STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395784	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Church of God Home, Inc	801 N. Hanover Street Carlisle, PA 17013

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 33879 Based on clinical record review and staff interviews, it was determined that the facility failed to provide a notice of transfer for two of six residents reviewed for hospitalization (Residents 28 and 53), and failed to provide five of six residents reviewed for transfers with a notice of transfer that included the required information (Residents 1, 28, 52, 58, and 69). Findings include: Review of Resident 1's clinical record revealed diagnoses that included heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs), chronic kidney disease (longstanding disease of the kidneys leading to renal failure), and hyperlipidemia (high fat levels in the blood). Review of Resident 1's clinical record revealed that on January 1, 2025, Resident 1 was transferred to the hospital due to an acute medical change in condition. Review of facility document, Notice of Resident Transfer or Discharge, provided to Resident 1's Representative, revealed the notice did not contain the mailing address of the entity which receives request for appeals; mailing address of the Office of the State Long-Term Care Ombudsman; the mailing address for the agency responsible for protection and advocacy of individuals with developmental disabilities; nor, the mailing address for agency responsible for the protection and advocacy of individuals with mental disorders. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on February 6, 2025, at 11:35 AM, the NHA confirmed that the required mailing addresses were not present on the facility transfer notices. Review of Resident 28's clinical record revealed diagnoses that included heart failure, chronic kidney disease, and dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning). Review of Resident 28's clinical record revealed that the Resident had been transferred and admitted to the hospital on June 29, 2024; July 21 and 30, 2024; August 8, 2024; and October 18, 2024. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 28's Notice of Transfer or Discharge forms signed by their Representative for their June 29, 2024; July 21 and 30, 2024; and October 18, 2024, hospital transfers revealed that the notice did not contain the mailing address of the entity which receives request for appeals; mailing address of the Office of the State Long-Term Care Ombudsman; the mailing address for the agency responsible for protection and advocacy of individuals with developmental disabilities; nor, the mailing address for agency responsible for the protection and advocacy of individuals with mental disorders. Further review of Resident 28's clinical record revealed that a Notice of Transfer or Discharge was not present for the August 8, 2024 hospital transfer. During a staff interview with Employee 9 on February 4, 2025, at 12:52 PM, Employee 9 indicated that they had called Resident 28's Representative about their August 8, 2024, transfer but failed to get the paperwork signed by Resident 28's Representative. During an interview on February 5, 2025, at 1:10 PM, the NHA confirmed that Resident 28's Representative should have been provided the notice and that they should have signed the form when received. During a staff interview on February 6, 2025, at 11:30 AM, the NHA confirmed that the required mailing addresses were not present on the facility transfer notices. Review of Resident 52's clinical record, revealed diagnoses that included hypertension (elevated/high blood pressure). Review of Resident 52's clinical record revealed that on September 14, 2024, Resident 52 was transferred to the hospital due to an acute medical change in condition. Review of facility document, Notice of Resident Transfer or Discharge, provided to Resident 52's Representative, revealed the notice did not contain the mailing address of the entity which receives request for appeals; mailing address of the Office of the State Long-Term Care Ombudsman; the mailing address for the agency responsible for protection and advocacy of individuals with developmental disabilities; nor, the mailing address for agency responsible for the protection and advocacy of individuals with mental disorders. Review of Resident 53's clinical record, revealed diagnoses that included dementia (irreversible, progressive degenerative brain disease that results in decreased contact with reality and decreased ability to perform activities of daily living) and hypertension. Review of Resident 53's clinical record revealed that Resident 53 was sent to the hospital for evaluation after Resident 53 suffered a fall at the facility on May 21, 2024. Review of available clinical records revealed no evidence that Resident 53 nor Resident 53's Representative was provided a notice of transfer for the transfer to the hospital on May 21, 2024. During a staff interview on February 6, 2025, at approximately 11:00 AM, DON confirmed that the facility did not have documentation that Resident 53, nor Resident 53's Representative was provided with a transfer notice. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 58's clinical record revealed diagnoses that included dementia, heart failure, and hydronephrosis (a condition where one or both kidneys swell due to a blockage or obstruction that prevents urine from draining properly). Review of Resident 58's clinical record revealed that the Resident had been transferred and admitted to the hospital on October 17, 2024. Review of Resident 58's Notice of Transfer or Discharge form signed by their Representative for their October 17, 2024, hospital transfer revealed that the notice did not contain the mailing address of the entity which receives request for appeals; mailing address of the Office of the State Long-Term Care Ombudsman; the mailing address for the agency responsible for protection and advocacy of individuals with developmental disabilities; nor, the mailing address for agency responsible for the protection and advocacy of individuals with mental disorders. Review of Resident 69's clinical record on February 5, 2025, revealed diagnoses that included type two diabetes mellitus (decreased ability of the body to utilize insulin for the transport of glucose from the blood stream into the cells for nourishment) and hypertension. Review of Resident 69's clinical record revealed that on November 12, 2024, Resident 69 was transferred to a hospital due to an acute medical change in condition. Review of facility document, Notice of Resident Transfer or Discharge, provided to Resident 69's representative, revealed the notice did not contain the mailing address of the entity which receives request for appeals; mailing address of the Office of the State Long-Term Care Ombudsman; the mailing address for the agency responsible for protection and advocacy of individuals with developmental disabilities; nor, the mailing address for agency responsible for the protection and advocacy of individuals with mental disorders. During a staff interview with the NHA and DON on February 6, 2025, at 11:30 AM, the NHA confirmed that the required mailing addresses were not present on the facility transfer notices. 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 46253 Based on clinical record review and staff interviews, it was determined that the facility failed to provide a copy of the facility's bed-hold notice upon transfer or discharge from the facility for two of six residents reviewed for transfer or discharge (Residents 28 and 53), and failed to provide bed-hold notices that included the required information for five of six residents reviewed for transfer or discharge (Residents 1, 28, 52, 58, and 69). Findings include: Review of Resident 1's clinical record revealed diagnoses that included heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs), chronic kidney disease (longstanding disease of the kidneys leading to renal failure), and hyperlipidemia (high fat levels in the blood). Review of Resident 1's clinical record revealed that the Resident had been transferred and admitted to the hospital on January 1, 2025. Review of Resident 1's Bed Hold Prior to Transfer forms signed by their Representative for their January 1, 2025, hospital transfer revealed that the notice did not contain written information as to the duration of the state bed-hold, if any, or the reserve bed payment, if any. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on February 5, 2025, at 1:10 PM, the NHA confirmed that the duration of the state bed-hold and bed-reserve rate should have been included in the bed-hold notice. Review of Resident 28's clinical record revealed diagnoses that included heart failure, chronic kidney disease, and dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning). Review of Resident 28's clinical record revealed that the Resident had been transferred and admitted to the hospital on June 29, 2024; July 21 and 30, 2024; August 8, 2024; and October 18, 2024. Review of Resident 28's Bed Hold Prior to Transfer forms signed by their Representative for their June 29, 2024; July 21 and 30, 2024; and October 18, 2024, hospital transfers revealed that the notice did not contain written information as to the duration of the state bed-hold, if any, or the reserve bed payment, if any. Further review of Resident 28's clinical failed to reveal that a Bed Hold Prior Transfer or Discharge or was present for their August 8, 2024, hospital transfer. During a staff interview with Employee 9 on February 4, 2025, at 12:52 PM, Employee 9 indicated that they had called Resident 28's Representative about their August 8, 2024, transfer but failed to get the paperwork signed by Resident 28's Representative. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a staff interview with the NHA and DON on February 5, 2025, at 1:10 PM, the NHA confirmed that Resident 28's Representative should have been provided the facility bed-hold policy at the time of each hospital transfer and the duration of the state bed-hold and bed-reserve rate should have been included in the bed-hold notice. During a staff interview with the NHA and DON on February 6, 2025, at 11:30 AM, the NHA confirmed that the required mailing addresses were not present on the facility transfer notices. Review of Resident 52's clinical record on February 3, 2025, revealed diagnoses which included hypertension (elevated/high blood pressure) and diabetes mellitus type two (decreased ability of the body to utilize insulin for the transport of glucose from the blood stream into the cells for nourishment). Review of Resident 52's clinical record revealed that on September 14, 2024, Resident 52 was transferred to the hospital due to an acute medical change in condition. Review of the facility bed-hold notice, provided and signed by Resident 52's Representative on September 16, 2024, revealed that the notice did not contain written information as to the duration of the state bed-hold, if any, or the reserve bed payment, if any. Review of Resident 53's clinical record on February 4, 2025, revealed diagnoses which included dementia and hypertension. Review of Resident 53's clinical record revealed that Resident 53 was sent to the hospital for evaluation after Resident 53 suffered a fall at the facility on May 21, 2024. Review of available clinical records failed to revealed documentation that Resident 53, or Resident 53's representative, received a copy of the Facility's bed-hold policy upon transfer to the hospital on May 21, 2024. During a staff interview on February 6, 2025, at approximately 11:00 AM, DON confirmed that the facility did not have documentation that Resident 53, nor Resident 53's Representative was provided with the facility's bed-hold policy upon transfer on May 21, 2024. Review of Resident 58's clinical record revealed diagnoses that included dementia, heart failure, and hydronephrosis (a condition where one or both kidneys swell due to a blockage or obstruction that prevents urine from draining properly). Review of Resident 58's clinical record revealed that the Resident had been transferred and admitted to the hospital on October 17, 2024. Review of Resident 58's Bed Hold Prior to Transfer form signed by their Representative for their October 17, 2024, hospital transfer revealed that the notice did not contain written information as to the duration of the state bed-hold, if any, or the reserve bed payment, if any. Review of Resident 69's clinical record on February 5, 2025, revealed diagnoses which included type two diabetes mellitus and hypertension. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 69's clinical record revealed that on November 12, 2024, Resident 69 was transferred to a hospital due to an acute medical change in condition. Review of the facility bed-hold notice, provided and signed by Resident 69's representative on November 12, 2024, revealed that the notice did not contain written information as to the duration of the state bed-hold, if any, or the reserve bed payment, if any. During a staff interview with the NHA and DON on February 5, 2025, at 1:10 PM, the NHA confirmed that the duration of the state bed-hold and bed-reserve rate should have been included in the bed-hold notice. 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46253 Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for three of 30 residents reviewed (Residents 17, 28, and 58). Findings include: Review of Resident 17's clinical record revealed diagnoses that included vascular dementia (a type of dementia caused by brain damage from impaired blood flow marked by memory disorders, personality changes, and impaired reasoning), dysphagia (difficulty swallowing), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest in things). Review of Resident 17's clinical record revealed he had a significant weight loss of 31 pounds (-11.5%) from May 10, 2024, to November 4, 2024. Review of Resident 17's Quarterly MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) with the assessment reference date (last day of the assessment period) of November 19, 2024, revealed in Section K. Swallowing and Nutritional Status, the question weight loss of more than 5% in the last month or loss of 10% or more in the last 6 months, was marked no or unknown. Email correspondence with the Nursing Home Administrator (NHA) on February 4, 2025, at 4:08 PM, revealed the MDS should have been marked for weight loss and was being modified by the RNAC (Registered Nurse Assessment Coordinator). During a follow-up interview with the NHA on February 6, 2025, at 2:33 PM, she confirmed that she would expect a resident's MDS to be coded accurately. Review of Resident 28's clinical record revealed diagnoses that included heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs), chronic kidney disease (longstanding disease of the kidneys leading to renal failure), and dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning). Review of Resident 28's clinical record revealed a nutrition/dietary note dated October 28, 2024, at 12:04 PM, that indicated a comprehensive nutrition assessment had been completed as Resident 28 had returned from a hospital stay. The note indicated that Resident 28 had experienced a significant weight gain over 30 days, 3 months, and 6 months. In addition, there was a late entry nutrition/dietary note dated October 28, 2024, at 3:28 PM, that indicated Resident 28 had experienced a significant weight loss following hospitalization , not a significant gain as previously documented. Review of Resident 28's Medicare 5 Day MDS with the assessment reference date of November 1, 2024, revealed in Section K. Swallowing and Nutritional Status that did not have a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a staff interview with the NHA, Director of Nursing (DON), and Employee 2 (Dietician) on February 6, 2025, from 2:10 PM, to 2:25 PM, Employee 2 confirmed that Resident 28's MDS was coded inaccurately regarding their weight loss. The NHA confirmed that she would expect a resident's MDS to be coded accurately. Review of Resident 58's clinical record revealed diagnoses that included dementia, heart failure, and hydronephrosis (a condition where one or both kidneys swell due to a blockage or obstruction that prevents urine from draining properly). Review of Resident 58's physician orders revealed an order for an indwelling Foley catheter dated October 22, 2024. Review of Resident 58's October 2024 and November 2024 Treatment Administration Records revealed that Resident 58 had a foley catheter in place. Review of Resident 58's Quarterly MDS with the assessment reference date November 8, 2024, revealed in Section H. Bowel and Bladder that they were not coded as having a urinary catheter. Email communication received from the NHA on February 5, 2025, at 8:33 AM, confirmed that Resident 58's foley catheter was not coded correctly on their Quarterly assessment dated [DATE], and indicated that the Registered Nurse Assessment Coordinator would complete a modification. During a staff interview with the NHA and DON on February 6, 2025, at 11:20 AM, the NHA confirmed that she would expect that she would expect a resident's MDS to be coded accurately. 28 Pa Code 211.12 (d)(3)(5) Nursing services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46253 Based on facility policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure the residents right to participate in the care planning process for one of 18 resident's reviewed (Resident 4), and the facility failed to review and revise the resident plan of care for three of 18 residents reviewed (Residents 28, 37, and 58). Findings include: Review of facility policy, titled Comprehensive Care Plans with a last revised date of October 23, 2022, and a last review date of January 17, 2025, revealed, in part, 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. Review of facility policy, titled Care Plan Revisions Upon Status Change, with a last revised date of April 18, 2023, and a last review date of January 17, 2025, revealed, in part, The Comprehensive Care Plan will be reviewed, and revised as necessary, when a resident experiences a status change; the MDS Coordinator and Interdisciplinary Team will discuss the resident condition and collaborate on intervention options; the team meeting will be documented in the progress notes; and the care plan will be updated with the new or modified interventions. Review of facility policy, titled Care Planning- Resident Participation, last revised April 18, 2023, read, in part, Policy: This facility supports the resident's right to be informed of, and participate in, his or her care planning and treatment (implementation of care). The facility will honor the resident's choice in individuals to be included in the care planning process. The facility will honor requests for care plan meetings and acknowledge requests for revisions to the person-centered plan of care. The facility will discuss the plan of care with the resident and/or resident representative at regularly scheduled care plan conferences. Review of Resident 4's clinical record revealed she was admitted to the facility on [DATE], with diagnoses that included dysphagia (difficulty swallowing), hypertension (high blood pressure), and overactive bladder (a bladder control problem which leads to a sudden urge to urinate). Interview with Resident 4 on February 4, 2025, at 1:13 PM, revealed she has not been invited to a care plan meeting. Review of Resident 4's clinical record revealed three multidisciplinary care conference notes dated November 5, 18, and 22, 2024; further review of the care conference notes failed to reveal Resident 4 attended the meetings. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Email correspondence with the Nursing Home Administrator (NHA) on February 5, 2025, at 11:49 AM, revealed it is her expectation that residents are invited to their care plan meetings. She further revealed there is a new activities director that has taken a lead on coordinating care plan meetings, and they need to make sure she knows to document attendance in the notes and whether residents declined or attended. During a follow-up interview with the NHA on February 6, 2025, at 11:36 AM, she revealed the documentation that Resident 4 was invited to her care plan was missed. Review of Resident 28's clinical record revealed diagnoses that included heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs), chronic kidney disease (longstanding disease of the kidneys leading to renal failure), and dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning). During an interview with Resident 28 on February 3, 2025, at 10:12 AM, she indicated that she has a rash that itches, which has been going on for about 6 months and that the staff applies a cream to the rash. Review of Resident 28's clinical record revealed that the Resident was identified as having a skin rash on November 22, 2024. Review of Resident 28's physician orders revealed orders for a dermatology consult dated November 22, 2024; [NAME] External Lotion 0.5-0.5 % (Camphor &Menthol) apply to rash topically two times a day for rash/itchiness, dated November 22, 2024; anti-fungal powder (house stock) every morning and at bedtime for fungal areas to groin and under breasts, dated December 2, 2024; and hydroxyzine HCl (hydrochloride) oral tablet 25 mg (milligrams) Give 1 tablet by mouth at bedtime for itch, dated December 19, 2024. Review of Resident 28's care plan failed to reveal any documentation of the presence of any rash or their interventions for the treatment of the rash. During a staff interview with the NHA and Director of Nursing (DON) on February 6, 2025, at 11:26 AM, the DON confirmed that she would expect the rash to have been on Resident 28's care plan. During the same interview with Resident 28 on February 3, 2025, at 10:17 AM, she indicated that she would like to wear a bra every day. Resident 28 reported that she was not wearing one. During a follow-up interview with Resident 28 on February 4, 2025, at 11:43 AM, she again indicated that she was not wearing a bra. She said she did not know if it was because she did not have one. Review of Resident 28's Significant Change MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) with the assessment reference date (last day of the assessment period) of August 21, 2024, revealed in Section F. Preferences for Routine & Activities that it was somewhat important to her to be able to choose her clothing. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 28's Significant Change MDS with the with the assessment reference date of August 21, 2024, revealed in Section V. Care Area Assessment Summary that they needed assistance with eating, oral hygiene, toileting hygiene, showering/bathing, upper body dressing, lower body dressing, putting on and taking off footwear, personal hygiene, transfers, and mobility. The summary also indicated that these areas would be care planned. Review of Resident 28's care plan revealed a care plan focus for personalized care general. Interventions included keep phone in reach at all times, dated November 5, 2024; and may go out on therapeutic leave with medication, dated October 29, 2024. Further review of Resident 28's care plan revealed a care plan focus for ADL (activities of daily living) self-care performance deficit related to activity intolerance and limited mobility. The only intervention was Transfer: full mechanical lift with 2 assist, dated September 27, 2024. During an interview with Employee 9 on February 4, 2025, at 12:50 PM, they indicated that they had searched Resident 28's room and found 3 bras. Employee 9 further indicated that staff had put a bra on the Resident. Email communication received from the NHA on February 5, 2025, at 8:33 PM, indicated that it was determined that when Resident 28 was discharged to the hospital in August, her care plan was closed and then, upon return, a new care plan needed completed. She indicated that preferences were not completed upon that re-admission because they were not required on that assessment and, therefore, no preferences were pulled to their care plan. The NHA indicated that this concern was missed during facility care plan reviews and that a preference form will be completed and care plan updated accordingly. In an email communication received from the NHA on February 6, 2025, at 1:29 PM, she confirmed that when Resident 28's next MDS was completed on November 6, 2024, their care plan should have been reviewed and someone should have identified that Resident 28's care plan was missing Resident-specific ADL information. Review of Resident 37's clinical record revealed diagnoses that included chronic diastolic congestive heart failure (heart failure that occurs when the heart does not relax properly between beats, causing the heart to be unable to pump an adequate amount of blood to the body), chronic kidney disease, and dementia. Observation of Resident 37 on February 3, 2025, at 11:48 AM, revealed the presence of a raised red rash across their chest and bilateral arm. Resident 37 was observed to be scratching their left arm. Review of Resident 37's clinical record revealed that were identified as having a skin rash on November 26, 2024. Review of Resident 37's physician orders revealed orders for [NAME] External Lotion 0.5-0.5 % (Camphor &Menthol) Apply to bilateral legs and groin topically every day and evening shift for rash, dated November 26, 2024; and an order for hydroxyzine HCl Oral Tablet 25 mg Give 1 tablet by mouth at bedtime for itchiness/rash, dated February 4, 2025. (continued on next page)

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	395784	A. Building B. Wing	02/06/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 37's progress notes revealed a note dated February 3, 2025, at 10:27 PM, that indicated, in part, Resident continues with rash to entire body. Resident reports feeling itchy and noted taking clothes off to scratch .[NAME] itch lotion applied. Resident stated it helped her not feel itchy. Review of Resident 37's care plan failed to reveal any documentation of the presence of any rash or their interventions for the treatment of the rash. During a staff interview with the NHA and DON on February 6, 2025, at 11:26 AM, the DON confirmed that Resident 37's rash should have been included on their care plan. Review of Resident 58's clinical record revealed diagnoses that included dementia, heart failure, and hydronephrosis (a condition where one or both kidneys swell due to a blockage or obstruction that prevents urine from draining properly). Review of Resident 58's physician orders revealed an order for quetiapine (Seroquel) [an antipsychotic medication] 25 mg tablet give 12.5 mg by mouth at bedtime for dementia, dated October 22, 2024. Review of Resident 58's Significant Change MDS with the with the assessment reference date of October 29, 2024, revealed in Section V. Care Area Assessment Summary that the Resident received an antipsychotic medication daily. The summary also indicated that these areas would be care planned. Review of Resident 58's Quarterly MDS with the with the assessment reference date of November 8, 2024, revealed in Section N. Medications that the Resident was still receiving an antipsychotic medication daily. Review of Resident 58's care plan failed to reveal any documentation of their antipsychotic medication use or their identified target behaviors the antipsychotic medication was being utilized to manage. Email communication received from NHA on February 5, 2025, at 8:33 PM, indicated that Resident 58's care plan was updated to reflect antipsychotic use. During a staff interview with the NHA and DON on February 6, 2025, at 11:20 AM, the DON confirmed that Resident 58's care plan should have included their antipsychotic medication use as well as their identified target behaviors. 42 CFR 483.21(b) Comprehensive Care Plans 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(5) Nursing services

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 33879 Based on observation, policy review, clinical record review, and staff interviews, it was determined that the facility failed to provide care and services to promote healing and prevent infection in accordance with professional standards for one of two residents reviewed for pressure ulcers (Resident 2). Findings include: Review of facility policy, titled Enhanced Barrier Precautions, last reviewed January 17, 2025, revealed the facility's policy stated, It is the policy of the this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Review of the aforementioned policy revealed section 2. Initiation of Enhanced Barrier Precautions, subsection b stated, An order for enhanced barrier precautions will be obtained for residents with any of the following .Wounds (e.g., chronic wounds such as pressure ulcers .even if the resident is not known to be infected or colonized with a [multi-drug resistant organism. Section 3, Implementation of Enhanced Barrier Precautions, subsection a stated, Make gowns and gloves available immediately near or outside of the resident's room . Further, review of subsection 9 Droplet Precautions, revealed it included, f. Based upon the pathogen or clinical syndrome, if there is risk of exposure of mucous membranes or substantial spraying of respiratory secretions is anticipated, gloves and gown as well as goggles (or face shield) should be worn. Review of Resident 2's clinical record on February 4, 2025, revealed diagnoses that included dementia (progressive, irreversible degenerative disease of the brain that results in decreased contact with reality and decreased ability to perform activities of daily living) and hypertension (elevated/high blood pressure). Review of Resident 2's clinical record revealed Resident 2 had an unstageable pressure injury (wound of the skin that has an undetermined depth due to the wound bed being covered with dead tissue or other wound debris) of the third toe on the right foot. Prior to wound treatment observation on February 5, 2025, at approximately 12:45 PM, Employee 3 (Licensed Practical Nurse) stated that Resident 2 had been diagnosed with influenza. Prior to entering Resident 2's room for wound treatment observation on February 5, 2025, at approximately 12:50 PM, the door to Resident 2's room was observed to have a sign that stated the room was on droplet precautions, which required the use of a facemask and gloves. Upon entering Resident 2's room, it was observed that a sign indicating enhanced barrier precautions (use of gloves, mask, gown when performing high contact procedures such as wound treatment) was attached the back of Resident 2's door. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employee 3 was observed entering the Resident room with a facemask and was observed performing hand hygiene and glove changes while performing the wound treatment to Resident 2's toe; however, Employee 3 did not place a gown on during the wound treatment, per Enhanced Barrier Precautions. During a staff interview after the wound treatment, Employee 3 was asked about the Enhanced Barrier Precaution sign. Employee 3 stated that Resident 2 was placed on droplet precautions for influenza and was no longer on Enhanced Barrier Precautions, which is why the sign for Enhanced Barrier Precautions was on the back of Resident 2's door. During a staff interview on February 5, 2025, at approximately 1:30 PM, Director of Nursing (DON) revealed that Resident 2 would still be considered under the Enhanced Barrier Precaution protocol while also under droplet precautions. During the staff interview, DON confirmed that possible coughing by Resident 2 could present possible exposure to respiratory secretions for those in the room. DON revealed that Employee 3 should have worn a gown while performing the treatment to Resident 2's pressure ulcer per the Enhanced Barrier Precaution requirements. 28 Pa code 211.12(d)(1)(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. 47966 Based on record review, observation, and staff interviews, it was determined that the facility failed to prevent accident and hazards for two of 18 residents reviewed (Residents 35 and 47.) Findings include: Review of Resident 35's clinical record revealed diagnoses that included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and, eventually, the ability to carry out the simplest tasks) and hyperlipidemia (high levels of fats in the bloodstream). Review of Resident 35's fall incident report that occurred on September 8, 2024, revealed Resident 35 had an un-witnessed fall that occurred in the Resident's bathroom. The Incident Description revealed, in part, This writer was called to residents' room related to unwitnessed fall in bathroom. [NAME] noted to foot of bed in residents' room. Bathroom call bell was not activated. Staff reports assisting resident to the bathroom and providing her with the call bell prior to fall. No staff member present in the bathroom when resident attempted to get herself off the toilet. No apparent injuries noted. Review of Resident 35's comprehensive care plan revealed an Activities of Daily Living (ADL) focus area with an intervention for toilet use: assist of one, with an initiation date of June 13, 2024; and an intervention for transfer: one assist with rolling walker and gait belt, with an initiation date of June 13, 2024. During an interview with Employee 3 on February 5, 2025, at 12:09 PM, revealed Resident 35 was not able to use her call bell and does not ever use it. During an interview with Employee 4 on February 5, 2025, at 9:57 AM, revealed Resident 35 did not understand how to use their call bell, and will often yell out instead when the Resident needed assistance. During an interview with Employee 5 on February 5, 2025, at 9:43 AM, revealed Resident 35 did not understand how to use their call bell. Review of Resident 35's clinical record reveals the Resident has a BIMS (brief interview for mental status) score of 3, which suggest severe cognitive impairment. During an interview with the Nursing Home Administrator (NHA) on February 5, 2025, revealed that Resident 35 should not have been left alone in the bathroom during the fall incident that occurred on September 8, 2024, and that the staff member involved was terminated. NHA revealed they determine if a resident is able to use a call bell based off of their BIMS in most circumstances. Review of Resident 47's clinical record revealed diagnoses that included dementia (a brain disorder that causes a decline in cognitive function, memory, and behavior, severe enough to interfere with daily life) and hypertension (high blood pressure). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on February 3, 2025, on 1:04 PM, revealed Resident 47 was not in their room, although there was a fall mat on the floor to the left side of their bed. Review of Resident 47's comprehensive care plan revealed a focus area for being a fall risk with an intervention for their fall mat to left side of bed when Resident in bed. Remove when out of bed, with an initiation date on April 8, 2024. Review of Resident 47's clinical record revealed an incident note on December 17, 2024, that read, in part, A staff member responded to an unwitnessed fall in Resident 47's room. Arrived to Resident 47 sitting on the left side of her bed leaning up against her bed with grip socks on and fall mat not in place. No injuries were found. Staff educated on placing fall mat. During an interview with the NHA on February 5, 2025, at 8:32 PM, revealed education was provided in ensuring Resident 47's fall mat is properly in place. 28 Pa. Code 201.18(b)(1)(2)Management 28 Pa. Code 211.12(d)(3)(5)Nursing services

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 46253 Based on facility policy review, clinical record review, and staff and resident representative interviews, it was determined that the facility failed to ensure proper monitoring to maintain acceptable parameters of nutritional status for three of six residents reviewed for nutrition or hydration (Residents 17, 28, and 58). This failure resulted in harm for Resident 17, as evidenced by significant weight loss. Findings include: Review of facility policy, titled Weight Monitoring, last reviewed January 17, 2025, read, in part, The facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the residents clinical condition demonstrates this is not possible or residents preferences indicate otherwise .the facility will utilize a systematic approach to optimize a residents nutritional status. This process includes .Monitoring the effectiveness of interventions and revising them as necessary .Residents with weight loss-monitor weight weekly .the physician should be informed of a significant change in weight and may order nutritional interventions .The Registered Dietitian or Dietary Manager should be consulted to assist with interventions; actions are recorded in the nutrition progress notes .the interdisciplinary plan of care communicates care instructions to staff. Review of Resident 17's clinical record revealed diagnoses that included vascular dementia (a type of dementia caused by brain damage from impaired blood flow marked by memory disorders, personality changes, and impaired reasoning), dysphagia (difficulty swallowing), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest in things). Review of Resident 17's clinical record revealed he had oral surgery on May 20, 2024, with recommendation to follow a soft diet for a week after surgery. Review of Resident 17's physician orders revealed a diet order, Regular diet, Mechanical Soft texture, Regular/Thin consistency, Soft diet is recommended for first week post extractions, with a start date of May 20, 2024, and discontinued May 27, 2024. Review of Resident 17's physician orders revealed a diet order, Regular diet, Regular texture, Regular/Thin consistency, mechanical soft meats; add gravy to meats, with a start date of May 28, 2024, and discontinued on June 16, 2024. Review of Resident 17's physician orders revealed a change to the diet order on June 16, 2024, Regular diet, Puree texture, Regular/Thin consistency. Review of Resident 17's clinical record revealed a progress note on June 16, 2024, that stated Resident was in dining room at lunch and resident was observed coughing on corn. Resident was able to clear the corn. Resident also noted to be coughing on mechanical soft ground ham. Spoke with resident and resident is ok with puree foods. Spoke with POA (power of attorney- legal representative) who was unaware that resident went back to Regular diet mechanical soft meats. POA is ok with resident being pureed. Dietary made aware. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 17's clinical record revealed a significant weight loss of 28 pounds (-10.4%) from April 23, 2024, to October 18, 2024. Review of Resident 17's clinical record revealed a dietitian note on October 25, 2024, that read, in part, Review of monthly weight. Current weight of 241.8 pounds (October 18, 2024) triggers as a significant loss in 6 months. Weight fluctuations anticipated related to diuretic therapy. Recommending weekly weights to monitor trend. Resident continues to tolerate a regular diet, puree, thin liquids. Weight loss and intake reviewed with POA; POA is not interested in supplementation at this time. POA sees weight loss as beneficial. Care plan reviewed/updated. A follow up dietitian note was linked to the aforementioned note on October 29, 2024, that read, Per nursing, resident with decreased snacking between meals; may contribute to weight loss. Review of Resident 17's physician orders on February 5, 2025, revealed that the diuretic was not a new medication for him, and he had been on it since March 1, 2023. Review of Resident 17's physician orders revealed an order to Weigh weekly every day shift every Monday, with a start date of October 28, 2024. Review of Resident 17's clinical record failed to reveal weekly weights were obtained on the week of November 11 and 18, 2024. During an email correspondence with the Nursing Home Administrator (NHA) on February 5, 2025, at 11:49 AM, the surveyor inquired if the aforementioned weekly weights were obtained, she revealed, These weights were not obtained. On November 11, 2024, the PRN [as needed] nurse who was working didn't sign off with no explanation. On November 18, 2024, the agency nurse signed off saying it would be obtained on 3-11 shift, but the weight was then missed by 3-11. Additionally, during the email correspondence with the NHA on February 5, 2025, at 11:49 AM, she revealed [Physician notification of] weight loss missing on [Resident 17] due to communication between dietitian and POA stating she felt the weight loss was ok due to his current weight. Therefore, no notification was made to the physician. We had lots of conversation at interdisciplinary meetings around this as [Resident 17] had recently had oral surgery and was not snacking as prior. He also had been downgraded to puree diet and he was not happy with his meal options. All weight loss (anticipated and not) is discussed at QAPI (quality assurance meeting) monthly. [Resident 17's] weight loss situation did not follow normal protocol due to circumstances explained. In an additional interview with the NHA on February 5, 2025, at 1:39 PM, she stated that residents with weight loss are discussed in QAPI, and the physician signs the QAPI sign in sheet. No physician notification or response to the weight loss was noted in Resident 17's medical record. Review of Resident 17's weight measures revealed his weight loss continued 8.8 pounds (-3.6%) from October 18, 2024, to December 2, 2024. Review of Resident 17's clinical record revealed a dietitian note on December 4, 2024, that read, in part, Weight and intake reviewed with [POA]; she maintains wish for no supplementation at this time. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Further review of Resident 17's weight measures revealed his weight loss continued 8.2 pounds (-3.5%) from December 2, 2024, to January 20, 2025. Review of Resident 17's clinical record revealed a physician note written by Employee 6 (Medical Director) on January 30, 2025, that read, Resident weight noted down some, intake good, on Lasix [diuretic medication] monitor [electro]lytes, NAD, today eating lunch. Interview with Employee 2 (Registered Dietitian) on February 5, 2025, at 1:35 PM, revealed she was concerned about Resident 17's weight loss, but the Resident's POA did not want him on supplements. During an interview with the NHA and the Director of Nursing (DON) on February 5, 2025, at 1:39 PM, revealed the weekly weights that were missed should have been obtained per physician order, and that Resident 17 has remained on a puree diet because his POA refused speech therapy services for a potential diet upgrade. The surveyor requested documentation in the medical record to indicate the refusal of speech therapy services and any physician involvement in response to weight loss prior to January 30, 2025. Interview with Resident 17's POA on February 6, 2025, at 2:58 PM, revealed she did not refuse speech therapy services and that, when supplements were discussed with her, she was concerned that Resident 17 needs more food rather than supplements, and he would eat more food if he wasn't on a puree diet. Follow-up interview with the NHA and DON on February 6, 2025, at 3:38 PM, the surveyor revealed the concern with lack of documentation to indicate speech therapy services were refused and lack of physician response to the significant weight loss, no further information was provided. The Resident was noted to have significant weight loss. The Resident was not reassessed by speech therapy after his diet was downgraded in June 2024. There was no evidence that a speech therapy consult or supplements were discussed with the physician. There were no physician progress notes that addressed Resident 17's weight loss from when his weight loss became significant in September 2024, until January 30, 2025. Review of Resident 28's clinical record revealed diagnoses that included heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs), chronic kidney disease (longstanding disease of the kidneys leading to renal failure), and dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning). Review of Resident 28's physician orders revealed an order for Daily weight - Notify MD if increase of 3 pounds in 24 hr or gain/loss of 5 pounds in 1 week every night shift for fluid balance management, with an original order date of October 26, 2024. Review of Resident 28's Treatment Administration Record for October revealed that on October 28, 2024, the weight and signature box were both blank; October 30, 2024, was signed as completed on night shift but the box where the weight was to be entered was marked with an X and the entries for the weight and signature boxes on day shift were blank; and October 31, 2024, was signed as completed on night shift with an X marked in the box where the weight was to be entered. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of additional information provided by the facility revealed that Resident 28 weighed 144 pounds on October 30, 2024, and weighed 152.3 pounds on October 31, 2024, indicating an 8.3-pound weight gain in 24 hours. Review of Resident 28's progress notes failed to reveal any documentation that their physician was notified of the greater than 3-pound weight gain in 24 hours on October 31, 2024. Review of Resident 28's Treatment Administration Record for November 2024 revealed that the Resident refused their weight on November 15 and 24, 2024. All other entries for the month were signed that the weight was obtained, but the box where the weight was to be entered was marked with an X. Review of Resident 28's Treatment Administration Record for December 2024 revealed that on December 10 and 11, 2024, the weight and signature box were both blank; December 1-9, and 12-20, 2024, were signed that the weight was obtained, but the box where the weight was to be entered was marked with an X. Further review of Resident 28's Treatment Administration Record for December 2024 revealed that on December 24, 2024, the Resident weighed 146.8 pounds and on December 25, 2024, weighed 150 pounds; indicating a 3.2-pound weight gain in 24 hours. In addition, on December 28, 2024, the Resident weighed 153.5 pounds and on December 29, 2024, weighed 156.8 pounds; indicating a 3.3-pound weight gain in 24 hours. Review of Resident 28's progress notes failed to reveal any documentation that their physician was notified of the greater than 3-pound weight gain in 24 hours on December 25 or 29, 2024. Review of Resident 28's Treatment Administration Record for January 2025 revealed that the Resident refused their weight on January 11, 13, 16, 17, and 24, 2025; and on January 1 and 19, 2025, the weight and signature boxes were both blank. Further review of Resident 28's Treatment Administration Record for January 2025 revealed that on January 29, 2025, the Resident weighed 150.8 pounds and on January 30, 2025, weighed 157 pounds; indicating a 6. 2-pound weight gain in 24 hours. Review of Resident 28's progress notes failed to reveal any documentation that their physician was notified of the greater than 3-pound weight gain in 24 hours on January 30, 2025. Review of Resident 28's Treatment Administration Record for February revealed that on February 1 and 4, 2025, the weight and signature boxes were both blank. Further review of Resident 28's clinical record revealed a nutrition/dietary note dated October 28, 2024, at 12:04 PM, that indicated a comprehensive nutrition assessment had been completed when Resident 28 returned from a hospital stay. The note indicated that Resident 28 had experienced a significant weight gain over 30 days, 3 months, and 6 months. There was a late entry nutrition/dietary note dated October 28, 2024, at 3:28 PM, that indicated Resident 28 had experienced a significant weight loss following hospitalization , not a significant gain as previously documented. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 28's progress notes revealed a physician's progress note dated October 29, 2024, at 4:27 PM, which indicated that Resident 28 was seen post hospital stay and the vital signs and appetite were ok and that the Resident had minimal edema (swelling) to their bilateral legs. There was no documentation of an assessment of Resident 28's significant weight loss. Email communication received from the NHA on February 5, 2025, at 8:33 PM, indicated that she acknowledged Resident 28 had missing weights. During an interview with the NHA, DON, and Employee 2 (Dietician) on February 6, 2025, at 11:53 AM, Employee 2 confirmed that Resident 28 had a significant weight loss upon return to the facility from a hospital stay. Employee 2 indicated that the weight loss was reviewed with Resident 28's physician during the Quality Assurance Performance Improvement (QAPI) Meeting on November 15, 2024. The DON confirmed that she would expect staff to obtain and document resident weights as ordered and that staff should have notified Resident 28's physician of the greater than 3-pound weight gains as per physician order. Email communication received from the NHA on February 6, 2025, at 1:29 PM, confirmed that Resident 28's October 28, 2024, weight loss was reviewed in the facility's QAPI Meeting on November 15, 2024, at which Resident 28's physician was in attendance. She confirmed that she had no information to provide that the physician assessed Resident 28 for their weight loss. In addition, the NHA confirmed that she would expect that Resident 28's daily weights to be obtained, documented, and physician follow-up completed as indicated in the order. During a staff interview with the NHA and the DON on February 6, 2025, at 2:10 PM, the NHA acknowledged that the Resident 28's physician was not made aware of their weight loss identified on October 28, 2024, until November 15, 2024. During a final staff interview with the NHA, DON, and Employee 2 on February 6, 2025, 2:25 PM, the DON indicated that she could not give a direct expectation of physician notification of a weight loss because it is on a case-by-case basis. She said that she felt Resident 28's physician was aware that she had been hospitalized in October and that he would have been aware of treatment received at the hospital regarding her fluid status and the continued monitoring at the facility. Review of Resident 58's clinical record revealed diagnoses that included dementia, heart failure, and dysphagia (difficulty swallowing). Review of Resident 58's progress notes revealed a weight change note dated August 1, 2024, at 3:56 PM, that indicated Resident 58's weekly weights were reviewed and that Resident 58 current weight triggered as a significant loss (7.1%) over 30 days. The note also indicated that the weight fluctuations would be anticipated related to diuretic therapy. Review of Resident 58's progress notes revealed a nutrition/dietary note dated August 16, 2024, at 10:06 AM, that indicated that Resident 58's weekly weights were reviewed and that Resident 58's weight was fairly stable over approximately a 3-week span, but the Resident continued to trigger for a significant loss over 30 days. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 58's physician progress notes that were dated August 7, 11, 15, 16, 22, and 28, 2024, all of which failed to reveal any documentation of them being aware of or evaluating Resident 58's significant weight loss. Review of Resident 58's clinical record revealed a nutrition/dietary note dated October 24, 2024, at 3:00 PM, that indicated a comprehensive nutrition assessment was completed upon the Resident's return to the facility from a hospital stay, and Resident 58 was noted to have a significant loss over 30 and 180 days following hospitalization . The note further indicated that weekly weight monitoring was in place per admission protocol, that Resident 58's oral intake was not adequate to meet needs, and supplements were added. Review of Resident 58's physician progress notes revealed notes that were dated October 25, 28, 29, and 30, 2024, all of which failed to reveal any documentation of them being aware of or evaluating Resident 58's significant weight loss. Review of Resident 58's Treatment Administration Record for November 2024 revealed that on November 18, 2024, it was signed that the weight was obtained, but the box where the weight was to be entered was marked with an X. Email communication from the NHA on February 5, 2025, at 8:33 PM, regarding Resident 58's identified weight losses on August 1 and 16, 2024, the dietician documented that weight was stable and that weight loss was anticipated due to diuretic therapy and this would not be considered emergent and would be discussed at QAPI. The NHA further indicated that in November 2024 and December 2024 Resident 58's weight loss remained on the dietician's report and that there was still monitoring of the weight loss. She also indicated that Resident 58's weight loss was first discussed in August QAPI meeting reports, in which Resident 58's physician participated. During a staff interview with the NHA, DON, and Employee 2 on February 6, 2025, at 12:20 PM, the NHA confirmed that they could not provide any information for Resident 58's weight being signed as completed with no weight recorded on November 18, 2024. She said that she would expect weights to have been obtained as ordered by the physician. She again indicated that weight losses were reviewed with the physician during the facility's monthly QAPI meeting. She confirmed that there was no physician documentation regarding Resident 58's weight loss. During a final staff interview with the NHA, DON, and Employee 2 on February 6, 2025, at 2:25 PM, the DON indicated that she could not give a direct expectation of physician notification of weight loss because it is on a case-by-case basis. 28 Pa Code 201.18(b)(1) Management 28 Pa Code 211.2(d)(3) Medical director 28 Pa Code 211.12(c)(d)(1)(2)(3)(5) Nursing services

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 33879 Based on clinical record review, policy review, and staff interviews, it was determined that the facility failed to adequately monitor possible side effects and target behaviors for two of five residents reviewed for unnecessary psychotropic medications (Residents 53 and 58). Findings include: Review of facility policy, titled Psychoactive Medication Policy, last reviewed January 17, 2025, revealed subsection Psychoactive Medication Monitoring, stated, 'Monitoring' is the ongoing collection and analysis of information and comparison to resident baseline in order to [sic] [a]scertain the resident's response to treatment and care, including progress or lack of progress toward therapeutic goal[;] [d]etect complications or adverse consequences of the condition or of the treatments[; and,] [s]upport decisions to modify, discontinue, or continue any interventions. Further review of the aforementioned policy revealed subsection, titled Psychoactive Medication Monitoring Procedure, revealed it stated, Behavior Management Flow Records (BMFR) will be utilize to record and monitor the number of mood/behavior events each shift, non-pharmacological interventions attempted, and observed adverse consequences . Review of Resident 53's clinical record on February 4, 2025, revealed diagnoses that included dementia (irreversible, progressive degenerative brain disease that results in decreased contact with reality and decreased ability to perform activities of daily living) and hypertension (elevated/high blood pressure). Review of Resident 53's physician's orders revealed an order for Abilify (atypical antipsychotic medication used to treat mental health disorders) 2 mg (milligrams - metric unit of measure) once a day for the indication of hallucinations, which was most recently ordered on December 11, 2024. Review of Resident 53's care plan for the use of the atypical antipsychotic medication, with the focus of, [Resident 53] uses psychotropic medications [related to] [diagnosis] hallucinations, revealed the intervention to monitor possible side effects, specific to the use of an atypical antipsychotic medication, which included . unsteady gait, tardive dyskinesia [chronic, involuntary movement disorder that can occur with long-term us of antipsychotic medication], EPS [extrapyramidal symptoms] (shuffling gait, rigid muscles, shaking) . Review of Resident 53's monitoring for side effects of Abilify, documented by licensed nursing staff in Resident 53's Medication Administration Record (documentation tool utilize to record when medication, treatments, and/or other identified care and services ordered by the physician are completed), revealed the side effect monitoring for the Abilify medication was listed as an anti-depressant. Review of the specific symptoms monitored revealed that it did not include the side effects specific to antipsychotic medications as listed above and included in Resident 52' care plan. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a staff interview on February 6, 2025, at approximately 11:30 AM, Director of Nursing (DON) confirmed that the side effect monitoring for Resident 52's atypical antipsychotic medication did not include the side effects specific to antipsychotic medications. During the interview, it was confirmed that side effect monitoring for Resident 52 was changed to include the items identified in the care plan. Further, review of Resident 52's clinical record failed to reveal documented monitoring of Resident targeted behaviors and/or hallucinations. During the staff interview on February 6, 2025, DON confirmed that Resident 52 did not have behavior monitoring in place but that, it had been added as a result of the review. Review of Resident 58's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and depression. Review of Resident 58's physician orders revealed an order for quetiapine (Seroquel) [an antipsychotic medication] 25 mg tablet give 12.5 mg (milligrams) by mouth at bedtime for dementia, dated October 22, 2024; Ativan Oral Tablet 0.5 MG (lorazepam) Give 0.5 mg by mouth every 12 hours for Anxiety, dated October 22, 2024; and Cymbalta Oral Capsule Delayed Release Particles 30 MG (Duloxetine HCl) Give 60 mg by mouth one time a day for Depression, dated October 22, 2024. Review of Resident 58's clinical record revealed that nursing staff were monitoring for potential side effects of antipsychotic, antianxiety, and antidepressant medication use on their Medication Administration Records until October 18, 2024, at which time they were sent to the hospital for an acute illness. Further review of Resident 58's clinical record failed to reveal any documentation of what their actual identified target behaviors were, nor any monitoring of those target behaviors. Review of Resident 58's care plan failed to reveal any documentation of their antipsychotic medication use, potential side effects to monitor for, or their identified target behaviors for which the antipsychotic medication was being utilized to manage. During a staff interview with the Nursing Home Administrator (NHA) and DON on February 6, 2025, at 11:20 AM, the DON confirmed that Resident 58's care plan should have included their antipsychotic medication use, side effects to monitor for, as well as their identified target behaviors. She indicated that nurse aides document on the task documentation any behaviors that they observe. She further indicated that the facility expectation was that the Licensed Practical Nurse assigned to the Resident would write a progress note if a resident was exhibiting behaviors. She said the side effect monitoring was included in the Resident's orders until her hospitalization and, when she came back, it was not caught. DON confirmed that she would expect the side effect monitoring of Resident 58's antipsychotic, antianxiety, and antidepressant medications to have been included on their care plan and in their orders for documentation and monitoring purposes. She confirmed that she had no documentation to provide which would indicate Resident 58's identified target behaviors. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Email communication received from the NHA on February 5, 2025, at 8:33 PM, indicated that Resident 58's care plan was updated to reflect their antipsychotic medication use and that their newly formed psych[iatric] review team had been working with pharmacy and geriatric psychiatry consultant, as well as the Medical Director, to ensure that gradual dose reductions, pharmacy recommendations, and regulations were followed. She further indicated that they would add to that meeting a review of a Resident's behavior monitoring tool in the task section of electronic health record with each Resident review. Email communication received from the NHA on February 6, 2025, at 12:53 PM, the NHA confirmed that she would expect Resident 58's care plan to have included their antipsychotic medication use and that Resident 58's identified target behaviors should have been identified and care planned. The NHA further indicated that it was not facility practice for nursing staff to document and track behaviors on a Resident's Medication or Treatment Administration Record. The NHA confirmed that Resident 58's antipsychotic, antianxiety, antidepressant side effect monitoring should have been on their Medication Administration Record for staff to complete on every shift. 28 pa code 211.12(d)(1)(3)(5) Nursing services

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. 33879 Based on clinical record review, resident and staff interviews, and facility document review, it was determined that the facility failed to ensure residents are assisted with obtaining routine dental care for one of one residents reviewed for dental care (Resident 52). Findings include: Review of Resident 52's clinical record on February 3, 2025, revealed diagnoses that included hypertension (elevated/high blood pressure) and diabetes mellitus type two (decreased ability of the body to utilize insulin for the transport of glucose from the blood stream into the cells for nourishment). During a resident interview on February 3, 2025, Resident 52 indicated that he was awaiting teeth extraction of his upper teeth in order to have a full-upper denture created. During the interview, Resident 52 stated that he had a partial top denture that moves around as he eats. Review of Resident 52's clinical record revealed a dental consultation that was conducted on October 21, 2024. Review of the dental consultation sheet revealed that section Treatment notes, stated, [Patient] wears upper partial denture. [Patient] removed upper partial. Noted [patient] appears to have retained root tips under existing upper partial . recommend FMX [x-rays of the mouth] in order to evaluate dentition .will follow up with [patient] following xrays .[patient] will be set up for a oral surgery consult for extractions following xray review . Further, review of consult sheet's Recommended treatment, section revealed the box for Other X-Ray; FMX needed to evaluate dentition. Review of Resident 52's clinical record on February 5, 2025, revealed that, as of review, Resident 52 had not had any dental x-rays completed, nor had there been any consultation order for the extraction of Resident 52's upper teeth. Review of facility document, titled Visit Summary, submitted on February 6, 2025, at 2:29 PM, revealed it was a document that listed the Resident's evaluated on October 21, 2025, along with recommendations and/or orders made by the dentist, and future treatment(s) recommended by the dentist. Review of the Visit Summary, revealed Resident 52's Recommendations / Orders, and Future Treatment(s), did not include the recommendation identified on Resident 52's individual dental consult sheet of dental x-rays and surgical consult for extraction of teeth. During a staff interview on February 6, 2025, at approximately 3:20 PM, Nursing Home Administrator revealed that the physician reviews the Visit Summary and would provide orders that were indicated on that sheet, and since the recommendations identified on Resident 52's individual dental consultation form were not included in the Visit Summary document, Resident 52 would not have had further treatment or consultation. 28 Pa code 211.12(d)(3)(5) Nursing services (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa code 211.15 Dental services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48484 Based on review of select facility documentation and staff interviews, it was determined that the facility failed to utilize kitchen equipment in accordance with professional standards for food service safety in the main kitchen. Findings include: Review of the forms, titled Dish Machine Temperature Log, utilized by the kitchen, read, in part, Keep temperature log on file for 1 year. Record Temperatures once per meal period. Review of the May 2024 Dish Machine Temperature Log revealed dish machine temperatures failed to be recorded on May 10, 14-17, 28, 30, and 31 at breakfast; May 7-18, 27, 28, 30, and 31 at lunch; and May 1-31 at dinner. June and July 2024 Dish Machine Temperature Logs failed to be provided. Review of the August 2024 Dish Machine Temperature Log revealed dish machine temperatures failed to be recorded on August 10 and 14 at lunch; and August 1-31 at dinner. Review of the September 2024 Dish Machine Temperature Log revealed dish machine temperatures failed to be recorded on September 1-30 at dinner. Review of the October 2024 Dish Machine Temperature Log revealed dish machine temperatures failed to be recorded on October 1-31 at dinner. Review of the November 2024 Dish Machine Temperature Log revealed dish machine temperatures failed to be recorded on November 1-30 at dinner. Review of the December 2024 Dish Machine Temperature Log revealed dish machine temperatures failed to be recorded on December 1-31 at dinner. Review of the January 2025 Dish Machine Temperature Log failed to reveal dish machine temperatures were logged during dinner on January 1-30; temperatures failed to be logged during all meal periods on January 31. Interview with Employee 8 (Food Service Director) on February 5, 2025, at 12:30 PM, revealed it's possible staff are not logging temperatures during dinner since management is not there to supervise. He further revealed he was unable to locate the June 2024 and July 2024 dish machine temperature logs. Interview with the Nursing Home Administrator on February 5, 2025, at 1:30 PM, revealed it is the facility's expectation that kitchen equipment is utilized in accordance with professional standards. 28 Pa. Code 201.18(b)(1) Management

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 33879 Based on observations, facility policy review, and staff interviews, it was determined that the facility failed to ensure staff implemented infection control policies to prevent the spread of infection by using PPE (personal protective equipment) in two of four resident care areas reviewed (Love one and Love two), and failed to handle potentially contaminated items to decrease the possibility for transmission of a infectious disease for one of one unit treatment carts observed (Love unit treatment cart). Findings Include: Review of facility policy, Transmission-Based (Isolation) Precautions, last reviewed January 17, 2025, revealed that, Contact precautions refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment. Further review of this policy under the section labeled, Contact Precautions, revealed that healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. Also, donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination. Review of the aforementioned policy, revealed subsection 7-g, stated, Use disposable or dedicated noncritical resident-care equipment .If sharing noncritical equipment between residents, the equipment will be cleaned and disinfected following manufacturer's instructions with an EPA-registered disinfectant after use. Review of Resident 2's clinical record on February 4, 2025, revealed diagnoses that included dementia (progressive, irreversible degenerative disease of the brain that results in decreased contact with reality and decreased ability to perform activities of daily living) and hypertension (elevated/high blood pressure). Review of Resident 2's clinical record revealed Resident 2 had an unstageable pressure injury (wound of the skin that has an undetermined depth due to the wound bed being covered with dead tissue or other wound debris) of the third toe on the right foot. Prior to wound treatment observation on February 5, 2025, at approximately 12:45 PM, Employee 3 (Licensed Practical Nurse) stated that Resident 2 had been diagnosed with influenza. Observation of Resident 2's room door revealed Resident 2 was on droplet precautions (use of gloves, mask, eye protection, and gown-if there is a risk of contamination e.g., coughing, aerosol treatments, splatter of infectious bodily fluids). Prior to wound treatment, Employee 3 was observed removing supplies from the Love unit treatment cart, which included individually packaged gauze. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During wound treatment observations, Employee 3 was observed placing the treatment supplies on Resident 2's bedside table. After Employee 3 was finished with the wound treatment to Resident 2's right third toe, Employee 3 was observed moving an unused, unopened pack of gauze from the bedside table to Resident 2's bed. Employee 3 was observed retrieving the pack of gauze from Resident 2's bed, exiting the room, and returning the pack of gauze into the box in the treatment cart from where they were removed. During a staff interview directly after the observation, Employee 3 confirmed that the gauze were in the Resident's room, who was on droplet precaution for influenza and that the gauze made contact with Resident 2's table and bed. Employee 3 was observed then removing the box of gauze from the treatment cart. During a staff interview on February 5, 2025, at approximately 1:30 PM, Director of Nursing (DON) revealed that Employee 3 should have discarded the pack of gauze and not returned them to the treatment cart. Review of Resident 5's clinical record revealed diagnoses that included dysphagia (difficulty swallowing foods or liquids) and dementia (a brain disorder that causes a decline in cognitive function, memory, and behavior, severe enough to interfere with daily life). Observation of Resident 5 on February 3, 2025, at 12:45 PM, revealed the Resident was laying in bed in their room. There was a sign on the door that revealed Resident 5 was on droplet precautions, that further read: Everyone must clean their hands, including before entering and when leaving the room. Make sure their eyes, nose, and mouth are fully covered before room entry. Remove face protection before room exit. Further observation on February 3, 2025, at 12:46 PM, revealed Employee 7 enter room to provide Resident 5 their lunch tray, exit their room and enter another resident's room, then back into Resident 5's room and proceeded to assist Resident 5 in eating their lunch. Employee 7 did not perform any hand hygiene prior to entering Resident 5's room or upon exiting Resident 5's room, and did not wear any face protection upon entering their room. Review of Resident 5's current physician orders reveal an order for Droplet precautions for influenza A, with an active date of January 30, 2025. During an interview with the Nursing Home Administrator (NHA) on February 5, 2025, at 8:32 PM, confirmed that droplet precautions were not followed during the observation of Resident 5 being served lunch by Employee 7 on February 3, 2025. Review of Resident 25's clinical record revealed diagnoses that included diabetes (a chronic disease that occurs when your blood sugar levels are too high) and dementia (a group of diseases and illnesses that affect your thinking, memory, reasoning, personality, mood and behavior). Observation of Resident 25 on February 3, 2025, at 10:17 AM, revealed the Resident 25 sitting in her room. There was a sign on the door that revealed that the Resident was on contact precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further observation at 12:19 PM, on February 3, 2025, revealed Employee 1 enter Resident 25's room to bring the Resident's lunch and set it up for Resident 26 to eat. Employee 1 then exited the room and continued taking meal trays to other residents. At no time did Employee 1 use any PPE while in Resident 25's room or even perform hand hygiene. Review of Resident 25's electronic medical record on February 3, 2025, revealed that Resident 25 was tested for scabies (a contagious skin condition caused by mites burrowing into the skin) on January 30, 2025, and the test returned positive, indicating that Resident 25 had scabies. Review of Resident 25's physician orders on February 3, 2025, revealed an order dated January 30, 2025, that indicated that Resident 25 was to be on contact precautions. Interview of the NHA on February 6, 2025, at 11:15 AM, revealed that she would expect employees to follow the facility policies and guidance regarding residents on contact precautions. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 46253 Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to provide evidence that education was provided to Residents and/or their Representatives on the risks, benefits, or side effects of the influenza vaccine for two of five residents reviewed for immunizations (Residents 8 and 25). Findings Include: Review of facility policy, titled Influenza Vaccination with an implementation date of April 7, 2022, and a last review date of January 17, 2025, revealed, in part, 5. Prior to the administration of the influenza vaccine, the person receiving the immunization, or his/her legal representative, will be provided with a copy of CDC's current vaccine information statement relative to the influenza vaccination. 6. The vaccine information statements (VIS) will, as appropriate, be supplemented with visual presentations or oral explanations to assist vaccine recipients in understanding the benefits and potential side effects of the influenza vaccine. (See Vaccine Information Statements Policy.) 7. Individuals receiving the influenza vaccine, or their legal representative, will be required to sign a consent form prior to the administration of the vaccine. The completed, signed, and dated record will be filed in the individual's medical record. 9. The resident's medical record will include documentation that the resident and/or the resident's representative was provided education regarding the benefits and potential side effects of immunization, and that the resident received or did not receive the immunization due to medical contraindication or refusal. Review of Resident 8's clinical record revealed diagnoses that included hypertension (high blood pressure), diabetes (disease that occurs when your blood glucose, also called blood sugar, is too high), and severe dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning). Review of Resident 8's clinical record revealed that Resident 8's Representative refused the flu and RSV vaccination on September 4, 2024. Further review of Resident 8's clinical record revealed no evidence that Resident 8's Representative was educated on the benefits, risks, or potential side effects of the vaccine. Review of Resident 25's clinical record revealed diagnoses that included diabetes, hypertension, and protein-calorie malnutrition (nutritional status in reduced availability of nutrients leads to changes in body composition and function). Review of Resident 25's clinical record revealed that the Resident last received an influenza vaccine on September 27, 2024. Further review of Resident 25's clinical record revealed no evidence that Resident 25 or Resident 25's Representative were educated on the benefits, risks, and potential side effects of the vaccine. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395784	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Church of God Home, Inc	801 N. Hanover Street Carlisle, PA 17013

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a staff interview with Employee 10 (facility Infection Preventionist) on February 4, 2025, at approximately 1:40 PM, Employee 10 revealed that the facility does not utilize influenza or pneumococcal vaccine consent or declination forms. Employee 10 indicated that they speak with Residents and/or their Representatives, distribute the appropriate Vaccine Information Statement to the Resident and/or their Representative and that they then complete a note in the Resident's medical record regarding consent or refusal and education provided. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing on February 6, 2025, at 2:09 PM, the NHA confirmed that influenza vaccine education should have been provided to Residents 8 and 25 and/or their Representative and that documentation should have reflected such. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(2)(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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 46253 Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to provide evidence that education was provided to Residents and/or their Representatives on the risks, benefits, or side effects of the COVID-19 vaccine for two of five residents reviewed for immunizations (Residents 8 and 25). Findings Include: Review of facility policy, titled COVID-19 Vaccination with a last revised date of June 19, 2023, and a last review date of January 17, 2025, revealed 26. The resident's medical record will include documentation of the following: a. Education to the resident or resident representative regarding the risks, benefits, and potential side effects of the COVID-19 vaccine; b. Each dose of the vaccine administered to the resident, or c. If the resident did not receive the COVID-19 vaccine due to medical contraindication or refusal. Review of Resident 8's clinical record revealed diagnoses that included hypertension (high blood pressure), diabetes (disease that occurs when your blood glucose, also called blood sugar, is too high), and severe dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning). Review of Resident 8's clinical record revealed that Resident 8's Representative refused the COVID-19 vaccination on September 4, 2024. Further review of Resident 8's clinical record revealed no evidence that Resident 8's Representative was educated on the benefits, risks, or potential side effects of the vaccine. Review of Resident 25's clinical record revealed diagnoses that included diabetes, hypertension, and protein-calorie malnutrition (nutritional status in reduced availability of nutrients leads to changes in body composition and function). Review of Resident 25's clinical record revealed that the Resident last received a COVID-19 booster vaccine on October 20, 2024. Further review of Resident 25's clinical record revealed no evidence that Resident 25 or Resident 25's Representative were educated on the benefits, risks, and potential side effects of the vaccine. During a staff interview with Employee 10 (facility Infection Preventionist) on February 4, 2025, at approximately 1:40 PM, Employee 10 revealed that the facility does not utilize COVID vaccine consent or declination forms. Employee 10 indicated that they speak with Residents and/or their Representatives, distribute the appropriate Vaccine Information Statement to the Resident and/or their Representative and that they then complete a note in the Resident's medical record regarding consent or refusal and education provided. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395784	A. Building B. Wing	02/06/2025

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Church of God Home, Inc	801 N. Hanover Street Carlisle, PA 17013

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing on February 6, 2025, at 2:09 PM, the NHA confirmed that COVID vaccine education should have been provided to Residents 8 and 25 and/or their Representative and that documentation should have reflected such. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(2)(5) Nursing services