STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395788	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyview Nursing and Rehabilitation Center	107 Sunnyview Circle Butler, PA 16001

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to accommodate the call bell needs for one of five residents (Resident R110).Findings include: Review of facility policy Call Light Resident Response/Monitoring/Reporting dated 4/1/25, indicated the call system must be accessible to residents while in their bed or other sleeping accommodations within the resident's room. Review of the clinical record indicated Resident R110 was admitted to the facility on [DATE]. Review of Resident R110's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/1/25, indicated diagnoses of anemia (too little iron in the blood), muscle weakness, and need for assistance with personal care. During an observation on 7/21/25, at 10:22 a.m. Resident R110's call bell was observed hanging from the wall unit at the head of the bed, out of the resident's reach. During an interview on 7/21/25, at 10:26 a.m. Registered Nurse Employee E1 confirmed Resident R110's call bell was not accessible and unavailable for use to the resident and that the facility failed to accommodate Resident R110's call bell needs. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 211. 12(d)(1)(5) Nursing services.

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 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observations, resident interview, and staff interview it was determined that the facility failed to have complete contact information for State Long-Term Care Ombudsman program posted at the facility.During an observation on 7/25/25, at 11:17 p.m. on Roseview Hallway there was a poster with Ombudsman contact information which only consisted of the phone number, and did not have name, address, or email address listed. During an interview on 7/25/25, at 12507 p.m. The Nursing Home Administrator confirmed that the facility failed post the Ombudsman's name, address, and email address as required. 28 Pa. Code: 201. 14(a)Responsibility of licensee.28 Pa. Code: 201.18(b)(3) Management.

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, clinical records and staff interviews it was determined that the facility failed to follow up on a concern/grievance for a resident (Resident R106).Findings include: Federal Regulation 483. 10(i)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. Review of Resident R106 was admitted on [DATE]. Review of Resident R106 MDS dated [DATE], anemia, and need for personal assistance. Review of the clinical record progress notes dated 7/4/25, indicated that Resident R106 family member requested for Resident R106 to receive assistance with eating due to recent weight loss. Review of Resident R106 clinical record failed to include documentation for response to this concern. During an interview on 7/25/25, Nursing Home Administrator confirmed that the facility failed to address concern for Resident R106. 28 Pa. Code 201.29(a) resident rights

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical records, and staff and resident interviews it was determined was determined that the facility failed to protect resident from neglect for one of three residents (Residents R54).Findings include: Review of the facility Abuse Policy-Prevention and Management last reviewed 4/1/25, stated it is the facility prohibits the mistreatment, neglect, and abuse of residents. Neglect is the failure of the facility, it's employees or service providers to provide goods and services that a resident requires but the facility fails to provide them to the resident. Review of the facility policy Resident Transfer Protocol last reviewed 3/19/25, stated appropriate transfer techniques shall be used according to each resident's strength, stamina, and ability to assist with the residents. Necessity for the amount and type of assistance shall be assessed upon admission and on an ongoing basis. Review of Residents R54's admission record indicated the resident was admitted on [DATE], and readmitted [DATE]. Review of Residents R54's care plan dated 11/11/22, revised 10/28/24, revealed the resident had an activity of daily living (ADL-the basic self-care tasks essential for independent living, including bathing, dressing, transferring, and toileting) self -care deficit due left below the knee amputation. It was revealed Resident R54 required assistance from staff for toilet use. Review of Residents R54's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/22/25, revealed diagnoses of dementia (loss of cognitive functioning- thinking remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), acquired absence of left leg below the knee, and anxiety. Review of Resident R54's clinical record revealed Nurse Aide (NA), Employee E27 documented the resident was incontinent at 10:24 a.m. on 7/24/25. Review of Resident R54's clinical record revealed NA, Employee E27 documented the resident was provided assistance with toileting hygiene at 10:25 a.m. on 7/24/25. During an observation on 7/24/25, at 11:31 a.m. Resident R54 was observed lying in bed with a soiled gown saturated in urine. The resident's bed sheet was soiled with brown and yellow discoloration. A noticeable odor of urine was present. Review of the facility's assignment sheet on 7/24/25, at 11:34 a.m. revealed NA, Employee E27 was assigned to Resident R54. During an interview on 7/24/25, at 11:38 a.m. NA, Employee E54 confirmed Resident R54 was included in their assignment. NA, Employee E27 confirmed Resident R54 was saturated in urine and the resident's sheets needed to be changed. NA, Employee E27 confirmed they did not assist Resident R54 with toileting. During an interview on 7/24/25, at 11:47 a.m. information was disseminated to the Nursing Home Administrator that the facility failed to protect residents from neglect for one of three residents (Residents R54). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(e)(1) Management. 28 Pa. Code: 211.10(d) Resident care policies.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for two of three residents sampled with facility-initiated transfers (Residents R113 and R164). Findings include:Review of the clinical record indicated Resident R113 was admitted to the facility on [DATE]. Review of Resident R113's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/11/25, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and need for assistance with personal care. Review of the clinical record indicated Resident R113 was transferred to the hospital on 4/16/25, and returned to the facility on 4/18/25. Review of Resident R113's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R164 was admitted to the facility on [DATE]. Review of Resident R164's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia, and muscle weakness. Review of the clinical record indicated Resident R164 was transferred to the hospital on 2/28/25, and returned to the facility on 2/28/25. Review of Resident R164's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. During an interview on 7/25/25, at 12:22 p.m. the Director of Nursing confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for two of three residents sampled with facility-initiated transfers (Residents R113 and R164). 28 Pa. Code: 201.29 (a)(c.3)(2) Resident rights.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observation, and staff interviews, it was determined that the facility failed to ensure the comprehensive care plan was implemented related to safety interventions for safe smoking for one of 11 residents (Resident R16).Findings include: Review of facility policy Care Planning Process and Care Conference dated 4/1/25, indicated the care plan is a working tool that provides a profile of the needs of the individual resident/patient; the resident/patient care plan will be available for use by staff caring for the resident. All resident/patient care and interventions must be carried out per the care plan. Review of the clinical record indicated Resident R16 was admitted to the facility on [DATE]. Review of Resident R16's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/4/25, indicated diagnoses of high blood pressure, hemiplegia (paralysis on one side of the body), and muscle weakness. Review of Resident R16's care plan dated 6/20/23, indicated Resident R16 will be able to go out with staff and visitors to smoke during stay at the facility. Interventions included Resident R16 will wear a smoking apron while smoking. Review of Resident R16's quarterly Smoking assessment dated [DATE], indicated Resident R16 required a smoking apron for safe smoking. During an observation on 7/24/25, at 1:06 p.m. Resident R16 was observed smoking in the designated smoking area without a smoking apron. Receptionist Employee E13 was supervising smoking during this observation. During an interview on 7/24/25, at 1:14 p.m. Receptionist Employee E13 stated, I've never been informed before that Resident R16 is supposed to wear a smoking apron. During this interview, Receptionist Employee E13 confirmed Resident R16 was not wearing a smoking apron as indicated during smoking. During an interview on 7/25/25, at 11:09 a.m. information was disseminated to the Director of Nursing that the facility failed to ensure the comprehensive care plan was implemented related to safety interventions for safe smoking for Resident R16. 28 Pa. Code 211.10(c)(d) Resident care policies.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to provide a assistance with toileting for one out of four residents (Resident R54).Findings include: Review of the facility ADL Care, Toileting-Bowel and Bladder Incontinence Care last reviewed 4/1/25, stated for a resident with urinary incontinence, based on resident's comprehensive assessment, the facility will ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence and services to restore to the extent as possible. ADL documentation will be completed by the nurse aides and any refusals must be reported to the supervisor. Review of Residents R54's admission record indicated the resident was admitted on [DATE], and readmitted [DATE]. Review of Residents R54's care plan dated 11/11/22, revised 10/28/24, revealed the resident had an activity of daily living (ADL-the basic self-care tasks essential for independent living, including bathing, dressing, transferring, and toileting) self -care deficit due left below the knee amputation. It was revealed Resident R54 required assistance from staff for toilet use. Review of Residents R54's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/22/25, revealed diagnoses of dementia (loss of cognitive functioning- thinking remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), acquired absence of left leg below the knee, and anxiety. Review of Resident R54's clinical record revealed Nurse Aide (NA), Employee E27 documented the resident was incontinent at 10:24 a.m. on 7/24/25. Review of Resident R54's clinical record revealed NA, Employee E27 documented the resident was provided assistance with toileting hygiene at 10:25 a.m. on 7/24/25. During an observation on 7/24/25, at 11:31 a.m. Resident R54 was observed lying in bed with a soiled gown saturated in urine. The resident's bed sheet was soiled with brown and yellow discoloration. A noticeable odor of urine was present. Review of the facility's assignment sheet on 7/24/25, at 11:34 a.m. revealed NA, Employee E27 was assigned to Resident R54. During an interview on 7/24/25, at 11:38 a.m. NA, Employee E54 confirmed Resident R54 was included in their assignment. NA, Employee E27 confirmed Resident R54 was saturated in urine and the resident's sheets needed to be changed. NA, Employee E27 confirmed they did not assist Resident R54 with toileting. During an interview on 7/24/25, at 11:47 a.m. the Nursing Home Administrator confirmed the facility failed to provide a assistance with toileting for one out of four residents (Resident R54). 28 Pa. Code: 211.12(d)(1)(5) Nursing services. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(e)(2.1) Management.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to notify the physician of medication refusal and increased Capillary Blood Glucose (CBG) levels per physician order and for two of three residents (Residents R153 and R203).Findings include: The Centers for Disease Control defines diabetes as: Diabetes Mellitus (DM) is a chronic (long-lasting) health condition that affects how your body turns food into energy. Most of the food you eat is broken down into sugar (also called glucose) and released into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy. If you have diabetes, your body either doesn't make enough insulin or can't use the insulin it makes as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in your bloodstream. Over time, that can cause serious health problems, such as heart disease, vision loss, and kidney disease. Hypoglycemia is a condition that occurs when blood glucose is lower than normal, usually below 70 mg/dL (milligrams per deciliter). If left untreated, hypoglycemia may lead to weakness, confusion, unconsciousness, arrhythmias and even death. People with Diabetes Mellitus may be prescribed injectable insulin to assist in maintaining acceptable levels of CBG's. Hyperglycemia, or high blood glucose, occurs when there is too much sugar in the blood. This happens when your body has too little insulin. Hyperglycemia is blood glucose greater than 125 mg/dL while fasting (not eating for at least eight hours, or a blood glucose greater than 180 mg/dL one to two hours after eating. If you have hyperglycemia and it's untreated for long periods of time, you can damage your nerves, blood vessels, tissues and organs. Damage to blood vessels can increase your risk of heart attack and stroke, and nerve damage may also lead to eye damage, kidney damage and non-healing wounds. Review of facility policy Hyperglycemia Management - Diabetes Management dated 4/1/25, indicated the facility will manage the resident's diabetes to prevent hyperglycemia based on physicians orders and monitoring. The Charge Nurse/Unit Manager will contact the physician if blood glucose is greater than 350 (if not on sliding scale coverage) or other specific blood glucose parameters identified by the physician order or if signs and symptoms noted. Resident R153 was admitted to the facility on [DATE]. Review of Resident R153 clinical record MDS (minimum data set a periodic assessment of resident needs) dated 6/28/25, indicated diagnosis of schizophrenia (mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior), anxiety disorder (are a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation) and seizure disorder (a sudden burst of electrical activity in the brain. It can cause changes in behavior, movements, feelings and levels of consciousness). Review of Resident R153 physician orders indicated: Humalog Injection Solution 100 unit/ml Inject 21 unit subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus without complications. Review of Resident R153 clinical progress notes indicated refusal of Humalog Injection on the following days and times: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/23/25: 20:51p.m. 7/23/25: 16:13 p.m. 7/21/25: 19:18 p.m. 7/16/25: 12:16 p.m. 7/15/25: 20:22 p.m. Review of the clinical notes failed to include that physician was notified of Resident R153 refusal of Humalog. During an interview on 7/25/25, at approximately 2:00 p.m. Nursing Home Administrator and Director of Nursing were informed that the facility failed to inform physician of Resident R153 refusal of Humalog. Review of the clinical record indicated Resident R203 was admitted to the facility on [DATE]. Review of Resident R203's MDS dated [DATE], indicated diagnoses of diabetes mellitus, hyperlipidemia (high levels of fat in the blood), and Post Traumatic Stress Disorder (PTSD – a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and may have triggers that can bring back memories of trauma accompanied by intense emotional and physical reactions).Review of a physician order dated 3/13/25, indicated to administer insulin lispro 100 units/mL, inject as per sliding scale subcutaneously (beneath the skin into the fatty tissue layer) before meals and at bedtime for DM: 70 - 140 = 0 units 141 - 200 = 3 units 201 - 250 = 6 units 251 - 300 = 9 units 301 - 350 = 12 units 351 - 400 = 15 units 401 - 999 = 18 units and call MD (physician) Review of Resident R203's July 2025, vitals record indicated the following blood glucose measurements: 7/8/25 at 8:28 p.m. = 455 mg/dL 7/10/25 at 9:33 a.m. = 477 mg/dL (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/15/25 at 7:53 p.m. = 455 mg/dL 7/16/25 at 9:32 a.m. = 539 mg/dL 7/20/25 at 7:37 p.m. = 419 mg/dL 7/21/25 at 11:51 a.m. = 459 mg/dL 7/21/25 at 9:19 p.m. = 470 mg/dL 7/22/25 at 8:59 p.m. = 459 mg/dL Review of Resident R203's progress notes from 7/1/25, through 7/23/25, failed to include documentation that the physician was notified of the resident's increased blood glucose levels on the dates listed above as per physician order. During an interview on 7/24/25, at 10:54 a.m. the Director of Nursing (DON) stated, They [nursing staff] print the blood sugars out and the nurse practitioner reviews them. During an interview on 7/24/25, information was disseminated to the DON that the facility failed to notify the physician of increased Capillary Blood Glucose levels per physician order for Resident R203. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 211.10 (c)(d) Resident Care policies. 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on review of facility policy and documents, clinical records, and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision, which resulted in an elopement for two of 36 residents (Resident R12 and R37). This failure created an immediate jeopardy situation. Findings include: Review of the facility Elopement Prevention policy last revised 3/26/25, and reviewed 5/25, indicated it is the facility's policy to strive to prevent resident elopement. The facility strives to provide an environment that is free from hazards over which the facility has control and provide supervision and assistance to each resident to prevent avoidable accidents. The facility strives to reduce the risks for elopement while optimizing residents independence to safely attain or maintain their highest practicable physical, mental, and psychosocial well-being. The facility will identify residents at risk for unsafe wandering and exit seeking behavior and develop individualized prevention and management interventions based on exit seeking/elopement evaluation. Elopement represents a risk to the resident's health and safety and places the resident at risk of heat or cold exposure, dehydration, and/or other medical complications, drowning, or being struck by a motor vehicle. The facility will define mechanisms and procedures for assessing or identifying, monitoring, and managing residents at risk for elopement to minimize the risk of the resident leaving a safe area without the staff awareness and/or supervision. Elopement is defined when a resident leaves the physical structure of the facility unattended and without staff knowledge and when a resident leaves the premises or a safe area without the facility's knowledge and supervision. Risk factors must be assessed and interventions implemented. Maintain door alarms and wander control systems in proper working order according to the manufacturer's recommendation. Monitor residents whereabouts of the at-risk residents during rounds. Check, through observation that the resident is wearing an electronic monitoring device as indicated. Electronic monitoring devices will be checked for placement each shift and documented on the TAR (Treatment Administration Record) or MAR (Medication Administration Record) by a licensed nurse and/or by the nursing assistant in their documentation. Electronic monitoring devices will be checked daily for function and documented on the TAR or MAR. If the electronic monitoring device is not found on resident or not working, staff will notify the charge nurse/supervisor to obtain a replacement. If a replacement is not readily available, other supervised monitoring processes will be implemented until a replacement is available. Review of the facility's Elopement-Management policy last reviewed 4/1/25, indicated the interdisciplinary team will reevaluate cognitively impaired residents who have attempted, unsuccessfully or successfully, to leave the facility without staff knowledge. With the assistance of the resident and/or resident representative, individualized intervention will be developed and initiated to manage the elopement behavior. Review and revise individualized interventions that may prevent further elopement attempts. Review of Resident R12's admission record indicated he was admitted on [DATE], with diagnoses of dementia (loss of cognitive functioning- thinking remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), anxiety, and age-cognitive decline. Review of Resident R12's active physician order dated 1/25/25, revealed the resident required an assist of one person and a front wheeled walker. (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 Resident R12's Exit Seeking/Elopement Evaluation/Wandering assessment dated [DATE], revealed the resident was not an elopement risk. The first question asked if the resident was ambulatory or able to self-propel in a wheelchair and if no, may stop evaluation. It was documented the resident was not ambulatory and the resident's elopement assessment was not completed. Review of Resident R12's Exit Seeking/Elopement Evaluation/Wandering assessment dated [DATE], revealed the resident was an elopement risk. It was revealed the resident had exit-seeking behaviors and expressed a desire to leave. The summary and plan stated to utilize wander detection system and care plan for risk of elopement. Review of Resident R12's care plan dated 2/12/25, revealed the resident has a memory problem and tend to wander which may get me into situations where I am lost or could be injured. Interventions included I have problems with my memory. I am always asking for someone to help me and wander aimlessly. Please remind me to not go on elevator or leave the unit unless supervised by staff/family. I now wear a wander guard bracelet to keep me safe. Please make sure it is in working order. If not, please have it replaced immediately. If I do get off the unit unsupervised, please make sure the staff and family are aware. Review of Resident R12's MDS (Minimum Data Set a periodic assessment of care needs) dated 4/23/25, indicated the diagnoses were current. Section C-Cognitive Patterns revealed the resident BIMS (Brief Interview for Mental Status) was 4, severe cognitive impairment. Review of Resident R12's clinical record on 5/7/25, 5/8/25, 5/9/25, 5/12/25, and 5/27/25, revealed Resident R12 displayed exit-seeking behaviors. The facility failed to update Resident R12's care plan. Resident R12's care plan was not revised until 5/30/25, for the resident chewing off wander guard. No new interventions were added. Review of Resident R12's May 2025 TAR revealed on 5/28/25, and 5/29/25, Resident R12's electronic monitoring device was not checked on night shift. It was documented to see nurses note. Review of Resident R12's progress note dated 5/28/25, revealed wander guard not on person. Review of Resident R12's progress note dated 5/29/25, revealed Resident removed device. Review of Resident R12's clinical record revealed the resident had exit-seeking behaviors on 5/30/25. Review of Resident R12's care plan dated 5/30/25, revealed Resident R12 was an elopement risk and had been witnessed attempting to chew off band. No new interventions were implemented to prevent the resident from eloping. Review of Resident R12's progress note dated 6/1/25, at 10:27 a.m. entered by Licensed Practical Nurse, Employee E12 stated Resident found by staff in basement trying to exit outside. Resident brought back to unit and 15-minute checks started. No wander guard on. (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 Resident R12's progress note dated 6/1/25, at 10:37 a.m. entered by Registered Nurse (RN), Employee E5 stated this RN found Resident R12 in the basement. Resident R12 was wandering around. When RN, Employee E5 questioned Resident R12, Resident R12 stated I'm stretching my legs I need to walk around. When Resident R12 was asked what unit they resided on, Resident R12 replied one, and would not tell this RN what unit they were from nor would the resident tell this RN their name. Resident R12 was escorted to the elevator and taken to the second floor where staff indicated the resident was from the third floor. Review of Resident R12's progress note dated 6/1/25, at 11:15 a.m. entered by LPN, Employee E12 revealed the wander guard was placed underneath the resident's wheelchair, due to the resident continuing to remove from self. Review of Resident R12's progress note dated 6/1/25, at 3:30 p.m. revealed the resident's daughter was notified of the resident's elopement and the resident will be moving to another unit for safety reasons and this unit being more secure. Review of information submitted to the Department of Health on 6/2/25, stated on 6/1/25, at approximately 10:00 a.m. Resident R12 was found in the basement by staff ambulating with the use of their wheelchair. The resident was last seen by staff 10-15 minutes prior. A room change was completed, and the resident was moved to the secure Dementia unit. The resident stated to staff I wanted to go outside, and I will do it again. Review of Resident R12's investigation on 7/21/25, revealed Resident R12 eloped on 6/1/25, and was found in the basement trying to exit out of a door by RN, Employee E5. Resident R12 stated I wanted to go outside, and I will do it again. It was indicated the Resident did not have their wander guard on when found. A review of the facility's documentation for checking the operation of door monitors and patient wandering systems failed to reveal the Resident Monitoring System was checked on 5/30/25. It was written I was off 5/30/25. Number 2 elevator down was documented under the remarks section. A further review revealed a work order was entered on 5/30/25, at 8:17 a.m. by Maintenance Director, Employee E17 for the #2 elevator wander control. The room/area was listed as the basement. The priority was assigned medium. Service for elevator called was documented in the comment section. Review of RN, Employee E5's witness statement dated 6/1/25, revealed around 9:30 to 9:45 a.m. RN, Employee E5 went downstairs to look for supplies. Resident R12 initially was seen coming from the intermediate side towards the skilled side of the building. RN, Employee E5 was unfamiliar with Resident R12, so I didn't think much of it then. Shortly after RN Employee E5 went back towards the skilled side and went into the cage for supplies, while in there, RN, Employee E5 heard the door open and close. RN, Employee E5 heard feet shuffling. Once RN, Employee E5 came out from the cage, Resident R12 was observed looking for something and was asked what they were doing. Resident R12 stated they were exercising and needed to walk around, then Resident R12 went over to the exit door just to the left of the dock door and attempted to push on the door, which didn't open. While walking back to the elevator Resident R12 looked at RN, Employee E5's badge and said, I'm not sure I want to tell you my name. When RN, Employee E5 and Resident R12 got on the elevator, the electronic monitoring system didn't alarm at that time, and went to the 2nd floor. The door opened, still no alarm. RN, Unit Manager, Employee E18 was at the nursing station and thought the resident was a resident from the third floor who continues to take their monitor off. RN, Unit Manager, Employee E18, RN, Employee E5, and Resident R12 went to the third floor, and once there, again the alarm did not go off. LPN, Employee E12 recognized Resident R12 and was notified the resident was found in the basement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review LPN, Employee E5's witness statement dated 6/2/25, revealed around 10:00 a.m. on 6/1/25, they were made aware Resident R12 was found in the basement trying to exit a door outside. No wander guard was on the resident due to her removing days prior. Resident was last seen in room during breakfast and medication pass around 10 minutes prior to staff bringing the resident back to the unit. Resident R12's wander guard was placed under their wheelchair, due to resident stating If you put that thing on me I will throw it in the garbage. Review of Nurse Aide (NA), Employee E15's witness statement dated 6/3/25, stated Resident R12 was last seen around at 9:15 a.m. During an interview on 7/21/25, at 10:20 a.m. NA, Employee E21 was asked how does the facility prevent residents from eloping and replied, We have wander guard, ones who wander the alarm goes off, elevator locks, and we have to put a code in. When asked if the facility has enough staff to supervise residents, NA, Employee E21 replied We have our days, some days residents can have their moments, act up, on those days we can always use more people. During an interview on 7/21/25, at 10:24 a.m. LPN, Employee E7 was asked how to prevent resident's from eloping and response They have wander guards. It was indicated they are checked daily. LPN, Employee E7 indicated they were not working when Resident R12 eloped on 6/1/25, however they were reeducated to make sure the resident's wander guards work. LPN, Employee E7 stated Resident R12 has one, I am not sure what happened, I know they turned up the sensitivity. During an interview on 7/21/25, at 1:50 p.m. Maintenance Director, Employee E17 stated there are wander guard monitoring systems in each elevator and they are checked Monday through Friday. If Maintenance Director, Employee E17 is not working, then staff would be assigned to complete the checks. In order for the wander guard system to pass a test, it must alarm, and the elevator car cannot travel. Staff must enter in a code. Maintenance Director, Employee E17 confirmed elevator #2 wander guard system was not working on 5/30/25. During an interview on 7/22/25, at 9:22 a.m. RN, Employee E5 stated if residents are identified as an elopement risk, then a wander guard bracelet is applied to the residents. The bracelets are supposed to be checked every shift that they are on, the night shift checks the function. RN, Employee E5 stated I recall all elevators were functioning when asked if any elevators were out of service on 6/1/25, the day Resident R12 was found in the basement. RN, Employee E5 stated I originally was coming down looking for supplies and walked passed Resident R12 in the basement. I didn't think a whole lot of it. Then as I was near the maintenance part of the basement, I heard feet shuffling, the resident came pass the maintenance door, trying to push it open and get out. RN, Employee E5 seen Resident R12 was looking for a way out and approached the resident. RN, Employee E5 then proceeded to take Resident R12 back onto the elevator to find out where the resident belonged. The nurse on the second floor told RN, Employee E5 maybe Resident R12 was the resident who cuts their wander guard off. Once on the third floor, LPN, Employee E12 identified the resident. It was indicated the elevator alarm did not sound on the second or third floor. RN, Employee E5 confirmed they are the nurse educator and stated, informal education was done, I don't remember doing a whole formal education. Hey, make sure you keep track of people. RN Employee E5 confirmed that the facility failed to reeducate staff on elopement. (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 on 7/22/25, at 9:55 a.m. RN, Employee E18 stated Resident R12 had a wander guard on their chair when asked how the facility prevents residents from eloping. RN, Employee E18 stated the wander guard system did not go off. During an interview on 7/22/25, at 10:49 a.m. LPN, Employee E12 stated Resident R12 continuously tries to elope. LPN, Employee E12 stated when Resident R12 eloped on 6/1/25, the resident did not have a wander guard on. LPN, Employee E12 stated I do not recall any elevators out of service. LPN, Employee E12 stated what I believe Resident R12 took the elevator that is next to the dining room area. LPN, Employee E12 saw Resident R12 enter the dining room. The elevator must open, and Resident R12 got on. LPN, Employee E12 stated we didn't even know Resident R12 made it onto the elevator, I did not realize the wander guard was not on the resident, I assumed the resident was in the dining room. Review of Resident R37 admission record indicated they were admitted on [DATE] and readmitted on [DATE], with diagnosis of paranoid schizophrenia (mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior) and muscle weakness. Review of Resident R37 physician orders indicated: Place electronic monitoring device dated 7/1/25. Review of Resident R37 elopement assessment dated [DATE], indicated resident was a risk for elopement, and there was a history of wandering, and the wandering placed the resident at significant risk of getting to a potentially dangerous place. Resident R37 MDS dated [DATE], indicated the diagnosis were current. Section C cognitive patterns revealed the resident BIMS was an 8, which indicated moderately impaired. Review of MAR/TAR indicated: Check electronic monitoring device functioning every night shift. Every night shift -Start Date-07/14/2025. Review of progress note dated 7/20/25, indicated Resident R37 made 2 attempts to elope this afternoon. Staff spoke with him and was able to get him off elevator and back to his room. Resident delusional and insist he can't stay here anymore and does not have a room. Alarming device is on as ordered. Review of Resident R37's progress notes dated 7/20/25, indicated: was on the unit when a staff ran up to this writer and stated that she saw resident walking down the street with his foley catheter in hand. This writer and other staff went to where resident was seen when he was noted to be laying down on the side of the road with other passengers after they state they witnessed resident fall and hit his head. resident was noted to have a large hematoma to his forehead and several abrasions to his face and hands. Resident was assisted to a wheelchair and 911 was called and resident was taken to the hospital. (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 witness statements indicated: Nurse Aide trainee Employee E28 stated I was on the porch visiting with family member when Resident I knew had begun walking outside along with three other people. I first thought it could have been family that he was with, so I gave it a moment until they started talking about how they didn't know him. I then went inside and told the front desk, the lady at the desk ran outside to get him and I slowly followed. She then turned around and said he fell on his face. At that point she went inside to grab help and a wheelchair. I ran down to Resident R37 where two civilians driving by had stopped as I arrived. We kept Resident R37 still and a civilian caller had called 911 for medical help. Soon after a family member, and a nurse and two staff members ran down. Review of witness statement indicated: LPN Employee E29 Stated Resident R37 was seen in room at 19:37 p.m. during medication pass. Before medication pass was complete Resident R86 stated that there was a commotion downstairs concerning a black gentleman from nursing unit shortly after this LPN heard overhead call at approximately 20:25 pm after speaking with caller on the phone, this LPN sought out RN supervisors and asked about incident. RN said Resident R37 found outside and sent to hospital. Resident R86 stated to LPN Employee E29 mentioned at 22:00 p.m. he saw Resident R37 get into elevator and leave Resident R86 stated no one put code in for elevator to move, after speaking to other staff, all state alarm for elevator did not go off. Review of witness statement indicated: Front desk employee E30 stated: A gentleman came downstairs; no wander guard went off. I did not recognize him, and he walked out with a group of people. A girl from the porch came in and said a resident was out and I ran out to try to get him. As soon as he heard me yell, he sped up. I was not able to keep up with him. Review of witness statement indicated: Resident R86 stated: I saw a white gentleman get in the elevator, with Resident R37. Resident R86 saw gentleman push the elevator button. The door closed and Resident R86 Didn't think anything of it. During an interview on 7/22/25, at 10:37 a.m. the Director of Nursing and Assistant Director of Nursing (ADON), Employee E10 confirmed the facility's elopement risk assessment tool failed to include a comprehensive scoring system. ADON, Employee E10 stated if you feel a resident is at risk, then you can proceed to implement interventions such as an electronic monitoring device or locked unit. The DON confirmed the facility does not have a locked unit. The DON stated, we don't trust it either, we are looking at everyone's charting every morning. On 7/22/25, at 11:57 a.m. the NHA and DON were notified that Immediate Jeopardy was called due to the elopement of Resident R12 on 6/1/25, and Resident R37 on 7/20/25, and facility staff were provided an Immediate Jeopardy template, and a corrective action plan was requested. On 7/22/25, at 2:30 p.m. the NHA confirmed the facility's plan of correction failed to reveal a designee and timeframe for when the elopement tool, resident-specific care plans will be completed, and that staff will be reeducated after the time the IJ was called. On 7/22/25, at 4:06 p.m. the NHA provided the facility's fourth plan of correction. On 7/22/25, at 5:21 p.m. an immediate action plan was received and accepted which included the following interventions: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The Facility is obligated to provide adequate supervision which does not rely on the Wander guard System and is based on the individual resident's assessed needs and the risks identified in the Exit Seeking Elopement Evaluation/ Wandering Tool, which does not replace an electronic monitoring device. (Wander guard System) -Will review and revise the elopement evaluation/wandering assessment to include comprehensive scoring system. To be completed by the Director of Nursing/designee within 24 hours, 7/23/25. -Current residents in-house will be reassessed for exit seeking / elopement by the Director of Nursing/designee within 24 hours, 7/23/25. -Residents will be assessed for exit seeking/elopement by the admitting RN upon admission. -Elopement binder will be revised upon completion of all assessments by the Director of Nursing/designee within 24 hours, 7/23/25. -Per results of assessments, care plans will be updated and implemented with resident-specific interventions by Director of Nursing/designee as warranted. -Elopement policies will be reviewed and revised as necessary by Nursing Home Administrator/designee within 24 hours, 7/23/25. -Wander guard system will continue to be audited by Environmental Director/designee daily. -Education of all facility staff will be conducted by Director of Nursing/designee on Elopement Risk and Supervision of residents within 24 hours, 7/23/25. -QA/QAPI was conducted 7/21 and 7/22/2025 related to plan of correction for F689. Meetings will be conducted 5 days/week until 8/5, 2x/week until 9/2, and monthly thereafter. The Elopement Risk assessment was revised on 7/22/25, to include a comprehensive scoring system. Residents with a risk greater than 12 are considered an elopement risk. Residents identified as elopement risk will have care plan updated to include individualized care interventions. On 7/23/25, 215/215 Residents were reassessed for an elopement risk, using the new Elopement. 27/215 residents were identified as an elopement risk. 4 residents were newly admitted to the facility since 7/22/25. 0/4 residents were identified as an elopement risk. Review of elopement binder on 7/23/25, included 27/27 identified elopement risks. 27/27 Residents that were identified as an elopement risk had care plans that were updated and implemented with resident-specific care interventions on 7/23/25. On 7/22/25, the Nursing Home Administrator reviewed the facility's Elopement policies. No changes were made. (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 facility documents revealed Wander guard system transmission box and all wander guards present on residents were audited on 7/23/25. Daily checks will be completed by Environmental Director Monday through Friday and the designees on the weekends. 234/255 educated Both in-person and phone. During in-person interviews on 7/23/25, from 10:36 a.m. to 11:17 a.m. 49 of 49 staff members verified education was completed on elopement risks and supervision. During phone interviews 8/8 staff members confirmed they were educated via phone. Facility conducted a QAPI meeting on 7/22/25. Meetings will be conducted 5 days/week until 8/5/25, 2x/week until 9/2/25, and monthly thereafter. Verification of the facility's Corrective Action Plan revealed all elements of plan were met. The Immediate Jeopardy was lifted on 7/23/25, at 1:45 p.m. During an interview on 7/25/25, at 3:45 p.m., the NHA and DON confirmed that the facility failed to make certain each resident received adequate supervision, which resulted in an elopement for two of 36 residents (Resident R12 and R37), resulting in Immediate Jeopardy. 28 Pa. Code§ 201.14(a) Responsibility of Licensee. 28 Pa. Code § 211.10(d) Resident care policies. 28 Pa. Code § 211.12(d)(5) Nursing Services.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records and staff interview, it was determined that the facility failed to obtain appropriate physician orders for a urinary catheter (insertion of a tube into the bladder to remove urine) for one out of five sampled residents (Resident R218). Findings include: The facility Catheter-foley policy reviewed 4/1/25, indicated that a resident who enters the facility with an indwelling catheter or subsequently receives on is assessed for removal unless the resident's clinical condition demonstrates that catheterization was necessary. Review of Resident R218's admission record indicated she was admitted on [DATE] and readmitted on [DATE]. Review of Resident R218's nursing initial assessment (assessment done upon admission by nursing related to resident care needs) dated 7/18/25, indicated she had diagnoses that included diabetes (a metabolic disorder impacting organ function related to glucose levels in the human body), hyperlipidemia (an elevated lipid levels within the blood), and chronic kidney disease (a loss of kidney function resulting in the swelling of feet, fatigue, high blood pressure and changes in urination). Section I-Bladder/Bowel indicated she had a catheter. Review of Resident R218's care plans dated 7/18/25, indicated to monitor for incontinence. Review of Resident R218's physician orders dated 7/21/25 did not include an order for a foley catheter. During an observation on 7/21/2025, at 10:03 a.m. Resident R218 was found with a catheter in use. During an interview on 7/22/25, at 10:37 a.m. Registered Nurse (RN) Employee E9 stated: the discharge of catheter was last evening. No specific order for the foley catheter on file; only the one from the hospital. During an interview on 7/22/25, at 11:02 a.m. the Assistant Director of Nursing (ADON) Employee E10 confirmed that the facility failed to obtain appropriate physician orders for Resident R218's urinary catheter as required. 28 Pa. Code: 211.5(f) Clinical records 28 Pa. Code: 211. 12(c)(d)(1)(3)(5) Nursing services

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of resident clinical records, facility policy and staff interview it was determined the facility failed to provide consistent and complete communication with the dialysis (a machine that filters wastes, salts, and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately) center for two of three residents (Resident R6, and R182).Findings include: Review of facility policy Dialysis Management (Hemodialysis) dated 4/1/25, indicated the facility will develop a resident binder/folder to send to dialysis with the resident. Communication form is placed in the binder after completion of the pre dialysis assessment. Facility to compete Pre-Dialysis information on the communication form and send with resident to dialysis on treatment days, to ensure communication of resident information and coordinate care between Dialysis Center and facility. Dialysis center personnel to complete Dialysis communication form and return to facility. Upon return from Dialysis Center, review information provided on Dialysis communication form. Facility to complete post-dialysis information/data. Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/5/25, indicated diagnoses of high blood pressure, End Stage Renal Disease (ESRD, an inability of the kidneys to filter the blood), and dependence on dialysis. Review of Resident R6's clinical record revealed a physician's order dated 7/15/25, that indicated the resident receives hemodialysis at an outside facility every Monday, Wednesday, and Friday. Review of Resident R6's clinical record revealed a physician's order dated 7/15/25, indicated the dialysis communication form must be sent with resident to dialysis and reviewed upon return every Monday, Wednesday, and Friday. Review of Resident R6's clinical record did not include complete communication forms for three days during the period of 7/1/25, through 7/23/25. The incomplete forms were on the following dates: 7/4/25, 7/16/25, and 7/18/25. During an interview on 7/22/25, at 2:17 p.m. Registered Nurse Unit Manager Employee E24 confirmed the above dates did not include complete dialysis communication forms, and that the facility failed to provide consistent and complete communication with the dialysis center for Resident R6. Review of the clinical record indicated Resident R182 was admitted to the facility on [DATE]. Review of Resident R182's MDS dated [DATE], indicated diagnoses of high blood pressure, End-Stage Renal Disease, and muscle weakness. Review of a physician order dated 6/25/25, indicated the resident receives hemodialysis at an outside facility every Tuesday, Thursday, and Saturday. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R182's clinical record did not include complete communication forms for eight days during the period of 6/21/25, through 7/21/25. The incomplete forms were on the following dates: 6/26/25, 6/28/25, 7/1/25, 7/3/25, and 7/5/25. Two communication forms did not have a date written on them and no communication form was observed for 7/12/25. During an interview on 7/21/25, at 11:19 a.m. Registered Nurse Employee E1 confirmed the above dates did not include complete dialysis communication forms and that the facility failed to provide consistent and complete communication with the dialysis center for Resident R182. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(c) Resident care policies.28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident record review, and staff interviews, it was determined that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for two of two residents (Residents R8 and R203).Findings include: Review of facility policy Trauma Informed Care dated 4/1/25, indicated facilities must identify triggers which may re-traumatize residents with a history of trauma. A trigger is a psychological stimulus that prompts recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening. Review of the clinical record indicated Resident R8 was admitted to the facility on [DATE], with diagnoses of post-traumatic stress disorder (PTSD), depression, and insomnia (difficulty staying or falling asleep). Review of Resident R8's Social Service Quarterly Review dated 4/16/25, revealed when agitated, Resident R8 will yell profanities and can be aggressive. Review of Resident R8's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/5/25, indicated diagnoses were current. Review of Resident R8's clinical record on 7/25/25, failed to include a PTSD care plan with triggers identified. Review of the clinical record indicated Resident R203 was admitted to the facility on [DATE]. Review of Resident R203's MDS dated [DATE], indicated diagnoses of diabetes mellitus, hyperlipidemia (high levels of fat in the blood), and Post Traumatic Stress Disorder (PTSD). Review of Resident R203's care plan on 7/22/25, did not include a plan of care developed with goals and interventions related to post-traumatic stress disorder. During an interview on 7/25/25, at 10:29 a.m. Registered Nurse Assessment Coordinator Employee E20 confirmed that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for Resident R8 and R203. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1) Management.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on resident observations, resident and staff interviews, it was determined that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of eleven of 13 residents (Group Resident (GR)1, GR2, GR3, GR4, GR5, GR6, GR7, Resident R16, R64, R113, and R203). Findings Include: During an interview on 7/21/25, at 10:20 a.m. Nurse Aide (NA), Employee E21 was asked how does the facility prevent residents from eloping (leaving a safe area without permission) and replied: We have Wanderguard (a device that alerts staff when a resident leaves a safe area), ones who wander the alarm goes off, elevator locks, and we have to put a code in. When asked if the facility has enough staff to supervise residents, NA Employee E21 replied We have our days, some days residents can have their moments, act up, on those days we can always use more people. During an interview on 7/21/25, at 10:34 a.m. Resident R203 stated the following: All the meals are cold because they're always late. They sit out there in the hallway before anyone passes them out. During an interview on 7/21/25, at 10:58 a.m. Resident R16 stated the following: When I get washed up, I have to argue with them to wash me. I'm supposed to have showers on Tuesdays. They don't offer to shower me, it rarely happens. During an interview on 7/21/25, at 1:33 p.m. Resident R64 stated the following: I don't get a bath on the weekend. I have to wash myself on the weekend. No one else will give one. I go to church; I have to get myself washed up and ready. We ask staff but they won't do it. They told me they don't shower people on weekends. They don't really care about us. During an interview on 7/21/25, at 1:38 p.m. Resident R113 stated the following: When you ring the buzzer you have to wait so long for an answer. My roommate and I both ring at the same time, it takes at least 15-20 minutes for someone to answer it. During a group interview on 7/22/25, at 2:00 p.m. seven out of seven residents voiced concerns with the facility being short on staff. During an observation on 7/24/25, at 3:09 p.m. State Agency was working in the conference room when two unidentified nurse aides entered the room unannounced to voice an anonymous concern over the facility's staffing. Anonymous NA Employee E25 stated We can have three aides for 60 residents. When asked what they are not able to do when they are short staffed, NA Employee E25 replied We can't answer lights timely, and we barely get showers done. They are always short help, and they never fix it. They don't care. During an interview on 7/25/25, at 11:29 a.m. NA Employee E26 stated the following: I don't feel safe with staffing. There isn't enough staff to do everything you need. Especially if they (residents) need more supervision. During an interview on 7/25/25, at 12:50 p.m. the Nursing Home Administrator confirmed that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for eleven of 13 residents. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(e)(6) Management.28 Pa. Code: 211.12(d)(1)(4) Nursing services.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on review of facility documentation and staff interview it was determined that the facility failed to ensure nurse aides who failed to ensure nurse aides who failed to become certified within four months were not working in the facility for one of four nurse aides (Nurse Aide trainee Employee E28). Findings include: Review of Title 42 Code of Federal Regulations 483.35(d) Requirement for facility hiring and use of nurse aides -483.35(d)(1) General Rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis unless -(i)that individual is competent to provide nursing and nursing related services; and(ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of 483. 151 through 483.154. Review of facility documentation, witness statement indicated NA trainee Employee E28 was a nurse aide trainee (refer to F689). Review of facility documentation personnel records indicated NA Employee E28 was hired 7/8/24 and completed the facility nurse aide training program 7/29/24. Review of facility documentation Timecards indicated NA trainee Employee E28 worked from July 2024 to July 2025 as a Nurse Aide Trainee. During an interview on 7/25/25, at approximately 2:06 p.m. Human Resource Director Employee E32, confirmed that NA Trainee Employee E28 worked past their 120 days, and the facility failed to become certified within four months were not working in the facility for one of four nurse aides (Nurse Aide trainee Employee E28). 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical records and facility policy review, and staff interview, it was determined that the facility failed to ensure that a resident who displayed mental or psychosocial adjustment difficulties received appropriate treatment and services for one of three residents (Resident R12).Findings include: Review of the facility policy Suicide Prevention dated 4/1/25, stated it is the policy of the facility to ensure that residents who voice and/or display suicidal ideation actions receive services and interventions to help them manage feelings and maintain their psychosocial wellbeing. Review of Resident R12's admission record indicated he was admitted on [DATE], with diagnoses of dementia (loss of cognitive functioning- thinking remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), anxiety, and age-cognitive decline. Review of Resident R12's MDS (Minimum Data Set a periodic assessment of care needs) dated 4/23/25, indicated the diagnoses were current. Section C-Cognitive Patterns revealed the resident BIMS (Brief Interview for Mental Status) was 4, severe cognitive impairment. Review of Resident R12's care plan dated 6/3/25, revealed the resident is grieving the loss of their husband. Interventions included to encourage resident to form peer to peer relationships, spend time with resident when feeling down and console resident, establish a rapport with resident to gain trust by providing consistent, positive, and honest environment. Review of Registered Nurse, Employee E5's witness statement dated 7/13/25, stated once on unit staff removed all objects that Resident R12 could harm themselves with. It was indicated another staff member called the resident's family member and the family expressed that Resident R12 was suicidal and they wouldn't past Resident R12 to harm themselves. Resident R12 became agitated with staff for removing the items and then started slamming the bedroom door. Resident R12's roommate was removed from the room to the common area for their safety. Resident R12 was commenting that they were going to bash their head in, and will fall on the floor so they can die. Review of Resident R12's 24 Hour Resident Observation Flow Record dated 7/13/25, revealed the resident was ordered every 15 minute checks for suicide prevention. A further review revealed the resident was started on every 15 minute checks on 7/13/25, at 12:45 p.m. until the resident was transferred to hospital at 4:00 p.m. It was documented Resident R12 was in their room from 1:00 p.m. to 2:15 p.m. During an interview and observation on 7/21/25, Resident R12 was observed sitting at the nursing station in a wheelchair, tearful, with a box of tissues. Resident R12 stated I have Alzheimer's and am not clear all the time, because of that they sent me to a hospital on a 302. It was indicated the 302 was denied, and the facility wanted the resident to go back and commit themselves. Resident R12 stated I still got a feeling I killed my husband. During an interview on 7/24/25, at 12:47 p.m. the Nursing Home Administrator confirmed the facility failed to implement a one-to-one observation for Resident R12 when the resident was suicidal on 7/13/25, prior to being sent to the hospital. During an interview on 7/25/25, at 11:36 p.m. Nurse Practitioner, Employee E31 stated if a resident has suicidal ideations, it is expected staff eliminate any danger items from the room, including any cords, call bells, and the resident is not to be left alone. Usually we put them on one to one for certain periods then every 15 minutes for another period of time until they are seen by a provider to ensure the resident has no plan in place. Nurse Practitioner, Employee E31 confirmed the facility failed to ensure that a resident who displayed mental or psychosocial adjustment difficulties received appropriate treatment and services for one of three residents (Resident R12). 28 Pa. Code 201. 18(b)(1) Management. 28 Pa. Code 211.12(d)(3)(5) Nursing services.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to ensure a resident with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being for two of six residents reviewed (Resident R12 and R54). Based on clinical record review and staff interview, it was determined that the facility failed to ensure a resident with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being for two of six residents reviewed (Resident R12 and R54). Findings include: Review of the facility Dementia Care policy last reviewed 4/1/25, indicated it is the policy of the facility to improve resident's function regardless of the individual's physical and mental diagnosis. It is the responsibility of each staff member to have a sound, general knowledge of what is pathologically happening to the resident and how medications and treatments affect them. It is the facility policy to provide care with dignity, understanding, and acceptance. Symptoms include the decline in the ability to perform routine tasks, impaired judgement, disorientation, and behavior problems. Review of Resident R12's admission record indicated he was admitted on [DATE], with diagnoses of dementia (loss of cognitive functioning- thinking remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), anxiety, and age-cognitive decline. Review of Resident R12's care plan dated 1/27/25, revised 3/12/25, revealed the resident has short term memory impairments and mildly impaired decision making. Review of Resident R12's MDS (Minimum Data Set a periodic assessment of care needs) dated 4/23/25, indicated the diagnoses were current. Section C-Cognitive Patterns revealed the resident BIMS (Brief Interview for Mental Status) was 4, severe cognitive impairment. Review of Resident R12's progress note dated 5/10/25, entered by Nurse Practitioner (NP), Employee E31 revealed the resident had increase anxiety, tearfulness, increased behaviors, and was unable to be redirected. The plan was to obtain labs including a urinalysis, and to adjust Ativan (antianxiety medication) to twice a day. Review of Resident R12's physician order dated 5/9/25, indicated to administer one tablet of 0.5 milligram (mg) Ativan two times a day for anxiety. Review of Resident R12's progress note dated 5/13/25, entered by Nurse Practitioner (NP), Employee E31 revealed the resident was seen for acute urinary tract infection and recent episodes of anxiety. It was indicated the resident was also seen by psychiatry on 5/12/25, and started on a low dose of Seroquel due to increased episodes of paranoia. The resident was ordered an antibiotic for seven days, and to monitor closely for compliance and encourage increase oral intake. Review of Resident R12's physician order dated 5/13/25, indicated to administer 500 milligrams (mg) of Ciprofloxacin (antibiotic used to treat different types of bacterial infections) for seven days for urinary tract infection. During an interview on 7/25/25, at 11:36 a.m. Nurse Practitioner, Employee E31 stated if a resident with dementia has increased or new behaviors first I would rule out any infections to make sure it's not contributing. Nurse Practitioner, Employee E31 stated I don't like to jump to antipsychotics at all. Nurse Practitioner, Employee E31 confirmed Resident R12 was started on an antipsychotic and had their Ativan increased prior to treating their urinary tract infection. Review of Residents R54's admission record indicated the resident was admitted on [DATE], and readmitted [DATE]. Review of Residents R54's care plan dated 4/18/25, revealed the resident had a cognitive and communication deficit due to dementia. It was documented the resident has confusion due to dementia and short term memory loss. Interventions included to remind the resident of care, repeat as needed to facilitate comprehension, anticipate my needs and wants whenever possible. Review of Residents R54's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/22/25, revealed diagnoses of dementia (loss of cognitive functioning- thinking remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), acquired absence of left leg below the knee, and anxiety. During an observation on 7/21/25, at 12:41 p.m. Resident R54 was observed sitting in their room. Resident R54 was odorous of urine. During an interview on 7/21/25, at 1:01 p.m. Licensed Practical Nurse (LPN), Employee E7 confirmed Resident R54 smelled of urine and stated the nurse aide did tell me she refused. When asked what LPN, Employee E7 did to follow up on the resident's refusal to being changed, LPN, Employee E7 stated the resident can be very resistant at changing. LPN, Employee E7 stated Resident R54 toilets themselves and when their bed is soiled Resident R54 strips it and does it all. Review of Resident R54's clinical record revealed Nurse Aide (NA), Employee E27 documented the resident was incontinent at 10:24 a.m. on 7/24/25. Review of Resident R54's clinical record revealed NA, Employee

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, clinical record review, and staff interview it was determined that the facility failed to provide medically related social services for four of four residents reviewed (Resident R2, R13, R153 and R205).Findings include: Review of facility policy Social Services Responsibilities and Medically Related Practices dated 4/1/25, indicated: The facility will provide, based on comprehensive assessment and care plan and the preferences of each resident, medically - related social services to assure that each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well-being. Social Services will act as a Liaison with the residents, the resident's family, the staff of the Facility, and the Community. Medically related social services are provided to maintain or improve each resident's ability to control everyday physical needs and working with individual and groups in developing supportive services for residents according to their individual needs and interest. Resident R2 was admitted on [DATE]. Resident R2 has diagnosis of paranoid schizophrenia and major depressive disorder.Review of Resident R2 MDS (minimum data set a periodic dated 5/2/25, indicated that the diagnosis remained current. Review of Resident R2 clinical record progress notes, and miscellaneous section and paper chart review failed to include current psychosocial support for mental health needs of schizophrenia (mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior) and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest). Review of Resident R13 was admitted on [DATE]. Resident R13 has diagnosis of unspecified mood disorder (mental health condition that primarily affects your emotional state), paranoid schizophrenia (mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior), and anxiety disorder (group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation). Review of Resident R13 clinical record indicated a physician appointment dated 10/8/24, for an outside provider and no follow up from the physician recommendations.Additional review of Resident R13 clinical record failed to indicate psychosocial reviews or follow up for mental health diagnosis on a consistent basis. Resident R153 was admitted to the facility on [DATE]. Review of Resident R153 clinical record MDS (minimum data set a periodic assessment of resident needs) dated 6/28/25, indicated diagnosis of schizophrenia (mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior), anxiety disorder (are a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation) and seizure disorder (a sudden burst of electrical activity in the brain. It can cause changes in behavior, movements, feelings and levels of consciousness). Review of Resident R153 clinical record indicated the following:Resident R153 was seen in - house by a psychiatric group with recommendations to be seen weekly in 6/2024.Resident R153 had documented behaviors in July 2025. Review of the clinical record failed to include any interventions for Residents R153. Resident R205 was admitted to the facility on [DATE]. Review of Resident R205 MDS indicated diagnosis of anxiety disorder (are a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation), poisoning by other psychotropic drugs, and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest). Review of Resident R205 clinical record computer and paper indicated that resident was last seen for psych - social support in 4/10/25 with recommendations: continue weekly therapy to work on depression. No other clinical documentation for psych social needs was included in the clinical records. During an interview on 7/24/25, at 2:00 p.m. Social Worker Employee E28 confirmed that the facility did not have a process for identifying who needed to be seen by additional psychiatric social services, that there was not a list or residents who need to be seen or were identified as being seen on a regular basis. SW Employee E28 indicated that they keep a list of residents that the see however the documentation was not noted in the clinical records of Resident R2, R13, R153 and R205, and was not provided, even after being requested. During an interview on 7/24/25, at 2:02 p.m. SW Employee E28 confirmed that the facility failed to provide medically related social services for four of four residents reviewed (Resident R2, R13, R153 and R205). 28 Pa. Code 211.10(a)Resident care policies

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of facility policy, review of controlled medication reconciliation records and staff interviews, it was determined that the facility failed to implement procedures to promote accurate accounting of controlled medications on two out of seven medication carts (Cardinal East medication cart and Cardinal South-west medication cart). Findings include: The facility Drug diversion prevention and narcotic management policy dated 4/1/25, indicated that control medications will be counted with two professional nurses at the beginning and end of each shift. Documentation that a count was completed and done accurately will be completed at the beginning and end of each shift. These medications are to be counted each shift until the medications are removed. The controlled substance received will be logged as an addition with a witness on the front of the log. During a review of the Narcotic count record log for the Cardinal East Medication Cart on 7/24/25, at 9:47 a.m. revealed the nursing staff failed to sign the record during shift change to verify counts of controlled drugs on the following dates:- 7/6/25, outgoing nurse for 11 p.m. shift- 7/7/25, outgoing nurse for 11 p.m. shift- 7/8/25, outgoing nurse for 11 p.m. shift- 7/17/25, outgoing nurse for 7 a.m. shift and 3 p.m. shift During an interview on 7/24/25, at 9:49 a.m. Licensed Practical Nurse (LPN) Employee E19 was asked if there was any other way to verify narcotic count and she stated: there is no other form to count narcotics. During a review of the Narcotic count record log for the Cardinal Southwest Medication Cart on 7/24/25, at 9:56 a.m. revealed the nursing staff failed to sign the record during shift change to verify counts of controlled drugs on the following dates:- 7/6/25, outgoing nurse for 3 p.m. shift- 7/7/25, outgoing nurse for 11 p.m. shift, 7 a.m. shift and 3 p.m. shift.- 7/8/25, outgoing nurse for 3 p.m. shift During an interview on 7/24/25, at 9:58 a.m. Licensed Practical Nurse (LPN) Employee E12 was asked if there was any other way to verify narcotic count and she stated: no. just this paper. During an interview on 7/24/25, at 1:55 p.m. information disseminated to the Nursing Home Administrator (NHA) that the facility failed to implement procedures to promote accurate accounting of controlled medications on the Cardinal East medication cart and Cardinal Southwest medication cart as required. 28 Pa. Code 211.12 (d)(3)(5) Nursing services 28 Pa. Code 211.9(a)(1)(k) Pharmacy services

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records and staff interviews, it was determined that the facility failed to provide evidence medication regimen reviews (MRR) were reviewed by the resident's attending physician monthly for three of three residents (Resident R12, R14 and R166).Finding include: Review of the clinical record indicated Resident R12 was admitted to the facility on [DATE], and readmitted [DATE], with diagnoses of dementia (loss of cognitive functioning- thinking remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), anxiety, and age-cognitive decline. Review of Resident R12's Minimum Data Set (MDS - a period assessment of care needs) dated 4/23/25, indicated diagnoses were current. Review of Resident R12's Medication Review Regimen dated 6/23/25, failed to include a response from the resident's attending physician. A Certified Registered Nurse Practitioner (CRNP) signed the note to the attending physician on 6/30/25, and the decision was made to not complete a gradual dose reduction (GDR) for the following medications:-12.5 milligram (mg) Quetiapine (antipsychotic medication), twice daily-75mg Sertraline (antidepressant medication), daily-Lorazepam (a benzodiazepine medication used to treat anxiety, insomnia, and certain medical conditions) 0.25 mg twice daily Review of the clinical record indicated Resident R14 was admitted to the facility on [DATE], with diagnoses of adult failure to thrive, high blood pressure, and dementia (loss of cognitive functioning- thinking remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). Review of Resident R14's Minimum Data Set (MDS - a period assessment of care needs) dated 4/10/25, indicated diagnoses were current. Review of Resident R14's Medication Review Regimen dated 6/24/25, failed to include a response from the resident's attending physician.A CRNP signed the note to the attending physician on 7/11/25, and the decision was made to discontinue the following medications:-100mg Tesslon [NAME] (used to relieve coughing) Review of the clinical record indicated Resident R166 was admitted to the facility on [DATE], and readmitted [DATE], with diagnoses of dementia (loss of cognitive functioning- thinking remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), anxiety, and age-cognitive decline Review of Resident R166's Minimum Data Set (MDS - a period assessment of care needs) dated 5/3/25, indicated diagnoses of depression, anxiety, and Alzheimer's disease (a loss of thinking, remembering, and reasoning skills.) Review of Resident R166's Medication Review Regimen dated 4/23/25, failed to include a response from the resident's attending physician.A CRNP signed the note to the attending physician on 4/29/25, and the decision was made to not complete a gradual dose reduction (GDR) for the following medications:-20 mg Aripiprazole (antipsychotic medication), at bedtime-200mg Gabapentin (anticonvulsant medication used to treat seizures, nerve pain, and restless leg syndrome), at bedtime-30mg Paroxetine (antidepressant medication), daily-25mg Hydroxyzine (used to treat anxiety), twice daily During an interview on 7/25/25, at 11:36 a.m. Nurse Practitioner, Employee E31 confirmed facility failed to ensure resident's medication regimen reviews (MRR) were reviewed by the resident's attending physician monthly for three of three residents (Resident R12, R14 and R166). Certified Registered Nurse Practitioner, Employee E31 confirmed Resident R12, R14, and R166's medication review regimen were reviewed by Nurse Practitioners. 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code 211.5(f) Medical records. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to properly store medications in one of seven medication carts (Dogwood [NAME] Medication Cart). Findings include: Review of facility policy Medication Storge dated 4/1/25, indicated the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. During an observation on 7/24/25, at 9:14 a.m. of the Dogwood [NAME] Medication Cart revealed the following outdated medications:Resident R183's Humalog insulin pen (a prefilled pen to inject rapid-acting insulin under the skin), open date 6/17/25, expiration date 7/14/25. During an interview on 7/24/25, at 9:15 a.m. Licensed Practical Nurse Employee E2 confirmed the above observation and that the facility failed to properly store medications in the Dogwood [NAME] Medication Cart. 28 Pa. Code: 201(a) Responsibility of licensee.28 Pa. Code: 211.9(a)(1)(k) Pharmacy services.28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on staff interviews it was determined that the facility failed to employ a qualified Food Service Director to manage the daily operations of the Dietary Department for nine out of 12 months (November through December 2024, and January through July of 2025.Findings include: During an interview on 7/21/25, at 10:25 a.m. Food Service Director (FSD) Employee E14 stated that she had been employed as the Food Service Director since November of 2024, and that she was not a Certified Dietary Manager. When FSD was asked what education she possessed that qualified her as a FSD, she replied none. During an interview on 7/21/25, at 10:25 a.m. Registered Dietitian (RD) Employee E22 stated that she was employed full time. When RD Employee E22 was asked what her role was for the facility she indicated that it was all clinical and did not manage the daily operations of the Main Kitchen. During an interview on 7/21/24, at 3:00 p.m., the Nursing Home Administrator (NHA) confirmed that the facility failed to provide documented evidence that FSD Employee E14 met the qualifications for the position of Food Service Director. Pa Code: 201.18(e)(6) Management.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, and staff interviews it was determined that the facility failed to provide a resident special eating equipment and utensils for one out of five residents (Resident R54).Findings Include: Review of Residents R54's admission record indicated the resident was admitted on [DATE], and readmitted [DATE]. Review of Residents R54's care plan dated 12/16/24, revealed the resident is to receive all disposable items from dietary due to my hoarding for safety/sanitary purposes as my hoarding is an infection control concern. Review of Residents R54's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/22/25, revealed diagnoses of dementia (loss of cognitive functioning- thinking remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), acquired absence of left leg below the knee, and anxiety. During an observation on 7/21/25, at 12:59 p.m. Resident R54 was observed with reusable plate and silverware. The facility failed to provide all Styrofoam as ordered. During an interview on 7/21/25, at 1:01 p.m. Licensed Practical Nurse (LPN), Employee E7 confirmed the facility failed to provide a resident special eating equipment and utensils for one out of five residents (Resident R54). LPN, Employee E7 stated Resident R54 will hoard items. Pa Code: 201.14(a) Responsibility of licensee.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on facility policy, observations, and staff interviews, it was determined that the facility failed to properly label and date food products, failed to ensure hand washing stations were equipped with essential supplies, and failed to maintain the cleanliness and sanitation of equipment in the Main Kitchen. (Main Kitchen). Findings include: Review of the facility policy Food Storage in Refrigerators and Freezers dated 4/12/25, indicated that all foods must be properly labeled and dated. Keep refrigerator clean. Food must be kept 6 inches off of the floor and 12 inches from the ceiling. Review of the facility policy Food Storage Dry Goods: dated 4/1/25, indicated that all food must be dated, labeled and sealed. Keep the floors, walls, ceilings, and shelving clean. During an observation and interview with Food Service Director Employee E14 in the Main Kitchen on 7/21/25, at 10:28 a.m. the following was observed:Refrigerator Number 1 contained a rag with brown and black substances.Refrigerator Number 1 contained a Meat and Cheese Stick Snack that did not have a label with a name or date.Meat slicer was observed to not be in use and did not have a cover in place to protect from contamination.Floor Mixer was observed to not be in use and did not have a cover in place to protect from contamination. During an observation and interview with Food Service Director Employee E14 in Walk-in Freezer Number 2 on 7/21/25, at 10:40 a.m. the following was observed:Large icicles were laying on the floor on the front right-hand corner. Meat was being stored on the top shelf and was touching the ceiling of the freezer. During an observation and interview with Food Service Director Employee E14 in the Dry Storage Area on 7/21/25, at 10:42 a.m. the following was observed:Loose sugar scattered on the floor beneath the shelf.An opened box of Grits with no date. During an observation and interview with Food Service Director Employee E14 in the Main Kitchen on 7/21/25, at 10:43 a.m. the hand washing sink was noted to not have any towels to dry hands. During an observation and interview with Food Service Director Employee E14 in Reach-in Freezer NUmber5 on 7/21/25, at 10:44 a.m. the following was observed:An opened box of chicken tenders with no dateAn opened box of soft pretzels with no date. During an interview on 7/21/25, at 10:50 am the Food Service Director Employee E14 confirmed that the facility failed to properly label and date food products, failed to ensure hand washing stations were equipped with essential supplies, and failed to maintain the cleanliness and sanitation of equipment in the Main Kitchen. Pa Code 201.14(a) Responsibility of licensee.Pa Code 201.18(b)(3) Management.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on review of facility policy, observation and staff interview it was determined that the facility failed to properly contain and dispose of garbage in one of three outside dumpsters to prevent the potential for rodent and insect infestation (Middle dumpster).Findings include: Review of facility policy Garbage and Rubbish Disposal dated 4/1/25 indicated that outside dumpsters provided by garbage pick-up services must be closed and free of litter around the dumpster area. During an observation and interview of the facility's outdoor trash receptacles on 7/21/25, at 10:45 a.m. Food Service Director Employee E14 confirmed that the lid/cover was not closed on the middle dumpster in the disposal area. 28 Pa. Code 201.18(b)(3) Management.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of job descriptions, clinical records and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to effectively manage the facility to prevent the elopement of two resident (Resident R12, and R37), which created an immediate jeopardy situation for two of 36 residents. Findings include: The job description for the Nursing Home Administrator dated 10/1/18, and revised 6/15/23, stated that the NHA is responsible to establish and maintain systems that are efficient and effective to operate the nursing home in a manner to safely meets residents' needs in accordance with federal, state, and local regulations. The job description for the Director of Nursing dated 10/3/18, specified it is the responsibility of the DON for the organization and oversight of all nursing operations and for the supervision of care for all residents at the facility. Must be knowledgeable of all regulations, guidelines, and best practices that pertain to long-term care. Based on findings identified in this report, the facility failed to prevent the elopement of two residents (Resident R12, and R37), which placed the residents in Immediate Jeopardy. The NHA and the DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed. During an interview on 7/22/25, at 11:57 a.m. the NHA and DON were notified that they failed to effectively manage the facility to prevent the elopement of a resident, which created an immediate jeopardy situation for two of 36 residents. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1)(3)(e)(1) Management.28 Pa. Code 211. 12(d)(1)(2)(3)(5) Nursing services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident records, observations, and staff interview it was determined that the facility failed to ensure enhanced barrier precautions (EBP) were implemented during a dressing change which a created the potential for cross contamination for one out of four sampled residents (Residents R140). Findings include: The facility Transmission Based Precautions policy dated 4/1/25, indicated that enhanced barrier precautions are an infection control intervention designed to reduce transmission of multi-drug resistance organisms (MDRO) in nursing homes. Enhanced barrier precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with MDRO as well as those with increased risk such as residents with wounds or indwelling medical devices. Indwelling medical devices include central lines, urinary catheters, feeding tubes and tracheostomies. Review of Resident R140's admission record indicated the resident was admitted to the facility on [DATE]. Review of Resident R140's physician order dated 6/5/24, revealed the resident was ordered enhanced barrier precautions. During an observation on 7/24/25, at 1:40 p.m. Licensed Practical Nurse, Employee E2 and LPN, Employee E32 failed to don a gown and gloves prior to performing wound care. Resident R140 stated you never wear those gowns. During an interview on 7/24/25, at 1:58 p.m. information was disseminated to the Director of Nursing (DON) that the facility failed to follow transmission-based precautions and utilize enhanced barrier precautions (EBP) creating the potential for cross contamination for Residents R140. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1)(e)(1) Management. 28 Pa Code: 211. 10 (d) Resident care policies.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on Effective Communication for one of five staff members (Nurse Aide (NA) Employee E6). Findings include: Review of facility policy Staff Development Training Program dated 4/1/25, indicated the following in-service orientation/training classes are mandatory (i.e., each employee must attend a training class on each of the following topics upon hire and at least annually): Accident Prevention and Management, Dementia Training, Infection Control, Resident Rights, Resident Abuse, Fire Safety and Disaster Preparedness, Hazard Communication Plan, Corporate Compliance, QAPI (quality assessment and performance improvement), Communication, Behavior Health, Restorative Nursing, training needs identified through a facility assessment, and training needs identified for job specific skills. Review of NA Employee E6's personnel file indicated a hire date of 12/2/14, and failed to include Effective Communication training between 12/2/23 and 12/2/24. During an interview on 7/25/25, at 11:14 a.m. the Registered Nurse Educator Employee E5 confirmed that the facility failed to provide training on Effective Communication for one of five staff members as required. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a) Staff Development.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on Resident Rights for one of five staff members (Nurse Aide (NA) Employee E6).Findings include: Review of facility policy Staff Development Training Program dated 4/1/25, indicated the following in-service orientation/training classes are mandatory (i.e., each employee must attend a training class on each of the following topics upon hire and at least annually): Accident Prevention and Management, Dementia Training, Infection Control, Resident Rights, Resident Abuse, Fire Safety and Disaster Preparedness, Hazard Communication Plan, Corporate Compliance, QAPI (quality assessment and performance improvement), Communication, Behavior Health, Restorative Nursing, training needs identified through a facility assessment, and training needs identified for job specific skills. Review of NA Employee E6's personnel file indicated a hire date of 12/2/14, and failed to include Resident Rights training between 12/2/23 and 12/2/24. During an interview on 7/25/25, at 11:14 a.m. the Registered Nurse Educator Employee E5 confirmed that the facility failed to provide training on Resident Rights for one of five staff members as required. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a) Staff development.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on Abuse, Neglect, and Exploitation for one of five staff members (Nurse Aide (NA) Employee E6).Findings include: Review of facility policy Staff Development Training Program dated 4/1/25, indicated the following in-service orientation/training classes are mandatory (i.e., each employee must attend a training class on each of the following topics upon hire and at least annually): Accident Prevention and Management, Dementia Training, Infection Control, Resident Rights, Resident Abuse, Fire Safety and Disaster Preparedness, Hazard Communication Plan, Corporate Compliance, QAPI (quality assessment and performance improvement), Communication, Behavior Health, Restorative Nursing, training needs identified through a facility assessment, and training needs identified for job specific skills. Review of NA Employee E6's personnel file indicated a hire date of 12/2/14, and failed to include Abuse, Neglect, and Exploitation training between 12/2/23 and 12/2/24. During an interview on 7/25/25, at 11:14 a.m. the Registered Nurse Educator Employee E5 confirmed that the facility failed to provide training on Abuse, Neglect, and Exploitation for one of five staff members as required. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a) Staff development.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on the Quality Assurance and Performance Improvement (QAPI) program for one of five staff members (Nurse Aide (NA) Employee E6). Findings include: Review of facility policy Staff Development Training Program dated 4/1/25, indicated the following in-service orientation/training classes are mandatory (i. e., each employee must attend a training class on each of the following topics upon hire and at least annually): Accident Prevention and Management, Dementia Training, Infection Control, Resident Rights, Resident Abuse, Fire Safety and Disaster Preparedness, Hazard Communication Plan, Corporate Compliance, QAPI (quality assessment and performance improvement), Communication, Behavior Health, Restorative Nursing, training needs identified through a facility assessment, and training needs identified for job specific skills. Review of NA Employee E6's personnel file indicated a hire date of 12/2/14, and failed to include QAPI program training between 12/2/23 and 12/2/24. During an interview on 7/25/25, at 11:14 a.m. the Registered Nurse Educator Employee E5 confirmed that the facility failed to provide training on the QAPI program for one of five staff members as required. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a) Staff development.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395788	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyview Nursing and Rehabilitation Center	107 Sunnyview Circle Butler, PA 16001

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 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on Infection Control for one of five staff members (Nurse Aide (NA) Employee E6). Findings include: Review of facility policy Staff Development Training Program dated 4/1/25, indicated the following in-service orientation/training classes are mandatory (i.e., each employee must attend a training class on each of the following topics upon hire and at least annually): Accident Prevention and Management, Dementia Training, Infection Control, Resident Rights, Resident Abuse, Fire Safety and Disaster Preparedness, Hazard Communication Plan, Corporate Compliance, QAPI (quality assessment and performance improvement), Communication, Behavior Health, Restorative Nursing, training needs identified through a facility assessment, and training needs identified for job specific skills. Review of NA Employee E6's personnel file indicated a hire date of 12/2/14, and failed to include Infection Control training between 12/2/23 and 12/2/24. During an interview on 7/25/25, at 11:14 a.m. the Registered Nurse Educator Employee E5 confirmed that the facility failed to provide training on Infection Control for one of five staff members as required. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a) Staff development.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395788	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on Compliance and Ethics for one of five staff members (Nurse Aide (NA) Employee E6). Findings include: Review of facility policy Staff Development Training Program dated 4/1/25, indicated the following in-service orientation/training classes are mandatory (i.e., each employee must attend a training class on each of the following topics upon hire and at least annually): Accident Prevention and Management, Dementia Training, Infection Control, Resident Rights, Resident Abuse, Fire Safety and Disaster Preparedness, Hazard Communication Plan, Corporate Compliance, QAPI (quality assessment and performance improvement), Communication, Behavior Health, Restorative Nursing, training needs identified through a facility assessment, and training needs identified for job specific skills. Review of NA Employee E6's personnel file indicated a hire date of 12/2/14, and failed to include Compliance and Ethics training between 12/2/23 and 12/2/24. During an interview on 7/25/25, at 11:14 a.m. the Registered Nurse Educator Employee E5 confirmed that the facility failed to provide training on Compliance and Ethics for one of five staff members as required. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a) Staff development.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395788	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyview Nursing and Rehabilitation Center	107 Sunnyview Circle Butler, PA 16001

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of facility policy, personnel files and staff interview it was determined that the facility failed to conduct the minimum 12 hours of nurse aide (NA) training per year for one of five NA personnel files (NA Employee E6) and failed to complete annual training on Dementia Management for two of six personnel files (NA Employee E6 and Licensed Practical Nurse (LPN) Employee E7).Findings include: Review of facility policy Staff Development Training Program dated 4/1/25, indicated the following in-service orientation/training classes are mandatory (i.e., each employee must attend a training class on each of the following topics upon hire and at least annually): Accident Prevention and Management, Dementia Training, Infection Control, Resident Rights, Resident Abuse, Fire Safety and Disaster Preparedness, Hazard Communication Plan, Corporate Compliance, QAPI (quality assessment and performance improvement), Communication, Behavior Health, Restorative Nursing, training needs identified through a facility assessment, and training needs identified for job specific skills. Review of NA Employee E6's personnel file indicated a hire date of 12/2/14, and failed to include Dementia Management training between 12/2/23 and 12/2/24. Review of NA Employee E6's personnel record revealed zero hours of in-service education from 12/3/23 through 12/2/24. During an interview on 7/25/25, at 11:14 a.m. the Registered Nurse Educator Employee E5 confirmed that the facility failed to provide training on Dementia Management for NA Employee E6. Review of LPN Employee E7's personnel file indicated a hire date of 6/9/21, and failed to include Dementia Management training between 6/9/24 and 6/9/25. During an interview on 7/25/25, at 1:49 p.m. the Registered Nurse Educator Employee E5 confirmed that the facility failed to provide training on Dementia Management for LPN Employee E7. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201. 20(a) Staff development.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on Behavioral Health for one of five staff members (Nurse Aide (NA) Employee E6). Findings include: Review of facility policy Staff Development Training Program dated 4/1/25, indicated the following in-service orientation/training classes are mandatory (i.e., each employee must attend a training class on each of the following topics upon hire and at least annually): Accident Prevention and Management, Dementia Training, Infection Control, Resident Rights, Resident Abuse, Fire Safety and Disaster Preparedness, Hazard Communication Plan, Corporate Compliance, QAPI (quality assessment and performance improvement), Communication, Behavior Health, Restorative Nursing, training needs identified through a facility assessment, and training needs identified for job specific skills. Review of NA Employee E6's personnel file indicated a hire date of 12/2/14, and failed to include Behavioral Health training between 12/2/23 and 12/2/24. During an interview on 7/25/25, at 11:14 a.m. the Registered Nurse Educator Employee E5 confirmed that the facility failed to provide training on Behavioral Health for one of five staff members as required. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.20(a) Staff development.