STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395763	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fellowship Manor	3000 Fellowship Drive Whitehall, PA 18052

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on policy review, observation, clinical record review, and resident and staff interview, it was determined that the facility failed determine a resident's capability to self administer their medications for one of one sampled residents. (Resident 77) Findings include: Review of facility policy entitled, Self Administration of Medications and Bedside Storage, last reviewed June 2025, revealed that if a resident indicated a desire to self administer medications, a member of the interdisciplinary team was to conduct a skills assessment form with the resident to determine the resident's ability to self-administer medications. Once the form was completed, the assessment was to be kept in the resident's medical record. Once determined safe to self administer, the physician/provider was to be notified and self-administration status was to be reflected in the resident's EHR (electronic health record). Bedside storage was to be permitted if the medication was able to be kept out of reach of other residents, could be kept in the original container and the nurse was able to verify and document use. Clinical record review revealed that Resident 77 had a diagnosis of end-stage renal disease for which they received hemodialysis. Review of the Minimum Data Set (MDS) assessment, dated March 20, 2025, revealed that Resident 77's cognitive ability was intact. Observations on June 24, 2025, at 10:00 a.m., and on June 25, 2025, at 11:00 a.m., revealed that there were two bottles of Velphoro (a medication used to control phosphorus levels in the blood) unsecured on the bedside table and on top of the dresser in the Resident 77's room. Additionally, there was one bottle of lidocaine spray and two tubes of lidocaine gel (medications used for numbing the skin) observed unsecured on the bedside table and on top of the dresser in Resident 77's room during the observation periods. In an interview on June 24, 2025, at 10:00 a.m., Resident 77 stated that the Lidocaine was to be applied prior to leaving for dialysis. There was no documentation to indicate that the facility had assessed Resident 77 for the ability to self-administer the Velphoro or the Lidocaine gel. There was no security of the medications in her room. In an interview on June 26, 2025, at 8:45 a.m., the Director of Nursing confirmed that Resident 77 was not assessed to self-administer the medications as per the facility policy. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to ensure that residents were free from potential chemical restraints for one of five sampled residents who were ordered psychotropic medications. (Resident 78) Findings include: Clinical record review revealed that Resident 78 had diagnoses that included Alzheimer's disease, dementia and anxiety. Review of the Minimum Data Set assessment dated [DATE], revealed that the resident was cognitively impaired and had been administered an anti-anxiety medication. On June 12, 2025, a physician ordered for staff to administer an anti-anxiety medication, (Ativan), every five hours as needed for agitated behaviors. There was no date in the order that indicated when staff was to stop administering the as needed medication. Review of the Medication Administration Record for June 2025, revealed that staff had administered the Ativan on June 12, 13, 14, 15 and 22, 2025, for a total of five times. There was no documented evidence that the physician had re-evaluated continued use beyond 14 days of the as needed anti-anxiety medication. In an interview on June 25, 2025, at 3:00 p.m., the Assistant Director of Nursing stated that there had been no date added to the order that indicated when staff was to stop administering the anti-anxiety medication. 28 Pa. Code 211.12(d)(1)(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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and review of incident reports it was determined that the facility failed to ensure that staff provided adequate supervision in order to prevent falls for one of nine sampled residents who were at risk for falls. (Resident 78) Findings include: Clinical record review revealed that Resident 78 was admitted on [DATE], and had diagnoses that included Alzheimer's disease, dementia and anxiety. Review of a fall risk evaluation dated February 23, 2025, indicated that he was at a high risk for falls. The Minimum Data Set assessment dated [DATE], indicated that the resident had a memory problem. A review of the care plan revealed that the resident was at risk for falls due to poor safety awareness, impulsivity, a history of falling and confusion. Review of nursing documentation and incident reports revealed that Resident 78 fell nine times between February 23, 2025, through May 9, 2025. He fell five times out of bed and four times out of his wheelchair. Six of the falls were between the hours of 6:00 a.m. and 1:00 p.m., and three of the falls were between the hours of 7:00 p.m. and 12:00 a.m. Nursing documentation dated February 23, 2025, indicated that the resident was nearly falling out of his wheelchair and had been crawling out of bed. On February 26, 2025, March 3, and March 4, 2025, nursing staff documented that the resident was awake all night, confused, was trying to either get out of bed or out of his wheelchair, making frequent attempts to stand on his own, and was not following any kind of direction from staff. Review of an incident report dated March 7, 2025, at 7:15 p.m., revealed that the resident was found on the floor in his room next to his bed. The incident report further indicated that the resident tries to get up and can not on his own. Nursing documentation dated March 18, 2025, at 2:46 a.m., revealed that the resident was restless and making several attempts to get up from his chair. Review of an incident report dated March 18, 2025, at 9:20 a.m., revealed that staff found the resident lying on his back in front of his wheelchair in the hallway. The report further indicated that he was displaying increased restlessness around the time of the incident. Nursing documentation dated March 21, 2025, at 6:28 a.m., revealed that the resident had been awake, anxious and restless all night. He was also making several attempts to get up from his chair to stand unassisted. Review of an incident report dated March 21, 2025, at 1:00 p.m., revealed that the resident was found in the hallway lying on the floor in front of his wheelchair. Review of incident reports dated March 24, 2025, and March 29, 2025, revealed that the resident had two more falls out of his wheelchair. Review of an incident report dated April 6, 2025, revealed that the resident had fallen out of bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing documentation dated April 23, 2025, revealed that the resident had been sitting on the edge of his bed and attempting to stand up. He was transferred to a chair and continued to attempt to stand up unassisted. Review of an incident report dated April 29, 2025, at 6:33 a.m., revealed that the resident had fallen out of bed. Nursing documentation dated May 5, 2025, revealed that the resident was climbing out of bed. The note further indicated that the resident was not put back to bed as it is unsafe. Review of an incident report dated May 6, 2025, at 11:09 p.m., revealed that the resident had again fallen out of bed. Nursing documentation dated May 8, 2025, at 3:23 a.m., revealed that the resident had been confused and had multiple times attempted to stand up from his chair unassisted. Review of an incident report dated May 9, 2025, at 9:20 a.m., revealed that the resident had again fallen out of bed. There was no documented evidence that the facility had provided adequate supervision at the aforementioned times when the resident was frequently exhibiting behaviors specifically attempts to get out of his bed our wheelchair or to stand unassisted by staff in order to prevent falls. 28 Pa. Code 211.12(d)(1)(5) Nursing services.