STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395782	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Nursing and Rehabilitation Center	184 Bethlehem Pike Philadelphia, PA 19118

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 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** 38947 Based on staff and resident interviews and the review of facility documentation, it was determined that the facility failed to conduct a complete and through investigation for a resident's allegation of missing cigarettes and the facility failed to ensure that residents in the facility were protected from further potential abuse related to an allegation of an alleged perpetrator stealing money and jewelry for 1 out of 3 residents reviewed. (Resident R2) Findings include: Review of the facility policy, Accidents and Incidents-Investigating and Reporting, that the facility identified as being their abuse investigation policy, dated July 2017, indicated that all accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator. The policy also indicated that the nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document the investigation of the accident or incident to include, but not limited to, the date and time the accident or incident took place; the nature of the injury of illness; the name(s) of witnesses and their accounts of the accident or incident and the injury. Continued review of the policy also indicated that investigation will also include any corrective action taken; follow-up information; other pertinent data as necessary or required; and the signature and title of the person completing the report. Review of the September 2024 physician orders for Resident R2 included the the diagnoses of cerebral infarction (a stroke); diabetes; hypertension (high blood pressure). Information received by the State Survey Agency on September 9, 2024 indicated that resident cigarettes have been going missing during cigarette breaks and identified Resident R2's cigarettes as missing. During an interview with Resident R2 on September 13, 2024, at 2:00 p.m. the resident reported that he was away on leave of absence from the facility with family. He reported that he left September 2, 2024 (Monday) and returned to the facility on [DATE] (Wednesday). The resident explained that prior to him leaving, he had 1 pack of cigarettes that were opened, and a 2nd pack of cigarettes that have not been opened yet, (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident reported that when he returned for his first smoke break on September 5, 2024 after returning from his leave of absence on September 4,2024, the resident reported that he did not have any cigarettes. Resident R2 reported that the activity director (Employee E12) told him that she could not find them. During an interview with assistant director of activities (Employee E15) on September 13, 2024 at 2:23 p.m. the assistant director reported that he was on vacation from August 31, 2024 through September 9, 2024 and upon his return, Resident R2 informed him that his cigarettes were lost. The activity director reported that he purchased a pack for him. The activity assistant director reported that all resident cigarettes are kept in a container that is locked up in the activity's office, and that each resident's pack of cigarettes have their name on them. The activity director further explained that the number of cigarettes that a resident has documented by the activity staff before the cigarette break and after the resident's cigarette break. During an interview with the Activities Director, Employee 12 on September 14, 2024 at 12:15 p.m. the Activities Director reported that Resident R2 was missing a pack of cigarettes when he came for his first smoke break on September 5, 2024 after returning from his leave of absence on September 4, 2024. The activity director stated that she looked for them, she could not find them, and that she is not sure what happened to his packs of cigarettes. During the above interview, the activity director reported that she did not initiate a grievance form or conduct a investigation regarding his missing packs of cigarettes. The facility did not ensure that a complete and through investigation was completed for Resident R1's allegation of missing cigarettes. Review of the facility policy, Protection of Residents During Abuse Investigations dated April, 2021, indicated that if the alleged perpetrator is an employee or staff member, the individual is immediately reassigned to duties that do not involve resident contact or are suspended until the findings of the investigation are reviewed by the administrator. Review of information reported to the State Survey Agency indicated that lost jewelry and money was found in the facility's social worker's office consisting of an envelope with $170 in it, three bags of jewelry, in addition to a bank card and a wallet. The concern also alleged that the director of the facility's activity department (Employee E12) took some of the jewelry (a bracelet, a watch and a ring), offered activity staff members some of the jewelry, and instructed them not to say anything. During an interview with the Activities Director, Employee E12 on September 14, 2024 at 12:15 p.m. it was reported that allegations regarding her stealing money and jewelry was reported during a meeting that was held on September 10, 2024. The Activities Director, Employee E12 also reported during the above referenced interview that on September 12, 2024, at approximately 1:50 p.m. she was notified by the facility's human services director (Employee E13) that she was being suspended from her position due to the concerns that were discussed during the meeting on September 10, 2024. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the human resources director (Employee E13) on September 14, 2024, at 12:40 p. m. the human resources director reported that allegations regarding the activity director were reported to her during a meeting that was held on September 10, 2024. The human resource director report that the regional human resource director (Employee E15), the director of the facility's Activities department (Employee E12), and an activity aide (Employee E14) were also present at that meeting. The human resource director reported that the meeting took place some time in the afternoon, and that during the this meeting, the activity aide reported that the Activities Director took money and jewelry that was left in an office that the activity department moved into after the social worker moved out of the office. The human resource director reported that the activity aide wrote a statement on September 10, 2024, after the meeting regarding the allegations that she made. The human resources director reported that the Director of Activities department was suspended from working at the facility due to the allegations reported on September 12, 2024 sometime in the afternoon. During an interview with the human resources director (Employee E13), the regional human resource director (Employee E15) and the Director of Nursing (DON) on September 14, 2024, at 2:50 p.m., the regional human resources director reported that she notified the DON on the morning of September 11, 2024, regarding the allegations reported by the activity aide regarding the activity director. The regional director of human services reported that the activity director was suspended on September 12, 2024. Based on the above referenced interviews, there was no evidence that the facility ensured that further potential abuse was prevented by allowing the activity aide to continue working with residents despite becoming aware of allegations of alleged misappropriation of resident property/funds. It was discussed with all those present during the above referenced meeting on September 14, 2024 at 2:50 p.m. that although the facility became aware of the allegations of misappropriate of resident funds and property, regarding Director of Activities on September 10, 2024, the facility did not ensure that the residents in the facility were protected from further potential misappropriation of funds/property from the Director of Activities until September 12, 2024 (2 days after it was reported to the facility) because the facility allowed that the Director of Activity to worked the remainder of the day on September 10, 2024 (after the allegations were reported to the facility), the full day on September 11, 2024, and well into the afternoon on September 12, 2024. The facility failed to conduct a complete and through investigation for Resident R2's report of missing cigarettes and the facility failed to ensure that residents in the facility were protected from further potential abuse from the alleged perpetrator related to an allegation of the perpetrator stealing money and jewelry. 28 Pa. Code 201.14(a)(e) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 201.29(c) Resident rights 28 Pa. Code 211.10(d) Resident care policies (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.12(c) 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 - Immediate jeopardy to resident health or safety 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** 38947 Based on staff interviews, the review of clinical records, and the review of facility documentation, it was determined that the facility failed to provide adequate staff supervision and monitoring to Resident R1 who was found to have a alcohol bottles in the resident's room. The facility's failure to provide adequate staff supervision and monitoring to Resident R1 with a history of storing and consuming alcohol resulted in Immediate Jeopardy to Resident R1 who sustained a fall, required transfer to the hospital and was diagnosed with a fracture hip for one of three residents reviewed. (Resident R1). Findings include: Review of the September 2024, physician orders for Resident R1 revealed the diagnoses of arthritis; hypertension (high blood pressure); bipolar disorder (condition in which a person has periods of depression and periods of being extremely happy); depression (major loss of interest in pleasurable activities), and repeated falls. Review of the nursing notes from May 1, 2024, through September 5, 2024, revealed that the resident sustained five falls. The falls occurred on: May 4, 2024, August 3, 2024, September 3, 2024, September 4, 2024, and September 5, 2024. Review of a nursing note dated May 4, 2024, at 11:09 p.m. indicated that the resident's nurse aide notified nursing staff that the resident had an unwitnessed fall in her room on the above referenced date at approximately 8:14 p.m. The note documented that the resident initiated a transfer from her bed, slid to the floor instead, and was found lying on her side in her room by the nurse aide. Review of the nursing notes dated May 7, 2024, at 1:50 p.m. indicated that the resident was seen by a nurse practitioner for the fall that occurred on May 4, 2024. The nurse practitioner documented that nursing reported to the nurse practitioner that the resident had a fall over the weekend (May 4, 2024) due to possible alcohol intoxication. Continued review of the nurse practitioner's note indicated that the resident admitted to the nurse practitioner on May 7, 2024, that she consumed alcohol on the day of fall. Patient admits to intake of alcohol on the day of the fall. Nursing staff who worked during the shift on which the resident's fall occurred (3:00 p.m. through 11: 00 p.m.) and the nurse practitioner were no longer employed by the facility, and they could not be reached for an interview. Review of Resident R1's Psychological Services note dated May 31, 2024, indicated that the licensed clinical social worker (LCSW) documented the unit nurse manager met with the LCSW on May 31, 2024, regarding the concern of Resident R1 having an increase in falls and alcohol consumption. The unit nurse manager met with the clinician regarding concern with [Resident R1]. The manager expressed increase falls and alcohol consumption. Continued review of the resident's encounter notes with the LCSW indicated that the resident denied alcohol use and contributed her falls to her health conditions.clinician agreed to follow up . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a nursing note dated August 3, 2024, at 12:10 a.m. documented that the resident had a witnessed fall while transferring from her bed to the wheelchair next to her bed. The note indicated that the wheels were unlocked on her wheelchair and that the resident fell in view of staff, and before staff could get to the resident. No further information was documented about this fall. Review of a nursing noted dated September 3, 2024, at 7:24 p.m. written by Employee E3 (licensed nurse) stated that the resident was found on the floor next to her bed. Employee E3 (licensed nurse) documented that the resident told him that she was trying to get into her wheelchair and fell . Review of the incident report completed by the licensed nurse indicted that the resident was placed back in her bed, encouraged to use the call bell, and wear the proper shoes while transferring. Review of a nursing note from Employee E4 (licensed nurse) on September 4, 2024, at 1:27 a.m. indicated that she found a bottle of vodka (1.5 L) underneath the resident's bed. Licensed nurse documented that she removed the bottle from the resident's bed and gave it to the nursing supervisor (Employee E5). During an interview with Employee E4 on September 14, 2024, at 11:27 p.m. licensed nurse reported that she relieved Employee E3 and started her shift on September 3, 2024, at 7:00 p.m. and it ended on September 4, 2024, at 7:00 a.m. Licensed nurse, Employee E4 reported that she was alerted by Resident R1's roommate that Resident R1 had a fall and was lying on the side of her bed. Licensed nurse, Employee E4 reported that she went in the room with the resident's nurse aide, asked the resident if she was in pain, obtained her vitals, which the licensed nurse reported were within normal limits. Licensed nurse, Employee E4 reported that both she and the nurse aide assisted the resident off the floor and back into her bed. Licensed nurse, Employee E4 reported that the nursing supervisor (Employee E5) told her to write a note and that he would follow-up with the Director of Nursing (DON) and the Nurse Practitioner in the morning. Licensed nurse Employee E4, reported that the bottle that she retrieved from underneath the resident's bed was a 1.5-liter bottle of vodka that was half empty. The licensed nurse, Employee E4 stated during the above interview, I knew something was not right with her because she was not herself, and she was laughing, and she did not recognize me. During an interview with the nursing supervisor, Employee E5 on September 14, 2024, at 11:50 p.m. the nursing supervisor reported that he worked from 11:00 p.m. starting on September 3, 2024 through 7:00 a.m. on September 4, 2024. Nurse supervisor was asked about the fall that the resident sustained on September 4, 2024. The nurse supervisor reported that he was only aware of the one fall. Continued interview with nursing supervisor indicated that nursing supervisor reported during the interview that Employee E4 (licensed nurse) did give him a bottle of vodka that was half empty close to the end of his shift (7:00 a.m.) as he was giving report to the Nursing Supervisor (Employee E6) for the 7:00 a.m. shift. Nursing supervisor reported that Employee E4 (licensed nurse) told him that she found the bottle in Resident R1's room. Nursing supervisor reported that he took that bottle to the Director of Nursing (DON) as he was leaving out and told the DON that it was found in Resident R1's room during his shift. Employee E4 (licensed nurse) reported that the Nursing Supervisor (Employee E6) for the 7:00 a.m. shift also accompanied him when he gave the bottle to the Director of Nursing (DON) in her office. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a note written on September 5, 2024, at 11:24 a.m. by Employee E7 (licensed nurse) indicated that the resident's nurse aide came to licensed nurse at 7:10 a.m. and informed the licensed nurse that the resident was sitting on the floor next to her bed. The note indicated that the licensed nurse went to the resident's room and the resident reported that her bed, was broken and that she fell twice the day before. The corresponding incident report indicated that the resident reported that she slid out of bed. The incident report documented that the resident was assessed and was subsequently sent out to the hospital on September 5, 2024, after complaining about hip pain. During an interview with Employee E7 (licensed nurse) on September 14, 2024, at 12:00 p.m. the licensed nurse reported that 2 nurses found 3-6 bottles of alcohol in the resident's room after she was transported to the hospital. There was no information in the above referenced incident report that was reviewed indicating that any bottle of alcohol were removed by nursing staff after the resident's fall. During an interview with Employee E7 on September 14, 2024, at 12:00 p.m. Licensed nurse reported that she was the charge nurse on the unit when the resident had a fall on September 5, 2024, and was sent out to the hospital. Licensed nurse reported that she entered the resident's room and the resident reported that the sides of her bed were broken, and that she was trying to get up to got to the bathroom, or something like that, as the licensed nurse stated. Licensed nurse also reported that the resident told her that she also had two falls the day before. Licensed nurse reported that she assessed the resident once she entered the room, and that afterwards, both she and the nurse aide assisted the resident from the floor and into a chair. Licensed nurse reported that the nurse aide for the resident reported that this happened yesterday and the nurse aide explained that nursing staff found alcohol in the resident's room the day prior. Licensed nurse reported that 2-3-unit managers came to the unit to assist with the fall that the resident had in her room. Licensed nurse reported that the resident was assessed by the nurse practitioner (Employee E8) and was subsequently sent out to the hospital due to resident complaining about hip pain during the nurse practitioner medical assessment. Review of a nursing note dated September 5, 2024, at 6:18 p.m. documented that the resident returned from the hospital with a diagnosis of Greater Trochanter fracture due to fall (Greater Trochanter part of the hip and the upper femur/thigh bone). During an interview with the facility's Medical Director (Employee E9) on September 12, 2024, at 2:42 p.m. it was reported that he was called by a nurse at the facility on September 5, 2024 who informed that someone found 5-6 empty bottles of alcohol in the resident's room. The Medical Director reported that he told the nurse that he will speak with the resident regarding the alcohol when he comes into the facility this week. The Medical Director reported that when he came into the facility on [DATE], he spoke with the resident regarding the empty bottles of alcohol in her room and asked her who gave her the bottles. The Medical Director reported that when he asked her the question regarding how she is obtaining the alcohol, the resident told him that a friend brings in a box of food supplies to her. The Medical Director reported that the resident did not directly state that the alcohol was in the box of food supplies that she stated that she received from her friend, but the Medical Director reported that although she did not state this, it was implied that the friend is supplying her with the alcohol. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with Employee E10 (Unit Manager on 1st floor) on September 14, 2024, at 1:54 p.m. Unit Manager reported that on September 5, 2024, both she and the nurse practitioner, Employee E11 (Unit Manager from the 3rd floor) and the nursing supervisor (Employee E6) were on the 2nd floor when someone call the DON to notify her that Resident R1 fell . Employee E10 reported that they, the nurse practitioner, the unit manager for the 3rd floor and the nursing supervisor all went on the unit to the resident's room. Employee E10 reported that the resident told them that she fell in the bathroom. Employee E10 reported that the nurse practioner sent her out to the hospital after she assessed the resident, and she screamed in pain when she asked the resident if she could flex a foot. Employee E10 reported that she then went back to her own unit. During an interview with Employee E11 (Unit Manager for 3rd floor) on September 14, 2024, at 1:54 p.m. the unit manager reported that both she and the nursing supervisor (Employee E6) were the 2 nurses who found the 3 empty alcohol bottles in the resident's room after the resident left for the hospital on September 5, 2024. Unit Manager reported that both she and the nursing supervisor took the 3 empty bottles of alcohol to the Director of Nursing (DON) office and gave them to her. Review of the Psychiatric Evaluation and Consultation dated September 11, 2024, documented the nurse practitioner's visit with the resident on the above referenced date. The note documented that nurse practitioner's notification by nursing staff of the resident's fall and nursing staff's report that the alcohol was found in the resident's possession and staff concern that the resident's falls are related to her alcohol consumption. Continued review of the notes documented that during this session the resident told the nurse practitioner that she drank 2 shot glasses as needed and would not tell the nurse practitioner how she obtained the alcohol: .Pt reported drinking only 2 shot glasses as needed but won't tell how she obtained the alcohol. There has been a few other instances where alcohol was found, and staff believe the falls are related to her being drunk. During an interview with the Director of Nursing (DON) on September 14, 2024, at 4:12 p.m. the DON reported that she was unaware of the falls that the resident had in May 2024, or concerns that the staff had that the resident's falls could be attributed to alcohol use. During the above interview, the DON reported that she was aware of the falls that the resident had on September 3, 2024, and on September 5, 2024. The DON reported that she not aware of the documented fall that the resident had on August 3, 2024 or the documented fall that the resident had on September 4, 2024 with charge nurse (Employee E4). During an interview with the DON on September 15, 2024, at 4:20 p.m. the DON reported that she was provided with 1 bottle of alcohol on September 4, 2024 (prior to the resident's fall with injury on September 5, 2024), that was given to her by the night nursing supervisor (Employee E5) and the day nursing supervisor (Employee E6). The DON reported that she disposed of the bottle down the drain in the laundry room. The DON was asked during the interview what did she do to address the issues of the bottle of alcohol that was found in the resident's room by nursing staff after they brought it to her attention, and she responded nothing. The facility failed to provide adequate staff supervision and monitoring to Resident R1 who was found to have alcohol bottles in the resident's room. The facility's failure to provide adequate staff supervision and monitoring to Resident R1 with a history of storing alcohol in her room and consuming alcohol resulted in Immediate Jeopardy to Resident R1 who sustained a fall and was diagnosed with a hip fracture. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on the above findings, an Immediate Jeopardy was identified to the Nursing Home Administrator on September 13, 2024 at 11:25 p.m. The immediate jeopardy template was provided to the Administrator and an immediate action plan was requested. On September 13, 2024, at 4:14 p.m. the facility provided the following corrective action plan: -A facility sweep was completed on 9/12/24 on the 3-11 shift to ensure no residents have any illegal substances or alcohol was in their possession at that time. Permission was granted for all room searches. No other illegal substances or alcohol were found within the resident rooms. -ROBO call was made to all families on 9/13/24 to remind them, not to bring in any illegal substances or alcohol into the facility. -New admissions to the facility will be reviewed by Social Services to identify any history of or active use of illegal substances or alcohol to identify interventions to ensure the safety of the resident. -If current residents are identified to be in possession of an illegal substance or alcohol, the physician and family will be notified and interventions will be implemented to ensure their safety and supervision. -All staff are being educated on steps to address when alcohol is found in a resident room and what steps to take to ensure the safety of the resident at that time. Education was completed for staff working in the building on 9/13/24. -Education will continue until all staff have been in serviced on the safety of residents. -Residents attending a facility outing will be educated on not purchasing any illegal substance or alcohol on a facility outing prior to the outing. Resident purchases will be closely monitored by the supervising staff to ensure that no illegal substances or alcohol has been purchased during the outing. -The policy regarding supervision to prevent accidents with the use of illegal substances and alcohol was updated. All staff in the building will be educated today 9/13/24, or prior to encountering any residents. -A random audit will be conducted to ensure staff understand the above education. These audits will continue weekly x 3 and monthly x 3 months. -The facility will continue to conduct random audits of resident rooms per resident permission to ensure that there are no illegal substances or alcohol in the resident rooms. These audits will continue daily x 5 days, weekly x 3 and monthly x 3. -The facility activities staff will conduct an audit during the facility outing to ensure residents have not purchased illegal substances or alcohol during the facility outing, weekly x3 and monthly x3. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Audit results will be reviewed at QAPI (Quality Assurance Performance Inprovement Plan) X 3 months. Following verification of the implementation of the immediate action plan and review of staff education documentation, the Immediate Jeopardy was lifted on September 15, 2024, at 4:33 p.m. 28 Pa. Code 201.18(a) Management 28 Pa. Code 201.18(b)(1)Management 28 Pa. Code 201.18 (b)(3)Management 28 Pa. Code 201.18(d) Management 28 Pa. Code 211.10(b) Resident care policies 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(3) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services 28 Pa. Code 211.11(a) Resident care plans

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 38947 Based on a review of clinical records, facility documentation, and interviews with staff, it was determined that the Nursing Home Administrator and the Director of Nursing failed to effectively manage the facility regarding a resident who was storing and consuming alcohol at the facility, sustained a fall, required transfer to the hospital and diangnosis of right hip fracture, which resulted in an Immediate Jeopardy situation for one out of three residents reviewed (Resident R1). Findings include: Review of the job description for the Nursing Home Administrator (NHA) provided by the facility indicated that the primary purpose of the position is to manage the facility in accordance with current applicable federal, state, and local standards, following all facility policies and applying them uniformly to all employees, in addition to ensuring the highest degree of quality care is provided to the facility residents at all times. The duties and responsibilities of NHA included, but are not limited to: reviewing policies and procedures periodically, at least annually, and make recommendations for changes to assure continued compliance with current regulations; making written, and/or oral reports/recommendations concerning facility needs, problem areas deemed necessary or appropriate; supervising all departmental heads and administrative staff; conduct in-service education and orientation for departmental staff to ensure a well-educated department Review of the job description for the Director of Nursing (DON) indicated that the purpose of the position is to plan, organize, develop and direct the overall operation of the Nursing Service Department in accordance with current federal, state and local standards, guideline and regulations that govern the facility, and as may be directed by the Administrator and Medical Director, to ensure that the highest degree of quality care is maintained at all times. The duties and responsibilities of DON included, but are not limited to: organizing and directing nursing administration, nursing services and resident care developing, organizing, implementing evaluating and directing the day-to-day functions of the nursing service department, it programs and activities; participate in developing, maintaining, and periodically updating written nursing policies, procedures, reference materials, manuals objectives, and philosophies; complete incident reports and follow up on reports; review nursing notes to ensure proper documentation is maintained related to resident's treatment, medication and conditions; review nurse notes and monitor resident to determine if the care plans are being followed and if each resident's needs are being met, and participate in assessing, reviewing and revising care plans as required. Review of the September 2024, physician orders for Resident R1 revealed the diagnoses of arthritis; hypertension (high blood pressure); bipolar disorder (condition in which a person has periods of depression and periods of being extremely happy); depression (major loss of interest in pleasurable activities), and repeated falls. Review of nursing notes from May 1, 2024 through September 11, 2024 documented nursing staff's suspicion that Resident R1 falls were a result of her consuming alcohol, finding alcohol in the resident's room after a fall, in addition to the resident's admission two nurse practitioners to drinking prior to at least 2 falls. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of nursing notes from May 1, 2024 also indicated that nursing staff who found alcohol bottles after two of the three falls in September 2024 provided those bottles to the Director of Nursing (DON) on September 4, 2024 and on September 5, 2024. On September 4, 2024 a 1.5 L 1/2 empty bottle of vodka was found by nursing staff after a resident's fall, and on September 5, 2024 between 3-6 empty alcohol bottles were found by nursing staff after the resident fell , was transfer to the hospital. Review of the resident's hospital records documented that the resident returned from the hospital on September 5, 2024 with a diagnosis of acute right greater trochanter fracture of the hip (greater Trochanter-part of the hip and the upper femur/thigh bone). Continued review of the resident's clinical record from May 2024-September 2024 indicated that despite staff suspecting that resident's falls were related to substance abuse, residing admitting that she drink prior to falls, and staff finding alcohol bottles in the resident's room, the staff failed to ensure adequate monitoring and supervision for Resident R1, and failed to ensure that a person-centered plan of care was developed for Resident R1 to address the resident's substance abuse. Based on the deficiencies identified in this report, the NHA and DON failed to fulfill essential duties and responsibilities of their position, contributing to the Immediate Jeopardy situation. Refer to F656 and F689. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(1) Management 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 201.18(e)(1) Management

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38947 Based on observations, staff interviews and review of pest control logs, it was determined that the facility failed to ensure an effective pest control environment. Findings include: During an interview with the facility's maintenance director on September 13, 2024, at 9:55 a.m. the maintenance director reported that the facility contracted for pest control services twice a week. It was also explained that books are located on each nursing unit on the 1st, 2nd and 3rd floor, and the kitchen where staff document sightings of roaches, bugs, flies mice on the unit, in resident rooms, and in the kitchen. Review of the pest control contract provided by the facility indicated that the kitchen, dining room, staff cafeteria, vending machine areas and nursing stations will be serviced on a regular basis with all other areas will be serviced as necessary. Continued review of the contract indicated that interior and exterior deficiencies will be noted and reported to the maintenance personnel (e.g. gaps under doors, holes in walls, screens around pipes, crevices around windows or doorways, faulty downspouts) and addressed by maintenance staff in order to reduce the potential of ongoing pest problems. Review of the pest control invoices indicated that the facility did not maintain an effective pest control environment/pest free environment by not ensuring that rooms that needed services were available for treatment and the time of the visits. Review of pest control invoices also indicated that an effective pest control environment/pest free environment was not properly maintained in the facility due to staff not documenting pest concerns in the log books for the technician and instead verbally telling him when he is at the facility. The proper documentation of pests/bugs by staff should be documented in the book each week so that the technician is able to provide services to all the reported areas, which will aide in a pest free environment: Review of the May 13, 2024, invoice indicated that service could not be provided in rooms 133-138 due to rooms not being prepared. The pest control company reported that residents were still inside the room either eating breakfast or still in bed sleeping. Review of the May 15, 2024, invoice indicated that he checked the pest reporting logbooks on the first and second floors and there were not written reports from staff in either book. Verbal report were provided by nursing staff regarding concerns with roaches. The pest control recommended that staff utilize the logbook to document their concerns. Review of May 20, 2024 invoice indicated that the pest control representative returned to services rooms 133-138 that he could not service on but the rooms were not prepared. The representative reported the residents were still in their bed. The representative did recommend better sanitation in the above referenced rooms and also recommended that the rooms be cleaned thoroughly. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of pest control invoice May 22, 2024 indicated that the representative received verbal reports from staff when he arrived and recommended that staff utilize the logbooks. Review of May 29, 2024 invoice indicated that the pest control representative returned to services rooms 133-138 but the residents were still inside the room. The representative recommended better sanitation of the rooms and for the rooms to be thoroughly cleaned before service. The representative also recommended that the staff utilize the pest logbooks. Review of a June 3, 2024 invoice indicated that there was no service performed due to the facility failing to provide a list of areas to service to the pest control representative when he arrived. The representative documented that he spoke to someone at the front desk who told him that the administrator left the building. Review of a June 10, 2024 invoice indicated there was no service performed due to the facility failing to provide a list of areas to service. The pest control representative stated that the maintenance director was not present for service and that the administrator was in a meeting. Review of a June 17, 2024 invoice indicated that there was no service performed due the facility failing to provide a list of areas for the representative to service. The representative reported that he checked with the front lobby and was told that the administrator left the building. Review of a June 19, 2024, invoice indicated that there was a large hole in wall in room [ROOM NUMBER] near the bottom of the heating/ air system. The pest control representative recommended sealing all voids throughout. Review of a June 24, 2024 invoice indicated that there was no services provided due to the listed rooms not being prepared for service: Rooms 336, 328,315, 317, 335, 131, 114, 118, 242, and 249. Review of a July 1, 2024 invoice indicated that there was no services provided due to rooms due to the listed rooms not being prepared for services. The representative documented that residents were still inside rooms with oxygen machines running, eating lunch or sleeping (Rooms 336, 328, 315, 317, 335, 131, 114, 118, 242 and 249). The pest representative report recommended better sanitation in all rooms to be cleaned thoroughly before service. Review of a July 8, 2024 invoice indicated that there was no services provided due to rooms due to the listed rooms not being prepared for services. The pest representative report recommended better sanitation in all rooms to be cleaned thoroughly before service (Rooms 336, 328, 315, 317, 335, 131, 114, 118, 242, and 249). Review of July 15, 2024, invoice indicated that there was no service performed due to rooms not being prepared and residents were still inside the rooms in bed, with some residents with food in front of them (Rooms 336, 328, 315, 317, 335, 131, 114, 118, 242 and 249). Review of July 15, 2024, invoice indicated that there was no service performed due to rooms (Rooms 336, 328, 315, 317, 335, 131, 114, 118, 242, 249). Review of July 15, 2024 invoice indicated that there was no service performed due to rooms (Rooms 336, 328, 315, 317, 335, 131, 114, 118, 242 and 249) due to the rooms not being prepared. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of August 12, 2024 invoice indicated that room [ROOM NUMBER] was inspected for mice activity. The pest representative reported that the resident for room [ROOM NUMBER] also reported to him that he has seen mice run in and out of the heating and air unit in his room and that he recommended that maintenance inspect and seals holes in the heating/air unit. The representative also made the recommendation to declutter the resident's room for better treatment. The August 12, 2024 invoice also indicated that the pest control representative spoke with housekeeping to follow up with the recommendation from the last time they were service regarding them replacing the soiled linen carts. The invoice explained that replacing the soiled linen carts were explained due to the amount of roach activity that was coming from the carts. The pest representative reported that housekeeping notified him that the carts have not been replaced and that it was recommended again, that they have the carts replaced. Review of the August 26, 2024 invoice indicated that room [ROOM NUMBER] was treated for mice activity and that pest representative recommended that maintenance inspect and seal voids in the heating/air unit in the room. The pest representative also reported that he followed up with housekeeping regarding the soiled linen carts and housekeeping reported that they have not replaced them. Review of the September 4, 2024 invoice indicated that nursing staff on duty reported roach activity throughout, but there were no reports listed in the logbook. Review of September 9, 2024 invoice recommended servicing the side of the building where the villa (abandoned historical building) is attached to the nursing home. There was also a recommendation to service the boiler room/basement area of the villa. The pest representative reported that he would need to be escorted to these areas since they are isolated and potentially dangerous. Review of the service provided on September 9, 2023, indicated that the pest representative treated rooms for mice activity and recommended better sanitation in the rooms and for the rooms to be cleaned thoroughly (Rooms 232, 236, 245, 253, 233, 248, 251, 234, 237, 243, 231, 244, 337,335, 336, 328, 314, and 327). Continued review of the pest control invoice notes and observations and interviews in the facility indicated that recommendations made by the company to seal holes in walls, declutter resident rooms, clean resident rooms were not completed by the facility: For room [ROOM NUMBER], there was no evidence produced by the facility that the recommendations from the pest control company from an August 24, 2024 visit were implemented by the facility when requested on September 18, 2024 at 4:23 p.m. The room was treated for mice activity and the recommendation was for maintenance staff to seal and inspect the resident's heating and air conditioning unit. During an observation on room [ROOM NUMBER] on September 17,2024 at 12:54 p.m. Resident R3 reported that he sees mice every night and that they come out of the heating/air conditioning unit, and they need to do something about this. Review of the pest control log from May 29, 2024, recommended better sanitation for room [ROOM NUMBER]. During the above referenced observations, a large area of brown dried up substance was observed under the resident's bed. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation in room [ROOM NUMBER] on September 17, 2024 at 1:08 p.m. the floor was sticky and made a sticky sound when walking on it. The agency nurse (Employee E17) walked into the room and stated, this floor is sticky. Flies were observed flying in the room. 2 pieces of trash items which appeared to be food wrapping was observed under the heating/air cooling system. May 13, 20, and 29 pest invoices indicated that this room could not be serviced due to it not being prepared by the facility. The pest representative also recommended better sanitation of this room on May 20 and May 29. The pest control visit on June 19, 2024 where he was escorted by the maintenance director mentioned a large void in the wall near the bottom of the heating/air conditioning unit in room [ROOM NUMBER]. The pest control company recommended sealing all voids throughout. During an observation in room [ROOM NUMBER] on September 17, 2024 at 2:00 p.m. a large hole in the wall on the left side of the heating/air conditioning was observed. The hole referenced in the June 19, 2024 was still present and not filled by maintenance staff, and could be a potential pathway for rodents. The heating/air unit cover was also off and on the resident room floor. Resident R4 reported that although he is blind, he can hear the mice making a screeching noise. Review of the August 12, 2024 pest control invoice indicated that room [ROOM NUMBER] was inspected for mice activity. The pest representative reported that the resident for room [ROOM NUMBER] also reported to him that he has seen mice run in and out of the heating and air unit in his room and that he recommended that maintenance inspect and seals holes inside the heating/air unit. The representative also made the recommendation to declutter the resident's room for better treatment. During an observation on room [ROOM NUMBER] on September 17, 2024 at 5:26 p.m. Resident R5 was observed lying in his bed. There was no evidence that the resident's room was decluttered. Upon entering the room and facing the resident in his bed, a big pile of items could be observed on the left of the resident's bed. Amongst that pile were several bags from two convenience stores. A clear plastic bag was filled with what appeared to be trash. There was 1 empty plastic container lying on top of a pile of something that was at some point filled with a beverage. There was also an empty plastic container on the resident's bedside table. There was also a smaller pile (closer to the heating/air unit) which consisted of a pizza box that was on the floor, a empty container of cranberry juice, more food paper bags from convenience stores. Resident R5 reported that he currently sees mice running from under the heating/cooling units and that the exterminator put mice traps under the heater, but that the holes need to be covered underneath so that the mice cannot get through. There was no evidence produced by the facility that the recommendations from the pest control company from an August 12, 2024 visit were implemented by the facility, when requested on September 18, 2024 at 4:23 p.m. During an observation on room [ROOM NUMBER] on September 18, 2024 at 11:31 a.m. a hole in the wall to the right of the heating/air system was observed. The hole is a potential pathway for mice to get into the room. During an interview with the nurse aide (Employee E18) who was present in the room, the nurse aide reported that she did not see any mice or roaches today, but they are definitely here. Employee E19 who was also in the room, responded Yes! During an observation in room [ROOM NUMBER] on September 18, 2024 at 11:38 a.m. Resident R6 reported that he sees mice come from underneath the heating/air system in his room. During the above observation, a hole on the right side of the wall near the heating/air conditioning unit was present, which can be potential pathway for mice to get into the room. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On September 17, 2024, at 1:40 p.m. an interview with the housekeeping director (Employee E16) in the facility's laundry room took place regarding the soiled linen carts and the recommendation that the pest control representative made. The housekeeping director reported that there was a total of 5 carts that are utilized for soiled linen. The housekeeping director (Employee E16) reported that he was aware of the concern that was brought to his attention related to the pest control's company recommendation to the replaced the linen carts due to concerns regarding the roach activity that was coming from the carts. The soiled linen carts were observed in the laundry room during the observation, and the housekeeping director confirmed that the carts had not been replaced, as recommended. During an interview with the Nursing Home Administrator and the Regional Nurse on September 18, 2024 at 4:30 p.m, the above information was reviewed. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(3) Management