted that Resident 48 was transferred to the emergency roiagnom on [DATE], from the orthopedics office and was admitted . According to nurse's note dated February 25, 2024, at 10 AM, resident was readmitted to the facility after being hospitalized for a fractured leg, pain management, and exacerbation of cardiac condition. (continued on next page)

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F 0713 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Nursing (DON) on June 28, 2024, at approximately 12:10 PM, confirmed that approximately 4 days (February 17, 2024, to February 21, 2024), had passed before a physician responded to the facility's repeated calls regarding an acute change in Resident 48's condition. Interview with the Director of Nursing on June 28, 2024, at approximately 1:30 AM, acknowledged that the physician failed to respond timely. Refer F610, 697 28 Pa. Code 201.18 (e)(1)(3) Management 28 Pa. Code 211.2 (d)(3) Medical Director

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460 Based on a review of clinical records and select facility policies and interviews with staff and residents it was determined that the facility failed to provide sufficient nursing staff to provide timely and quality care to each resident including three residents out of 21 sampled (Resident 7, 21, 80). Findings included: A review of facility policy titled General Dose Preparation and Medication Administration, reviewed last by the facility on May 10, 2024, revealed that during medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to, the following: administer medications within timeframes specified by facility policy or manufacturer's information. A clinical record review revealed Resident 7 was admitted to the facility on [DATE], with diagnoses that include atrial fibrillation (a condition that causes the heart to beat irregularly and sometimes much faster than normal), cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body), and heart failure (a condition that develops when the heart doesn't pump enough blood to meet the body's needs). A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 23, 2024 revealed that Resident 7 is cognitively intact with a BIMS score of 14 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). The resident had a physician order for Metoprolol Succinate extended-release oral tablet 24 hour 50 mg (a beta blocker medication that relaxes the blood vessels and slows heart rate to improve blood flow and decrease blood pressure) by mouth two times a day related to hypertension (high blood pressure) initiated May 19, 2024; Tramadol HCL oral tablet 50 mg (an opioid medication that changes how the body feels and responds to pain) by mouth two times a day for pain management initiated on May 19, 2024; Eliquis oral tablet 5.0 mg (apixaban- an anticoagulant medication that helps to prevent the body from forming blood clots) by mouth two times a day related to atrial fibrillation dated May 19, 2024; and Cefdinir Oral Capsule 300 MG (an antibiotic medication) 300 mg by mouth two times a day for a urinary tract infection for 7 days initiated on June 20, 2024. A review of Resident 7's Medication Administration Record for June 2024 revealed that nursing staff failed to timely administer Metoprolol Succinate extended release oral tablet 24 hour 50 mg to Resident 7 on the following dates: June 1, 2024, at 9:15 AM (one hour and 15 minutes late) June 2, 2024, at 9:23 AM (one hour and 23 minutes late) (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	June 4, 2024, at 9:30 AM (one hour and 30 minutes late) June 4, 2024, at 9:51 PM (one hour and 51 minutes late) June 6, 2024, at 9:38 AM (one hour and 38 minutes late) June 7, 2024, at 9:12 AM (one hour and 12 minutes late) June 8, 2024, at 9:18 AM (one hour and 18 minutes late) June 9, 2024, at 9:35 AM (one hour and 35 minutes late) June 11, 2024, at 9:18 AM (one hour and 18 minutes late) June 14, 2024, at 9:10 AM (one hour and 10 minutes late) June 16, 2024, at 9:41 AM (one hour and 41 minutes late) June 17, 2024, at 9:25 AM (one hour and 25 minutes late) June 22, 2024, at 9:57 AM (one hour and 57 minutes late) June 23, 2024, at 9:46 AM (one hour and 46 minutes late) June 24, 2024, at 9:15 AM (one hour and 15 minutes late) June 25, 2024, at 9:30 AM (one hour and 30 minutes late) June 25, 2024, at 9:55 PM (one hour and 55 minutes late) June 26, 2024, at 9:38 AM (one hour and 38 minutes late) A review of Resident 7's Medication Administration Record for June 2024 revealed that nursing staff failed to timely administer Tramadol HCL oral tablet 50 mg on the following dates: June 1, 2024, at 9:16 AM (one hour and 16 minutes late) June 2, 2024, at 9:31 AM (one hour and 31 minutes late) June 4, 2024, at 9:30 AM (one hour and 30 minutes late) June 6, 2024, at 9:38 AM (one hour and 38 minutes late) June 7, 2024, at 9:11 AM (one hour and 11 minutes late) June 8, 2024, at 9:16 AM (one hour and 16 minutes late) June 9, 2024, at 9:33 AM (one hour and 33 minutes late) (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	June 11, 2024, at 9:18 AM (one hour and 18 minutes late) June 17, 2024, at 9:25 AM (one hour and 25 minutes late) June 23, 2024, at 9:47 AM (one hour and 47 minutes late) June 24, 2024, at 9:16 AM (one hour and 16 minutes late) June 25, 2024, at 9:30 AM (one hour and 30 minutes late) June 26, 2024, at 9:34 AM (one hour and 34 minutes late) A review of Resident 7's Medication Administration Record for June 2024 revealed that nursing staff failed to timely administer Eliquis oral tablet 5.0 mg on the following dates: June 2, 2024, at 9:23 AM (one hour and 23 minutes late) June 4, 2024, at 9:30 AM (one hour and 30 minutes late) June 6, 2024, at 9:38 AM (one hour and 38 minutes late) June 9, 2024, at 9:33 AM (one hour and 33 minutes late) June 17, 2024, at 9:21 AM (one hour and 21 minutes late) June 19, 2024, at 9:43 AM (one hour and 43 minutes late) June 22, 2024, at 9:58 AM (one hour and 58 minutes late) June 23, 2024, at 9:47 AM (one hour and 47 minutes late) June 25, 2024, at 9:29 AM (one hour and 29 minutes late) A review of Resident 7's Medication Administration Record for June 2024 revealed that nursing staff failed to timely administer Cefdinir Oral Capsule 300 mg on the following dates: June 21, 2024, at 6:07 PM (one hour and 7 minutes late) June 23, 2024, at 9:46 AM (one hour and 46 minutes late) June 24, 2024, at 9:15 AM (one hour and 15 minutes late) June 25, 2024, at 9:29 AM (one hour and 29 minutes late) June 25, 2024, at 8:29 PM (three hours and 29 minutes late) June 26, 2024, at 9:31 AM (one hour and 31 minutes late) (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a resident group interview on June 25, 2024, at 11:00 AM, Resident 7 stated that nursing staff does not administer her medication timely. She explained that the nursing staff is often late administering her medications, and it happens frequently. During an interview on June 27, 2024, at approximately 1:30 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that the facility failed to ensure that Resident 7 received medications timely as scheduled. A clinical record review revealed that Resident 80 was admitted to the facility on [DATE], with diagnoses that included a cerebral infarction (brain damage that results from a lack of blood). A review of a comprehensive admission MDS assessment dated [DATE] revealed that Resident 80 is cognitively intact with a BIMS score of 14 (a score of 13-15 indicates cognition is intact), dependent on staff for toileting hygiene (the ability to maintain perineal hygiene and adjust clothes before and after voiding having a bowel movement) and required substantial or maximal assistance from staff for lower body dressing, showering, bathing, and moving from a sitting position to a standing position or transferring to the toilet. A facility investigation, dated June 6, 2024, revealed Employee 15, NA, explained that the resident was soiled through her clothes and had dried bowel movement on her at 5:20 PM. Employee 15, NA, indicated that Resident 80 was upset because she asked to be changed after lunch, but no one changed her. A witness statement provided by Resident 80 dated June 6, 2024, revealed that on June 5, 2024, Resident 80 indicated she rang her call bell between 1:00 PM and 2:00 PM to be changed. Resident 80 explained that the nurse aide told her she would change her, then told her the next shift staff would provide her care and left without providing her care. A witness statement provided by Employee 11, Registered Nurse, dated June 6, 2024, revealed that she entered Resident 80's room {on June 5, 2024,} at 5:20 PM and saw urine dripping to the floor from the resident's lift pad. Employee 11, RN, explained that Resident 80 looked at her with tear-filled eyes and said they said they would be back, but they didn't come. During an interview on June 27, 2024, at 10:30 AM, Resident 80 stated that she sometimes waits over 30 minutes or more for care when she needs to be changed. The resident stated that she needs staff assistance because she is not able to care for herself. Resident 80 recalled that on June 5, 2024, nursing staff came into her room and told her that they couldn't change her because they were assisting others and were too busy to provide her care. She explained that nursing staff told her the next shift would have to take care of her. She stated that she waited in a soiled brief for hours that day. Resident 80 indicated that she is upset, frustrated, and cries when she needs to wait for care after soiling her brief. Resident 80 indicated that staff continue to check on her, turn her call bell light off, but leave her without providing care. A clinical record review revealed that Resident 21 was admitted to the facility on [DATE], with diagnoses that include cerebral infarction (brain damage that results from a lack of blood) and hemiplegia (paralysis on one side of the body). (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a quarterly MDS assessment dated [DATE] revealed that Resident 21 is cognitively intact with a BIMS score of 15 (a score of 13-15 indicates cognition is intact). A review of the MDS assessment Section GG Functional Abilities dated May 11, 2024 revealed that Resident 21 required substantial or maximal assistance for lower body dressing, showering, bathing, and moving from a sitting position to a standing position or transferring to the toilet. A facility investigation, dated May 23, 2024, revealed that Resident 21 reported that in the middle of the night last night {May 22, 2024}, she rang her call bell for assistance from nursing staff because she was wet. Resident 21 stated that staff came in and told her she wasn't wet and would be back later but did not return to provide her care for about two hours. A facility investigation, dated May 24, 2024, at 11:00 AM, revealed that Employee 16, NA, indicated that {on May 22, 2024} she did not check to see if the resident was wet because she was trying to get caught up on documentation that night. Employee 16, NA, stated that she went back to the resident's room [ROOM NUMBER] to 25 minutes later. During an interview on June 27, 2024, at 10:00 AM, Resident 21 stated that sometimes she waits a long time for care from nursing staff. She stated that she waits 20 minutes for nursing staff to provide her care and longer when the facility is short on staff. Resident 21 stated that a few weeks ago, there was an incident when she rang her call bell for staff assistance to be changed, but nursing staff told her she had to wait to be changed. Resident 21 stated that she felt disappointed because she was treated in that manner. During an interview on June 28, 2024, at approximately 10:30 AM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that the facility investigation identified that Resident 21 rang her call bell because she soiled her brief but was not provided care because Employee 16, NA, was completing documentation. A review of Resident 80's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included epilepsy (a brain disease where nerve cells don't signal properly, which causes seizures)and transient ischemic attack [(TIA) is a short period of symptoms similar to those of a stroke. It's caused by a brief blockage of blood flow to the brain]. Resident 80's clinical record revealed a nurse note dated June 7, 2024, at 7:27 a.m., indicating that the facility contacted the resident's (RP) and advised her that the resident's appointment with neurosurgery that was scheduled that day at 11:00 a.m. today had to be rescheduled because the facility did not have enough nursing staff to have a nurse aide available to accompany the resident to the appointment. The RP said that she didn't have anyone to go to the appointment either and called the neurosurgery department to reschedule the resident's appointment. During an interview with the Director of Nursing (DON) on June 28, 2024, at 11:00 a.m., confirmed that the facility didn't have enough nursing staff to accompany Resident 80 to her to her scheduled follow up appointment with neurosurgery and that the appointment had to be canceled and rescheduled delaying the resident's follow-up. 28 Pa. Code 211.12 (c)(d)(4)(5)(f.1)(2)(4) Nursing services (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.18 (b)(1)(3)(e)(1)(2)(3)(6) Management

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on a review of clinical records and select facility policy, and staff interview it was determined that the facility failed to provide sufficient staff, involved in the direct care of residents, who possess the appropriate skills and competencies to promptly identify and address an escalation in inappropriate sexual behaviors displayed by one resident (Resident 8) out of 21 sampled to maintain the safety and well-being of other residents. Findings included: A review of Resident 8's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included unspecified dementia and adjustment disorder (difficulty in managing stressful life changes such as coping with work-related problems, loss of loved ones, or relationship issues that leads to significant impairment in functioning) with mixed disturbance of emotions and conduct. The resident had severe cognitive impairment. A review of Resident 8's plan of care dated June 25, 2023, and revised on March 26, 2024, revealed that the resident had the potential to demonstrate verbally abusive and sexually inappropriate behaviors related to dementia and poor impulse control, with the noted goal that the resident would verbalize understanding of the need to control verbally abusive behavior. Planned interventions included every fifteen-minute checks related to behaviors, analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document, monitor and document observed behavior and attempted interventions in behavior log, and intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later. Social Service progress notes dated October 16, 2023, at 5:13 p.m., indicated that it was called to the social worker's attention that Resident 8 may become a little too handsy with some female residents and likes to hold and sometimes kiss female residents hands and was known as a ladies' man. Employee 4, social services and the resident's daughter explained to him the best way possible. However, his BIMS (brief interview for mental status - a tool to assess cognitive status) score was 9 (moderate cognitive impairment) with his short-term memory impaired and res needs reminders. Also, the Activity Department was also made aware and will intentionally seat Resident 8 closer to men and all staff will continue to provide reminders. Employee 5, a licensed practical nurse (LPN), noted on January 7, 2024, at 12:09 p.m., that Resident 8 was observed multiple times this shift being sexually inappropriate with the female residents, rubbing their thighs up to their crotch. This was witnessed by this nurse {Employee 5} and by one of the CNAs. Resident 8 was placed in his room and told that he needs to be appropriate and to keep his hands to himself. This nurse {Employee 5} also called resident's daughter and explained the situation to her. Daughter seemed to be embarrassed and apologized. Daughter also stated that if it happened again, to give her a call and put him on the phone with her. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nurse progress note completed by Employee 6, RN Supervisor, dated January 7, 2024, at 12:31 p.m., revealed that related to inappropriate sexual behavior Resident 8 was redirected and placed on every 15-minute checks for behavioral observation. Resident made aware behaviors was inappropriate. Resident stated, I don't remember doing it. Daughter was in to visit and made aware of behavior and behavioral monitoring checks and was okay with same. Employee 7, RN/former DON, dated February 29, 2024, at 5:55 p.m., revealed that the resident's RP was made aware on February 28, 2024, that a female resident reported that on February 27, 2024, that Resident 8 approached her in the lobby and rubbed her leg over her clothes and stated oh you like this, and when she responded that she did not like this, he proceeded to grab her left breast over her clothes, female resident removed herself from the lobby. Resident's RP, daughter, very apologetic and has spoken with her father regarding these behaviors. RP reported that Resident 8 had no recollection of these behaviors when they happened, and he was remorseful and tearful when they discuss his actions. A review of Resident 48's care plan, initiated on May 17, 2022, and revised on November 24, 2023, identified that the resident had impaired/declined in cognitive function or impaired thought processes related to diagnosis of Alzheimer's dementia without behavioral disturbance diagnosis. A review of the resident's annual Minimum Data Set assessment dated [DATE], indicated that the resident had severe cognitive impairment with a BIMS of 3. An incident report, completed by Employee 1, a Registered Nurse (RN), dated June 6, 2024, at approximately 5:30 p.m., revealed that Employee 2, a nurse aide (NA), reported that while by nurses' station talking with the scheduler, she looked down the hall (300's hallway) and saw another resident {Resident 8} close to Resident 48. Employee 2 went to Resident 48 and observed that her right breast was exposed and a male resident {Resident 8} had his hand on the resident's bare breast. Residents were separated immediately and taken to their rooms. Resident 48 was assessed by this writer {Employee 1} and no signs or symptoms of distress and offered no complaints and was acting per usual, pleasantly confused. Vital signs were obtained, and skin check completed with no abnormalities or injuries noted. Voice message left for Resident 48's attending physician and responsible party (RP), son, were informed of incident. A review of a witness statement written by Employee 2, no date or time noted, described that at approximately 3:30 p.m., I was at the nurses' station talking to [scheduler] about staying tonight. I happened to look down the hall and saw Resident 8 feeling Resident 48's right exposed breast. I ran down the hall, separated them and I put her {Resident 48} in her room and Resident 8 in his room. Further review of the incident report indicated that Resident 8's attending physician and RP were notified of the incident and the facility immediately initiated one-to-one direct observation of Resident 8. A review of a physician's order dated June 6, 2024, at 8:28 p.m., revealed an order for one-to-one direct observation by staff at all times. There was no documented evidence that the facility consistently provided sufficient supervision of Resident 8 and monitored the resident every fifteen-minute checks as care planned as of March 26, 2024, to ensure the safety of other residents due to Resident 8's sexual behaviors towards female residents. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 8's clinical record revealed a nurses' progress note Health Status Note completed by Employee 3, a licensed practical nurse (LPN), dated June 6, 2024, at 10:26 p.m., revealed this writer last saw resident at approximately 5:00 p.m., seated in his wheelchair by nurses' station sleeping intermittently. One-to-one supervision and one-to-one supervision followed post incident and continued with no further incident this shift. An interview with the Director of Nursing (DON) on June 26, 2024, at 2:05 p.m., revealed that that Resident 8 was known to have sexually inappropriate encounters/behaviors with female residents as noted in his clinical record by staff. The DON confirmed that the facility could not provide documented evidence that every fifteen-minute checks were conducted to provide supervision of Resident 8 with known sexually inappropriate behaviors to prevent him from further sexually abusing other female residents. During an interview with the facility's RN/Staff Development on June 28, 2024, at 10:30 p.m., revealed that she educates all facility staff on abuse by means of an electronic educational platform and developed materials. However, the facility's actual abuse prohibition policy and procedures was not included in that online training. At the time of the survey ending June 28, 2024, the facility failed to provide evidence that they had identified the skills and competencies their staff required to work effectively with Resident 8 to manage his adjustment disorder, inappropriate sexual behaviors and meet his behavioral health needs. The facility failed to demonstrate the use of a competency-based approach to determine the knowledge and skills required among staff to ensure Resident 8 was able to maintain or attain their highest practicable psychosocial well-being and meet current safety needs of the female residents residing in the facility. The facility failed to demonstrate consistent monitoring of the effectiveness of the interventions planned to manage Resident 8's behaviors, including timely changing those approaches, if needed, in accordance with current standards of practice, and show evidence of ongoing assessment as to whether those care planned approaches were improving or stabilizing the resident's psychosocial status and de-escalating the resident's behaviors. Refer F600 28 Pa. Code 201.19 (6)(7) Personnel records 28 Pa. Code 201.18 (e)(2)(3) Management

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records and resident and staff interviews, it was determined that the facility failed to timely provide dental services required by one Medicaid Payor source resident out of the 21 sampled residents (Resident 7). Findings include: A clinical record review revealed Resident 7 was admitted to the facility on [DATE], with diagnoses that include atrial fibrillation (a condition that causes the heart to beat irregularly and sometimes much faster than normal), cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body), and heart failure (a condition that develops when the heart doesn't pump enough blood to meet the body's needs). A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 23, 2024 revealed that Resident 7 is cognitively intact with a BIMS score of 14 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). A review of Resident 7's care plan, initiated July 29, 2021, revealed she exhibits or is at risk for oral health or dental care problems with planned interventions to obtain dental consults as ordered. A progress note dated May 8, 2023, indicated that Resident 7 was out of the facility to see a dentist and a follow-up appointment was scheduled for November 9, 2023, for the extraction of tooth #28. A progress note dated November 14, 2023, at 11:39 AM indicated that the facility contacted the dentist to reschedule the resident's dentist appointment, a message was left, and that staff would call with a new appointment time and date. A progress note dated November 15, 2023, at 2:26 PM indicated that a new appointment was scheduled for Resident 7 on March 6, 2024, at 9:00 AM. A progress note dated March 3, 2024, at 1:19 PM indicated that the dentist was called and notified that Resident 7's appointment needed to be canceled, and an appointment would be rescheduled upon Resident 7's return to the facility. Continued review of the resident's clinical record conducted during the survey ending June 28, 2024, revealed no further documentation regarding the resident's dental appointment and if the resident received the necessary dental services following the appointment on May 8, 2023, during which toot extraction was planned. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on June 25, 2024, at approximately 9:30 AM, Resident 7 stated that she had an appointment to remove one of her teeth, but it was cancelled over a month ago. She explained that she has been waiting for a new appointment but has not heard anything recently. She explained that the facility schedules her appointments and provides transportation. In response to surveyor inquiry during the survey, the facility entered a progress note in Resident 7's clinical record dated June 27, 2024, at 1:20 PM noting that Resident 7 was not on the schedule for dental services. During an interview on June 27, 2024, at approximately 1:30 PM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) failed to provide evidence that the facility scheduled the required dental services for Resident 7. 28 Pa. Code 211.12 (d)(3)(5) Nursing services 28 Pa. Code 211.15 Dental services

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on observations, a review of facility's planned meal tickets, a review of clinical records, and resident and staff interviews, it was determined that the facility failed to accommodate resident's food allergies and provide weight loss interventions for one resident, Resident 53, out of 21 residents reviewed. Findings include: A review of a facility policy entitled Supplements that was last reviewed on May 10, 2024, revealed that if maintenance of acceptable nutritional status is difficult through delivery/intake of regular meals, the facility will consider and provide the resident with additional nourishment through between-meal or dietary supplements. A nutritional assessment will be completed to determine the need and appropriateness of dietary supplement use and a physicians' order for a dietary supplement will be obtained and maintained in the medical record. Dining services will provide supplements as ordered and nursing will document the acceptance of supplements in the electronic ADL (activities of daily living) flow records. A review of Resident 53's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included subarachnoid hemorrhage (is a type of bleeding stroke that happens between your brain and the membrane that surrounds it), cerebral aneurysm (bulging or ballooning of the artery due to weakness in the wall of the vessel that supplies blood to the brain), and seizure disorder. The resident had severe cognitive impairment. Additionally, the resident's profile indicated an allergy to lactose. A review of the resident's person-centered plan of care initiated on March 14, 2023, identified that Resident 53 was nutritionally at risk due to gradual weight loss, required a mechanically altered diet, and variable intakes with noted goals to prevent weight loss and for the resident to consume 50 - 75% of meals. Planned nutrition weight management interventions included to honor food preferences within meal plan, monitor intakes at all meals, and offer alternate choices as needed, alert dietitian and physician to any decline in intakes. A review of a nutrition evaluation completed by the facility's Registered Dietitian on May 15, 2024, at 2:50 p. m., revealed that the resident was readmitted from the hospital on May 11, 2024, due to facial drooping, rule out stroke. Working with SLP (speech therapy) for swallowing, diet currently regular with dental soft textures and thin liquids per SLP. Consuming 75-100% of meals with supervision and assistance. Fluid intakes approximately 260-480 milliliters (ml) per meal. No ordered nutritional supplements. Skin is without pressure related breakdown. Current weight: 141.8-lbs., obtained 5/11 and weight history 1 month ago 4/10/24 - 143. 7-lbs., 3 months ago 2/16/24 - 147.4-lbs., 6 months ago 11/21/23 - 148.2-lbs. Weight does not trigger for a significant change however notably down 6.4-lbs. over 6 months. Gradual decline noted and was previously on Magic Cup (high calorie/high protein supplement) with meals and will request to reorder same to encourage good oral fluids. Will monitor weekly weight trend. Med review completed with no diuretic therapy noted. Will continue to follow weights, skin, and oral intakes. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of physician's orders dated May 15, 2024, at 5:00 p.m., revealed an order for Magic Cup supplement with breakfast, lunch, and dinner. During a meal observation on June 25, 2024, at 12:48 p.m., revealed that Resident 53's meal ticket noted that the resident had an allergy to lactose and indicated that the resident was to receive a Magic Cup. Subsequently, the resident's tray had vanilla pudding present on the tray and the resident has an allergy to lactose and the tray failed to include the physician ordered supplement, Magic Cup, used to enhance nutrition support due to gradual weight declines and variable intakes. An interview with the Director of Nursing on June 25, 2024, at 1:00 p.m., confirmed that the facility failed to adhere to a resident's food allergy and failed to provide a planned nutrition intervention and physician ordered supplement on Resident 53's lunch tray.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 43944 Based on a review of the facility's assessment, select facility policies and procedures, and resident clinical records, staff and resident interviews, the facility failed to document a facility-wide assessment to identify the resources needed to meet the residents, including sufficient staff with the necessary skills and competencies to provide the needed care and services for residents with behavioral health care and dementia care needs. Findings include: The facility assessment, dated Quarter 1 2024, and reviewed during the survey ending June 28, 2024, revealed the facility's census and acuity and general information regarding the facility's religious denominations, recreation, social services and physical, occupational and speech therapy services. The facility assessment did not include evidence of an evaluation of diseases, conditions, physical, functional or cognitive status, of the residents that may affect and plan for the services the facility must provide for residents with behavioral health care and dementia care needs. The facility assessment failed to include the resources needed, including sufficient nurse staffing, and provision of necessary education and training, and competency evaluation for staff providing direct care and assessment of residents with behavioral symptoms to maintain the safety of residents residing in the facility. Interview on June 28, 2024, at 11:00 p.m. the Nursing Home Administrator (NHA) confirmed that the facility assessment did not address staffing requirements, training and competencies. The NHA confirmed that the facility's population included multiple residents requiring increased supervision, including one to one supervision, to meet the needs of residents diagnosed with dementia and exhibiting behaviors. The NHA confirmed that facility staff would benefit from enhanced dementia care, behavioral health and abuse training to better meet the needs of the resident population. Refer F600, F609, F610, F725, F741 28 Pa. Code 201.18 (b)(1)(3)(e)(1)(2) Management

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 43944 Based on review of facility QAPI meeting attendance records and staff interviews, it was determined the facility failed to ensure that the required committee members met at least quarterly for one quarter out of three reviewed. Findings include: An interview was conducted with the Nursing Home Administrator (NHA) on June 28, 2024, at approximately 12:30 p.m., revealed that facility's QA/QAPI committee members included the Administrator (NHA), Director of Nursing (DON), Medical Director, and department heads. The NHA reported that the committee should meet at least quarterly. Review of the facility's QA/QAPI committee attendance sheets for the QA meetings held since the last annual survey ending July 23, 2023, through annual survey ending June 28, 2024, revealed that the QA/QAPI committee only held one quarterly meeting that was conducted on April 30, 2024. Interview with the NHA, at approximately 12:33 p.m., reported that she was unable to locate the QA/QAPI signature sheets to show documented evidence that the facility's QA/QAPI committee met at least quarterly. 28 Pa. Code 201.18 (e)(2)(3)(4) Management.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460 Based on observation and review of select facility policy and staff interview, it was determined that the facility failed to maintain infection control practices during administration of resident medication by one nurse out of two observed administering medications (Employee 10). Findings include: Review of facility policy entitled General Dose Preparation and Medication Administration, last reviewed by the facility on May 10, 2024, indicated that appropriate hand hygiene should be performed before and after direct resident contact. Medications should not come in contact with any surface except for the medication cup. Facility staff should avoid touching the medication with bare hands when opening a bottle or unit dose package. During an observation of medication administration on June 28, 2024, at approximately 8:15 AM., with Employee 10, licensed practical nurse, Employee 10 was observed preparing medications for administration to a resident. Employee 10 was observed handling each medication, nine in total, with her bare hands prior to placing in the plastic medication cup. Employee 10 was not observed to perform hand hygiene prior to handling the medications. During verification of medications for accuracy with the surveyor, Employee 10 poured all the medications from the plastic medication cup into her bare hand, counted them, and placed them back into the plastic medication cup. One of the nine medications was very small, so Employee 10 picked it up from her bare hand with her long acrylic fingernails and placed into the cup. Employee 10 then administered the medications to the resident. The employee did not perform hand hygiene, prior to handling or administering the medications. Observation of the medication cart used by Employee 10, during this med pass revealed a [NAME] cup and personal cell phone on top of the medication cart. The observations were confirmed by the Director of Nursing on June 28, 2024, at 8:25 AM. Interview with the Director of Nursing on June 28, 2024, at 8:45 AM confirmed that Employee 10 failed to adhere to infection control practices during medication administration to prevent the potential spread of infection. 28 Pa. Code: 211.12 (c)(d)(1)(5) Nursing Services 28 Pa. Code 211.10 (a)(d) Resident care policies

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on a review of clinical records, facility policy, and the facility's infection assessment tool, and staff interview it was determined that the facility failed to consistently implement its antibiotic stewardship protocols for initiating antibiotic use for two residents out of 21 sampled. (Resident 2 and Resident 188) Findings included: Review of a facility policy entitled Antibiotic Stewardship last reviewed May 10. 2024, indicated it was the policy of the facility to provide optimal use of antibiotics based on clinical guidelines and avoided unnecessary adverse events related to the use of medications. Goals of the program were to provide a clearly defined empiric therapy for treatment of suspected infections when appropriate, promote safe and effective use of antibiotics that will adequately treat the patient for susceptible bacterial infections, and to change broad spectrum antibiotics to promote narrowed therapy to minimize bacterial resistance in the facility and community. The facility will utilize an empiric treatment protocols in residents who present with signs and symptoms of an infection. Cultures are ordered when indicated and microbiology reports are received by the unit, the pharmacy and the infection control office directly from the contracted laboratory. These are monitored for appropriate antibiotic selection. Minimum criteria for initiation of antibiotics based on the McGeer criteria. Review of McGeer Criteria for urinary tract infection ([UTI] an infection of the urinary system), surveillance indicates that UTI without indwelling catheter must fulfill both one and two under criteria which is listed as the following: One: at least one of the following sign or symptoms; acute dysuria (painful urination) or pain, swelling, or tenderness of testes, epididymis, or prostate. Fever or leukocytosis, and one or more of the following: acute costovertebral angle pain or tenderness, suprapubic pain, gross hematuria (blood in urine), new or marked increased incontinence (involuntary urination), urgency, or frequency. If no fever or leukocytosis, then two or more of the following: suprapubic pain, gross hematuria, new or marked increase in incontinence, urgency, or frequency. Two: at least one of the following microbiologic criteria; greater than or equal to 10^5 CFU (colony-forming-unit the estimated number of microbial cells)/milliliter (ml) of no more than two species of organisms in a voided urine sample or 10^2 CFU/ml of any organism(s) in a specimen collected by an in-and-out catheter. Urine specimens for culture should be processed as soon as possible preferably within one to two hours, if the specimen is not processed within 30 minutes of collection they should be refrigerated and used for culture within 24 hours. A review of Resident 2's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included urinary retention (inability for the bladder to completely drain when urinating) and neurogenic bladder (is when a person lacks bladder control due to brain, spinal cord or nerve problems) with need for Foley catheter [is a device that drains urine from your urinary bladder into a collection bag outside of your body when you can't pee on your own or for various medical reasons]. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employee 8, a RN, noted on June 3, 2024, at 10:38 a.m., that the resident displayed increased behaviors. The CRNP (certified registered nurse practitioner) was onsite and noted a new order for a urinalysis and culture & sensitivity lab studies [(C&S) is a lab test to check for bacteria or other germs in a urine sample and allows practitioners to select a susceptible antibiotic treatment to best treat the bacteria] Lab study results dated June 3, 2024, at 12:36 p.m., revealed that the complete blood count was within normal limits. The urine culture results dated June 7, 2024, at 2:42 p.m., revealed E. coli (the E. coli bacteria from the intestines is present in fecal matter and trace amounts of fecal matter make their way into the urinary tract through the urethra opening and begin to multiply) > 100,000 colonies/ml present in her urine and > 10,000 colonies/ml mixed normal flora. A facility communication tool, eINTERACT Change in Condition Evaluation - V4.2 documentation dated June 8, 2024, at 3:52 a.m., revealed that resident had a suspected infection of UTI, the date the symptoms were identified were June 7, 2024. The most recent vital signs documented included: blood pressure 138/74 on June 8, 2024, at 2:08 a.m., temperature 97.7 degrees on June 8, 2024, at 3:34 a.m., pulse 68 on June 8, 2024, at 3:39 a.m., respiration 18 on June 8, 2024, at 3:40 a.m., oxygen saturation 96 % on room air on June 8, 2024, at 3:41 a.m. Other relevant information noted was resident has indwelling catheter and history of recurrent UTIs. Protocol criteria not met resident does not need an immediate prescription for an antibiotic but may need additional observation. New orders received from the provider for urinalysis ([UA] is an analysis that includes various tests to examine the urine contents for any abnormalities that indicate a disease condition or infection), culture and sensitivity ([C & S] identifies the organisms create infections and illnesses. Sensitivity tests to identify the most effective medications to treat the illnesses or infections). However, Employee 8 noted on June 7, 2024, at 1:18 p.m., that the resident was positive for UTI and that the attending physician ordered the antibiotic drug Macrobid 100 mg on orally twice per day for ten days, despite not meeting the McGeer Criteria. An interview with the infection preventionist (IP) on June 28, 2024, at 10:05 a.m., revealed that Resident 2 did not meet McGeer's criteria for the attending to prescribe antibiotic therapy, Macrobid. Additionally, the IP confirmed that the facility failed to provide documented evidence that the facility's chosen McGeer Assessment Tool for a Urinary Tract Infection was used to ensure the administration of Macrobid was clinically indicated and the clinical necessity of initiating the antibiotic prior to and based on the urinalysis C&S results. A review of Resident 188's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included urinary tract infection, muscle weakness, and difficulty walking. Resident 188 was transferred to the hospital on February 18, 2024, at 10:01 a.m., for an evaluation due to positive urine culture and sensitivity results for Klebsiella present in the culture results and not too many antibiotic choices and many allergies.[is a Gram-negative bacterium that commonly causes urinary tract infections (UTIs) and is a part of the normal flora in the intestinal tract, but when it enters the urinary system, it can lead to various complications] and ESBL [(Extended Spectrum Beta-Lactamase) is a type of enzyme that is produced by certain bacteria, making them resistant to certain antibiotics. When ESBL is found in urine, it can cause urinary tract infections (UTIs) that are difficult to treat] (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 188 returned from the hospital later that evening, with diagnosis of UTI. Antibiotics were started in the emergency room (ER) due to positive urine culture, which was sensitive to Macrobid (is an antibiotic that fights bacteria in the body and used to treat urinary tract infections). However, Resident 188's clinical record failed to reveal that Macrobid was administered at the facility upon the resident's return as noted in the ER discharge instructions. A nurse's progress note completed by Employee 1, a Registered Nurse, dated February 20, at 9:21 p.m., revealed that Cefdinir (antibiotic that is used to treat many different types of infections caused by bacteria) 300 mg every 12-hours was initiated for UTI. A review of Resident 188's Medication Administration Record [(MAR, or eMAR for electronic versions), dated February 2024, revealed that the resident received four doses of Cefdinir ATB. On February 21, 2024, at 3:47 p.m., the attending physician was notified that the resident did not void during that shift and ordered to stop Cefdinir for UTI, and that he would be in tomorrow to see resident. A review of nurse progress notes dated February 22, 2024, at 6:59 a.m., revealed that the resident voided a moderate amount of dark amber urine time one this AM with no complaints of urinary discomfort. Employee 8, a RN, noted on February 22, 2024, at 1:52 p.m., that the resident's attending physician was in and assessed the resident and reviewed results of labs and U/A C & S results. Resident asymptomatic (producing or showing no symptoms) and afebrile (without fever). Physician ordered IV (intravenous) Zosyn [is used to treat many different infections caused by bacteria, such as stomach infections, skin infections, pneumonia, and severe uterine infections] for five days. Resident 188's MAR for dated February 2024, revealed that the resident received only one dose of Zosyn and refused administration of other prescribed doses. Employee 8 noted that the attending physician was notified at that time and updated on the resident's status. Resident remained asymptomatic and afebrile 97.1 A new order was noted to discontinue Zosyn. The resident's urinalysis was within normal limits. Resident was comfortable, no signs or symptoms of distress. The results of the the culture and sensitivity results dated March 3, 2024, at 9:22 a.m., revealed that less than 10,000 colonies/ml normal flora and greater than 100,000 colonies/ml Enterococcus species were present in urine and resistive to ampicillin. A new order was noted to start Macrobid 100 mg orally twice daily for seven days. Interview with the facility's Infection Preventionist (IP) on June 28, 2024, at 10:10 a.m., revealed that Resident 188's received doses of unnecessary antibiotic due to the resident's attending physician not adhering to McGeer's criteria for infection surveillance and prescribing practices and that staff failed to complete the necessary steps of ATB Stewardship to deter unnecessary antibiotic use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395717	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linwood Nursing and Rehabilitation Center	100 Florida Avenue Scranton, PA 18505

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no evidence that the facility consistently followed McGeer Criteria prior to initiating antibiotic therapy for Resident 2 and Resident 188 by failing to follow its Antibiotic Stewardship policy to improve antibiotic prescribing, administration, and management practices to reduce inappropriate use to ensure that residents receive the right antibiotic for the right indication, dose, and duration. 28 Pa. Code 211.10(a)(d) Resident care policies 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 43944 Based on staff interviews and a review of facility training and orientation records, it was determined that the facility failed to ensure that all employees received training on the facility's abuse prohibition policy and facility specific-procedures. Findings include: During an interview with the Nurse Educator on June 28, 2024, at 10:00 a.m., revealed that the facility utilizes an on-line education platform for staff to complete mandatory education and additional education topics were provided as needed on paper and offered a variety of educational methods present topics. The Nurse Educator provided the educational content on which staff received for their annual abuse prevention education program. The education failed to include the facility's specific procedures for identifying and reporting abuse, neglect, exploitation, or misappropriation of resident property or resident abuse prevention. During an interview on June 28, 2024, at 11:15 a.m., the Nursing Home Administrator (NHA) stated that prior to survey that it was identified that the mandatory annual abuse training and new hire abuse training failed to include the complete training on the facility's specific-abuse prohibition policy and procedures. 28 Pa. Code 201.20 (b) Staff development