STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395779	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centre Care Rehabilitation and Wellness Services	250 Persia Road Bellefonte, PA 16823

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20725 Based on clinical record review and staff interview, it was determined that the facility failed to ensure resident participation in formulating an advance directive for one of four residents reviewed for advance directive concerns (Resident 127). Findings include: Clinical record review for Resident 127 revealed a Medical Treatment Guidelines document (form the facility utilized to document a resident and/or resident's responsible party participation in decisions regarding actions taken in the event of a medical emergency) signed by Resident 127 on [DATE], that indicated she desired full resuscitation as part of her medical care decisions. A physician's order instructed staff to provide Full Code treatment (medical personal would do everything possible to save life in a medical emergency) for Resident 127 from [DATE], to [DATE]. A quarterly MDS assessment (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated [DATE], assessed Resident 127 as cognitively intact (BIMS, Brief Interview for Mental Status, score of 13 to 15, indicated no cognitive impairment). A Medical Treatment Guidelines document signed by two facility staff on [DATE], indicated that Resident 127's daughter gave verbal consent to withhold medical procedures to restart breathing or restart the heart (CPR would not be attempted) in the event Resident 127's heart stopped beating or she stopped breathing. A physician's order active since [DATE], instructed staff to not provide resuscitation (DNR). The surveyor requested any evidence that the facility ensured that Resident 127 participated in the decision to change her medical treatment in the event of a cardiac or respiratory emergency during an interview with the Nursing Home Administrator and the Director of Nursing on [DATE], at 1:45 PM. Interview with the Nursing Home Administrator and the Director of Nursing on [DATE], at 2:00 PM confirmed that the facility had no evidence that Resident 127 participated in the decision to change her advance directives before the surveyor's questioning. The facility admission coordinator discussed the change with Resident 127 on [DATE] (following the surveyor's questioning). (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 0578 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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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 20725 Based on clinical record review and staff interview, it was determined that the facility failed to ensure assessments accurately reflected a resident's status for one of 35 residents reviewed (Resident 143). Findings include: Clinical record review for Resident 143 revealed a Preadmission Screening and Resident Review (PASRR, a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that Medicaid-certified nursing facilities: evaluate all applicants for serious mental illness and/or intellectual disability, offer all applicants the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings), and provide all applicants the services they need in those settings) completed July 17, 2024, that indicated she had a positive screen, and that she required a Level II PASSAR. A Department of Human Services Office of Mental Health and Substance Abuse Services letter dated July 25, 2024, determined that Resident 143 was eligible for mental health services and that the facility must provide or arrange for the provision of those services. An admission MDS assessment (Minimum Data Set, an assessment tool completed at specific intervals) dated August 1, 2024, indicated that Resident 143 was not considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Interview with the Nursing Home Administrator and Director of Nursing on October 6, 2024, at 1:45 PM revealed that the coding on Resident 143's admission MDS assessment regarding her PASRR determination was incorrect. The facility completed a modification of Resident 143's admission MDS assessment on October 6, 2024, at 5:15 PM to reflect that Resident 143 was considered by the PASRR process have a mental health condition that made her eligible for additional services. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 44738 Based on clinical record review and staff interview, it was determined that the facility failed to implement a comprehensive person-centered care plan regarding a pacemaker for one of 35 residents reviewed (Resident 176). Findings Include: Clinical record review for Resident 176 revealed a medical history that included the presence of a cardiac pacemaker (surgically implanted device used to control the electrical activity of the heart and regulate the heartbeat). Review of a significant change Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated September 17, 2024, noted facility staff assessed Resident 176 as having a BIMS (Brief Interview for Mental Status) of 5, which indicated severe cognitive impairment. The MDS also noted the presence of a cardiac pacemaker. Review of documentation titled Electrophysiology Visit for Resident 176 dated August 19, 2024, revealed the resident had a biventricular pacemaker implanted on March 5, 2020. Review of Resident 176's clinical record on October 5, 2024, at 1:49 PM revealed no care plan was developed related to the resident's pacemaker or associated resident monitoring/assessment. The above information for Resident 176 was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on October 6, 2024, at 1:45 PM. 28 Pa. Code 211.10 (a)(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 19719 Based on observation, clinical record review, and resident and staff interview, it was determined that the facility failed to provide the highest practicable care regarding the use of medical devices for three of 35 residents reviewed (Residents 66, 155, and 167). Findings include: Observation on October 5, 2024, at 10:49 AM revealed Resident 155 was in her room with a sling to her left arm and shoulder immobilizing it. Review of Resident 155's clinical record revealed nursing documentation dated September 20, 2024, at 6:20 PM indicating that nursing staff found Resident 155 on the floor. The facility sent Resident 155 to the hospital on September 21, 2024, at 3:02 PM for continued complaints of left shoulder pain and a positive x-ray for shoulder fracture. Nursing documentation dated September 21, 2024, at 9:50 PM revealed that Resident 155 returned from the hospital with no new orders. Nursing documentation dated September 22, 2024, at 10:19 AM indicated that nursing staff sent a referral to therapy due to Resident 155 wearing a left arm sling. Review of Resident 155's hospital discharge summary dated September 21, 2024, indicated that Resident 155 sustained a closed left humeral fracture and should keep her left arm in a sling and swath for immobilization. There was no documented evidence in Resident 155's clinical record to indicate the use of a sling or swath for her fracture, or if she should have a therapy referral until September 27, 2024, after Resident 155 consulted with an orthopedic surgeon. The facility did not obtain any physician orders for the care and treatment of her left arm fracture until September 27, 2024, 6 days after Resident 155 returned from the emergency room . Interview with the Administrator and Director of Nursing on October 7, 2024, at 2:30 PM confirmed the above findings for Resident 155. Observation on October 5, 2024, at 11:09 AM revealed Resident 167 sitting at the nursing station with a black back brace wrapped around her midsection. Review of Resident 167's clinical record revealed nursing documentation dated June 7, 2024, that revealed the use of a back brace, but no indication why. Nursing documentation dated October 5, 2024, at 12:54 PM revealed that nursing staff found Resident 167 on the floor of another resident's room. The note continued to indicate that Resident 167 did not sustain any injuries but indicated that she did have her back brace on. There was no documented evidence in Resident 167's clinical record to indicate the use of a back brace. There was no physician's order, no plan of care regarding its use, and no therapy evaluation for proper use. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	After the surveyor brought up the concerns with the use of the back brace, nursing documentation dated October 7, 2024, at 4:56 PM indicated that Resident 167's family brought the back brace in for comfort, but that there was no physician's order. Nursing staff removed the back brace and will speak with family regarding the medical need for the back brace. Interview with the Director of Nursing on October 8, 2024, at 9:35 AM confirmed the above findings for Resident 167. Interview with Resident 66 on October 5, 2024, at 1:54 PM revealed that he brought a cardiac pacemaker (surgically implanted device used to control the electrical activity of the heart and regulate the heartbeat) check machine with him to the facility, and it was stored in his bedside cabinet. Resident 66 stated that he believed his pacemaker was last checked at an appointment in another town before his admission to the facility, and he typically has his pacemaker checked at least every two to three months. Clinical record review for Resident 66 revealed an Admission History and Physical dated August 20, 2024, that included the following diagnoses: ischemic cardiomyopathy (heart disease resulting in unhealthy heart muscle), atrial fibrillation (irregular heartbeat that increases risk for blood clots and stroke), on chronic anticoagulation (medication used to delay blood clotting), and a past surgical history that included an implanted pacemaker. The documentation indicated that Resident 66 noted that his pacemaker had a generator life of approximately seven months and would need replaced in the near future. The documentation indicated that he would need established with a local cardiologist as he did not wish to be transported back and forth to the other town any longer. The documentation indicated that the facility would establish services with the cardiologist to have Resident 66's pacemaker generator exchanged in 2024. Review of Resident 66's plans of care developed by the facility to address his care needs did not include the presence of an implanted cardiac pacemaker or an intervention of a pacemaker check machine. Observation of Resident 66's room on October 7, 2024, at 1:10 PM with Employee 2 (nurse aide) confirmed that Resident 66 had a Medtronic box in his bedside stand for his cardiac pacemaker checks. Interview with the Nursing Home Administrator and the Director of Nursing on October 7, 2024, at 2:13 PM confirmed that the facility did not contact Resident 66's cardiologist to determine the correct implementation of the cardiac pacemaker check machine. The facility was unaware when this type of machine was to be active and monitoring (e.g., continuous, or intermittent); or the mechanism that permitted the remote monitoring of Resident 66's pacemaker (e.g., cell phone, wi-fi internet, landline telephone, etc.). The interview confirmed that the facility did not incorporate Resident 66's cardiac pacemaker needs into Resident 66's plans of care. 483.25 Quality of Care Previously cited 2/22/24 28 Pa. Code 211.10 (a)(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 44738 Based on observation, clinical record review, and staff interview, it was determined that the facility failed to assess and implement physician ordered treatment to maintain range of motion for one of six residents reviewed with range of motion concerns (Resident 52). Findings include: Clinical record review for Resident 52 revealed a current physician's order dated August 10, 2023, that instructed staff to apply a right hand splint at all times except for care, remove daily for care. Clinical record review for Resident 52 revealed a current care plan that indicated the resident had an activities of daily living self care performance deficit related to the medical history and requires staff assistance for dressing, personal hygiene, bed mobility, and toilet use. An intervention included a right hand splint at all times except for care. A significant change Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated July 29, 2024, noted facility staff assessed Resident 52 as having a BIMS (Brief Interview for Mental Status) of 6, which indicated cognitive impairment. Clinical record review for Resident 52 revealed the following Orders Administration Note related to the splint: September 7, 2024, at 2:54 AM: not available September 8, 2024, at 1:33 AM: no splint available September 9, 2024, at 1:15 AM: Unable to locate. September 10, 2024, at 5:06 AM: Not on. September 11, 2024, at 1:50 AM: not available September 13, 2024, at 3:50 AM: not available September 17, 2024, at 12:45 AM: no splint September 18, 2024, at 4:12 AM and 11:58 PM: no splint September 21, 2024, at 2:15 AM: not available September 22, 2024, at 2:16 AM: none September 24, 2024, at 1:48 AM: No hand splint (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	September 25, 2024, at 12:50 AM: None present September 26, 2024, at 3:51 AM: no splint September 27, 2024, at 1:41 AM: none found October 1, 2024, at 2:53 AM: no splint on. October 2, 2024, at 2:45 AM: No splint October 4, 2024, at 1:16 AM: No splint available. October 5, 2024, at 1:52 AM: no splint found October 6, 2024, at 2:56 AM: no splint found October 8, 2024, at 2:11 AM: no splint available Observation of Resident 52 on October 6, 2024, at 10:21 AM and on October 8, 2024, at 9:41 AM revealed the resident was in bed. There was no observed splint on the right hand. An interview with Employee 6, licensed practical nurse, on October 8, 2024, at 9:41 AM revealed that Resident 52 sometimes removes the splint, and it should be somewhere in the room. Employee 6 proceeded to look in Resident 52's room for the splint but was unable to locate it. Employee 6 further reported that it may be in the laundry, which is located on the first floor. An interview with Employee 7, laundry staff, on October 8, 2024, at 9:50 AM revealed Resident 52's splint was not currently being laundered and further reported the last splint the employee remembers washing was approximately one week ago. The above information for Resident 52 was reviewed in a meeting with the Director of Nursing on October 8, 2024, at 1:45 PM. 483.25(c)(1)-(3) Increase/prevent Decrease In Rom/mobility Previously cited 9/29/23 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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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. 36798 Based on facility documents, clinical record review, and staff and resident interview, it was determined that the facility failed to implement appropriate interventions to prevent a fall for one of 11 residents reviewed for falls (Resident 33). Findings include: Clinical Record review for Resident 33 revealed a nursing progress note dated July 5, 2024, at 10:45 PM that indicated a nurse aide was changing Resident 33's brief and bed linen, when she rolled her away from her, and she rolled onto the floor on the right side of the bed. She was noted to have a 10-centimeter (cm) x 10 cm skin tear on her left elbow, an 8 cm x 8 cm skin tear on her right elbow, and a 3 cm x 3 cm closed hematoma (a collection of blood under the skin that can look like a bad bruise) above her left eyebrow. The note also indicated that the new intervention would be to utilize two staff when rolling the resident. Review of Resident 33's active care plan dated June 17, 2024, revealed that there was no current intervention to indicate the number of staff required to safely roll her in bed. Her fall care plan indicated that she was at risk for falls related to her dependence on staff for safe positioning due to her lack of adequate core strength and balance. Her activities of daily living care plan had an intervention indicating that for bed mobility she required staff participation to reposition and turn in bed. A review of Resident 33's state optional quarterly MDS (minimum data set, an assessment completed at periodic intervals of time to assess resident care needs) completed on June 3, 2024, revealed the highest assistance she required for bed mobility was extensive assist of two staff. An interview with Resident 33 in her room on October 6, 2024, at 11:30 AM related to the fall on July 5, 2024, revealed that there was one nurse aide in the room and the nurse aide rolled her towards the wall. She said she usually will place her foot on the wall to help hold her over but on that day her foot slipped because it was wet, and she rolled right to the floor. She indicated that she uses the wall because they tell her to. When asked who she is referring to as they, she indicated the aides. Concurrent observation of her bed on at this time revealed that it is about 12 inches from the wall. Review of the facility's investigation into Resident 33's fall on October 6, 2024, at 11:30 AM indicated that Resident 33 indicated that the nurse aide rolled her over and her foot slipped off the wall. Clinical record review revealed a fall risk evaluation completed on June 4, 2024, for Resident 33, indicating that she was a moderate risk for falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing on October 7, 2024, at 10:24 AM revealed that there was no clinical evidence to indicate the level of assistance Resident 33 required during the task of bed mobility, at the time of her fall. When the surveyor asked the Director of Nursing how the staff would know Resident 33's level of assistance required for bed mobility she indicated normally the care plan or task but Resident 33's does not indicate a level of assistance. She also confirmed that the Resident 33 should not be expected to utilize her foot on the wall as a fall prevention intervention. The facility failed to initiate appropriate interventions to prevent a fall out of bed for Resident 33. 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 19719 Based on clinical record review, and staff interview, it was determined that the facility failed to ensure that the resident's attending physician addressed pharmacy recommendations for two of five residents reviewed (Resident 84 and 195). Findings include: Review of Resident 195's clinical record revealed a form entitled Interdisciplinary Team Evaluation dated December 19, 2023, indicating that the team recommended Resident 195's physician consider a gradual dose reduction of Resident 195's Buspar (an antidepressant), Seroquel (a psychoactive medication used to treat mood disorders) and Trazodone (an antidepressant). Resident 195's physician responded to the recommendation indicating that patient still with outbursts and needs her ABH gel (a combination of medications used to treat anxiety), not able to decrease doses. Resident 195's physician refers to a medication that is not listed on the recommendation list and does not provide a clinical rationale as to why the listed medications cannot have a gradual dose reduction. An Interdisciplinary Team Evaluation dated June 24, 2024, indicated that the team recommended 195's physician again consider a gradual dose reduction of Resident 195's Buspar, Seroquel and Trazodone. The physician response to Resident 195's recommendation indicated that he has never met her and that a reduction would depend on symptoms, history and response to treatment, and side effects. The physician does not provide an order for a gradual dose reduction. Interview with the Director of Nursing on October 7, 2024, at 11:28 AM confirmed the above findings for Resident 195 and indicated that her June recommendation was sent to the wrong physician. The Director of Nursing indicated that the Interdisciplinary Team Evaluations recommending gradual dose reductions are completed in conjunction and with the guidance of the facility's pharmacist. Clinical record review for Resident 84 revealed an Interdisciplinary Team Evaluation dated April 24, 2024, that noted Resident 84 received the psychotropic medications Citalopram (antidepressant), Mirtazapine (an antidepressant), and Risperdal (an antipsychotic used to treat mental and mood disorders). An initial at the bottom of the document, dated May 1, 2024, indicated that a physician agreed with the interdisciplinary team's decision to not gradually reduce the dosages of the medications. An Interdisciplinary Team Evaluation dated July 30, 2024, again noted that Resident 84 received the psychotropic medications Citalopram, Mirtazapine, and Risperdal. An initial at the bottom of the document, dated July 31, 2024, again indicated that a physician agreed with the interdisciplinary team's decision to not gradually reduce the dosages of the medications. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing on October 8, 2024, at 11:35 AM, confirmed that the physician consulted by the facility to address Resident 84's mental health and behavioral needs, not Resident 84's attending physician, responded to the interdisciplinary team evaluations dated April 24, 2024, and July 30, 2024. The interview confirmed that the facility had no evidence that Resident 84's attending physician received a consultant pharmacist report regarding potential irregularities of, or requests to gradually reduce, Resident 84's psychotropic medications. Resident 84's medical record did not include evidence that her attending physician documented his or her evaluation of Resident 84's psychotropic medication or his or her rationale for not attempting a gradual dose reduction of the medications. 28 Pa. Code 211.9 (k) Pharmacy services 28 Pa. Code 211.12(d)(3)(5) Nursing services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44738 Based on observation and staff interview, it was determined that the facility failed to store food items and maintain equipment in a safe and sanitary manner in the facility's main kitchen. Findings included: Initial tour of the facility's main kitchen on [DATE], between 9:35 AM and 10:40 AM revealed the following: The walk-in freezer had multiple discarded items on the floor including under the storage shelves. These discarded items included the following: pieces of food (including broccoli and a piece of carrot), various paper products, and a balled-up hair net. Further observation of the walk-in freezer revealed four packages containing gluten free rolls with an expired use by date of ,d+[DATE]. One of the packages was open to air exposing the rolls to the ambient air. A prep area in front of the freezer contained a drawer with various cooking utensils. There was a significant amount of debris in the bottom of the drawer. An overlying stainless steel shelf contained dust and debris and various stains/splashes on the underside of the shelf. A commercial mixer had various dried stains on the mixing bowl seat and the base of the mixer. Two warmer units had dust and debris on the top of the units. A large appliance Employee 1, cook, identified as a soup kettle, was covered with a plastic covering. A brown garbage lid was found placed on top of the machine. The plastic covering had a significant amount of dried splash stains on it. There was a build-up of debris including black colored chunks of an unidentified substance on top of the oven. A smaller can cart located near the center of the kitchen revealed at least four cans with extensive staining on the labels from splashes. A prep area across from the oven revealed a container of fresh peeled garlic that was partially used. There was no open date on it and there were several dried splash stains on the exterior of the container. Additional observations revealed a container labeled salt and pepper that was partially used. The container had no dates to indicate when it was open or when it expires or should be discarded. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395779	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2024
NAME OF PROVIDER OR SUPPLIER: Centre Care Rehabilitation and Wellness Services		STREET ADDRESS, CITY, STATE, ZIP CODE: 250 Persia Road Bellefonte, PA 16823	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A stainless steel prep table next to the water fire extinguisher contained a significant amount of debris on the floor under the table that included a large onion. The bottom shelf of the table had several pans and cutting boards, and there was a build-up of debris on the shelf. A small muffin baking pan was stored upright with no protection from debris and the pan molds contained debris and a partial piece of onion skin. The spice shelf contained the following: Ground white pepper with a manufacturer's best by date of [DATE]. A container of rubbed sage with a manufacturer's best by date of [DATE]. All-purpose barbecue blend with a manufacturer's best by date of [DATE]. A large baking pan contained a dark brown cake type food item that was located on the bottom of a tray rack. The item was not labeled or dated, and the baking pan was not hot or warm to the touch (which would indicate it was recently removed from the oven). A walk-in cooler contained the following: A large plastic container of individually packaged commercially made peanut butter and grape jelly sandwiches. A large plastic container of individually packaged commercially made peanut butter and strawberry jam sandwiches. The package for the above sandwiches indicated to Thaw ,d+[DATE] minutes and eat within ,d+[DATE] hours. The packages were labeled with a PULL date of either ,d+[DATE] or ,d+[DATE]. The website for the product instructs to keep the sandwiches frozen until ready to thaw, thaw for ,d+[DATE] minutes at room temperature and eat within ,d+[DATE] hours. The product can be refrigerated for up to 24 hours. A plastic container with a green lid marked garlic only that was partially used had no dates on it to indicate when it was open or should be discarded. A plastic container with a green lid with an unidentified food item had no label or dates on it. A plastic container with a red lid that had water pooling on the lid was marked BBQ sauce ,d+[DATE]. A roll of Hot Spicy Ham and Water was on a shelf and dripping the liquid contents onto a cardboard box directly below it that contained pork tenderloin. A large plastic container that held multiple bags of garden salad. Three bags had a manufacturer's best by date of [DATE], and two additional packages (one of them open to ambient air) had a best by date of [DATE]. The dishwashing area contained the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The dishwasher had various dried stains on the exterior bottom panel of the machine. The end of the stainless steel shelf where the clean dishes were expelled from the dishwasher had a build-up of an orange, crusted substance stuck to the shelf. The wall at the end of the stainless steel shelf where the clean dishes were expelled had extensive brownish colored splash stains. There was a build-up of debris under the dishwasher. A large, gray colored, garbage receptacle with a lid had dried stains on the exterior of it and a build-up of debris in the handles on each side of it. Further observation of the dishwashing area revealed multiple pans of food from breakfast to be washed. Multiple winged insects were observed in the area. Additional winged insects were observed on the clock, two on the ceiling above the dishwashing area, multiple insects were observed to be on a piece of tubing under the stainless steel counter where the dishes entered the dishwasher. A winged insect was further observed around the main egress door to the kitchen, two winged insects were observed on the ceiling in the main kitchen outside of the dishwashing area. There were also 12 ants on the wall at the entry to the dishwasher and behind the dishwasher. The dishwasher contained two gauges to indicate the wash and rinse temperatures. The gauge labeled rinse had an extensive build-up of moisture on the inside of the gauge. Several observations of Employee 1 utilizing the dishwasher on [DATE], at 10:20 AM revealed the following temperatures during use: 158 degrees Fahrenheit wash / 132 degrees Fahrenheit rinse; 162 degrees Fahrenheit wash / 138 degrees Fahrenheit rinse; 170 degrees Fahrenheit wash / 138 degrees Fahrenheit rinse. Upon questioning Employee 1 about the accuracy of the gauges and if the temperature were recorded the employee responded, The supervisor usually does that. An interview on [DATE], at 11:00 AM with Employee 4, Director of Dining, and Employee 5, maintenance staff, revealed the dishwasher was a hot water sanitizing dishwasher and reported they are aware the machine is under temperature and contacted the repair company. The above information regarding the kitchen was reviewed with the Nursing Home Administrator on [DATE], at 1:35 PM. 28 Pa. Code 201.14(a) Responsibility of licensee

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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. 20725 Based on clinical record review, observation, and staff interview, it was determined that the facility failed to implement enhanced barrier precautions for one of six residents reviewed for infection prevention and control concerns (Resident 87). Findings include: Review of the Centers for Medicare and Medicaid Services (CMS) memo entitled, Enhanced Barrier Precautions in Nursing Homes, dated March 20, 2024, revealed that nursing care facilities are to use enhanced barrier precautions (EBP, gown and glove use) for residents with chronic wounds or indwelling medical devices (i.e., indwelling urinary catheters) during high-contact resident care activities regardless of their multidrug-resistant organism status. High-contact activity would include things like dressing, transferring, changing linens, providing hygiene, changing briefs, wound care, or device care. Clinical record review for Resident 87 revealed a plan of care initiated by the facility on June 7, 2024, to address Resident 87's need for Enhanced Barrier Precautions (for an indwelling medical device and a chronic wound) that listed interventions that included don gown and gloves prior to high-contact resident care activities and doff prior to exiting. EBP are in place due to a history of a multi-drug resistant organism (infection-causing bacteria that is resistant to commonly prescribed antibiotics), wounds, and a Foley catheter (indwelling urinary catheter, flexible tube inserted through the penis into the bladder to drain urine). Please use gown and gloves for high-contact resident care activities. Observation of Resident 87 on October 6, 2024, at 8:38 AM with Employee 3 (licensed practical nurse) revealed that Employee 3 donned gloves but did not don a gown before removing blue cushioned boots from Resident 87's feet and removing a dressing from Resident 87's right foot. Employee 3 completed the steps for wound care to Resident 87's right foot, that included cleansing the wound sites and applying new dressings, without wearing an isolation gown. Interview with Employee 3 on October 6, 2024, at 8:47 AM indicated that she did not don a gown, because she believed that a gown was not necessary since there were no gowns on Resident 87's door. Employee 3 verified that the EBP sign on Resident 87's door instructed staff to gown and glove when doing wound treatments. The surveyor reviewed the above concerns regarding the implementation of EBP for Resident 87 with the Nursing Home Administrator and the Director of Nursing on October 6, 2024, at 1:45 PM. 483.80(a)(1)(2)(4)(e)(f) Infection Prevention and Control Previously cited deficiency 4/9/24 and 9/29/23 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44738 Based on observation and staff interview, it was determined that the facility failed to ensure a safe and clean environment in the facility's main kitchen. Findings include: Observation in the main kitchen area on [DATE], at 10:38 AM revealed a first aid kit attached to the wall. Located on the top exterior of the kit were the following: a significant build-up of dust, four antiseptic towelettes that expired [DATE], an open triangular bandage box with no bandages, and burn spray with the plastic cap removed that expired [DATE]. The interior of the first aid kit contained multiple empty packages, alcohol cleansing pads that expired [DATE], and a container of burn treatment gel that had one open gel packet that was put back in the box with the others that had expired on [DATE]. The above information was reviewed with the Nursing Home Administrator on [DATE], at 1:35 PM. 28 Pa. Code 201.18 (b)(1)(3) Management