STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395796	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montgomeryville Skilled Nursing and Rehabilitati	640 Bethlehem Pike Montgomeryville, PA 18936

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 45244 Based on clinical record review and observation, it was determined that the facility failed to accommodate resident needs by providing access to the call bell system for one of 34 sampled residents. (Resident 124) Findings include: Clinical record review revealed that Resident 124 had diagnoses that included depression. Review of the care plan revealed that the resident was at risk for falls and that staff was to reinforce the need to call for assistance. On May 19, 2024, from 9:52 a.m. through 1:16 p.m., the resident was observed lying in bed. There was no call bell plugged into the system for the resident's side of the room. On May 20, 2023, at 9:53 a.m., the resident was observed lying in bed. There was no call bell plugged into the system for the resident's use. On May 21, 2024, from 9:12 a.m. through 12:08 p.m., the resident was observed lying in bed. The call bell was on the nightstand, out of reach. 28 Pa. Code 211.12(d)(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17709 Based on observations, it was determined that the facility failed to maintain the resident environment in a safe, clean and homelike manner for two of three nursing units. (Rehab and Second floor) Findings include: Observations on May 19, 2024, at 10:00 a.m., on the Rehab nursing unit revealed that in resident room [ROOM NUMBER], there was a piece of tile missing next to the door. In resident rooms [ROOM NUMBER], there were chunks of paint missing on the wall. In resident room [ROOM NUMBER], there were two small holes in the wall where the glove rack had been hanging, but the rack was missing. In resident room [ROOM NUMBER], white splatter was observed at the bottom of the door. There were stained ceiling tiles in resident room [ROOM NUMBER] and in the hallway near Resident rooms [ROOM NUMBER]. The central bathing area on the Rehabilitation unit did not have soap in the dispenser by the sink and the toilet tank cover was missing. Observations made during an environmental tour on May 19, 2024, at 10:14 a.m., revealed that the refridgerators in the pantry on the second floor nursing unit had multiple containers of food items that were not labeled or dated. There was a carton of thickened lemon flavored water that was opened and dated March 19, 2024. The manufacturer's instructions on the carton indicated that the water could be kept for up to seven days once opened in the refrigerator. The refrigerator bottom drawers were soiled with a red liquid substance. The freezer contained frozen bottles of water, a frozen milk carton, and food items that were either opened or in plastic that were not labeled or dated. Observations on May 20, 2024, at 12:41 p.m., on the second floor nursing unit revealed that there was a small linen cart located on the B wing in the hallway. On this cart, was a bottle of [NAME] butter lotion, a dirty glove, a soiled plastic cup, and an opened package of disposable razors. Observations on May 21, 2024, at 12:25 p.m. revealed that the fall mat by the bed in room [ROOM NUMBER] was soiled. In addition, the wall below the handrail near the entrance of room [ROOM NUMBER] was damaged and there was a hole in the wall. CFR 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike environment Previously cited 6/1/23. 28 Pa.Code 207.2(a) Administrator's responsibility.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 45244 Based on clinical record review, it was determined that the facility failed to complete a comprehensive assessment for two of 34 sampled residents. (Residents 106, 107) Findings include: Clinical record review revealed that Resident 106 was transferred to and admitted to the hospital for a change in condition on April 14, 2024. There was no Minimum Data Set (MDS) assessment completed to reflect that the resident was discharged from the facility. In an interview on May 22, 2024, at 9:57 a.m., the Director of Nursing confirmed an MDS assessment had not been completed for Resident 106's discharge to the hospital. Clinical record review revealed that on March 29, 2024, the physician ordered hospice services for Resident 107. Review of a recent doctor's note dated May 1, 2024, revealed that the resident continued to be on hospice services. There was no MDS assessment completed to reflect the significant change in his status. In an interview on May 22, 2024, at 9:50 a.m., the Director of Nursing confirmed that a significant change MDS had not been completed for Resident 107 when he had been placed on hospice services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45244 Based on clinical record review and staff interview, it was determined that the facility failed to develop a comprehensive care plan to meet each resident's needs for three of 34 sampled residents. (Residents 121, 124, 296) Findings include: Clinical record review revealed that Resident 121 was readmitted to the facility on [DATE], and had diagnoses that included acute pulmonary edema and congestive heart failure. There was no care plan developed to address Resident 121's needs. Clinical record review revealed that Resident 124 was admitted to the facility on [DATE], and had diagnoses that included bacteremia and benign prostatic hyperplasia (urinary condition). On April 25, 2024, the physician ordered for Resident 124 to have an indwelling urinary catheter. There was no evidence that interventions to address Resident 124's urinary status and catheter were included in the current care plan. Clinical record review revealed that Resident 296 was admitted to the facility on [DATE], and had diagnoses that included dependence on renal dialysis, nontraumatic ischemic infarction of the right lower leg muscle (blocked blood flow), and peripheral vascular disease. The Minimum Data Set (MDS) Care Area Assessment (CAA) summary dated May 11, 2024, noted that the resident's ADL (activities of daily living) function, urinary incontinence, pressure ulcers, and pain were to be addressed in the care plan. There was no evidence that interventions to address Resident 13's ADL function, urinary incontinence, pressure ulcers, or pain were included in the current care plan. In an interview on May 22, 2024, at 9:54 a.m., the Director of Nursing confirmed there was no documented evidence that the care areas were addressed in the residents' current care plans. CFR. 483.21(b)(1) Comprehensive Care Plans. Previously cited 6/1/23 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17709 Based on clinical record review and staff interview, it was determined that the facility failed to follow physician orders for three of 34 sampled residents. (Residents 107, 115, 296) Findings include: Clinical record review revealed that Resident 107 had diagnoses that included a history of sepsis (infection of the blood) and Alzheimer's disease. The Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident had been on an antibiotic medication in the last seven days and that he had a primary medical condition of sepsis of an unspecified organism. On March 18, 2024, a physician ordered for staff to administer an antibiotic medication (amoxicillin) twice a day for seven days for a total of 14 doses of the medication. Review of the March 2024 Medication Administration Record (MAR), revealed that staff had not administered the first dose of the antibiotic on March 18, 2024. Review of a nursing note dated March 18, 2024, revealed that the antibiotic was not administered because it had not been available. Further review of the MAR, revealed that he received the last dose of the antibiotic on March 24, 2024. The resident only received 13 doses of the antibiotic. There was no documented evidence that the resident received the full 14 dose antibiotic treatment for the sepsis. In an interview on May 22, 2024, at 9:49 a.m., the Director of Nursing confirmed that the resident had not received the full treatment of the antibiotic medication to treat sepsis. Clinical record review revealed that Resident 115 had diagnoses that included a traumatic brain injury and pressure ulcers. Review of Resident 115's care plan revealed he had an alteration in skin integrity with an intervention for staff to elevate heels and use assistive devices. On March 23, 2024, the physician ordered for staff to apply pressure reducing boots while in bed. Observations on May 20, 2024, from 9:16 a.m. through 1:12 p.m., and May 21, 2024, from 9:12 a.m. through 12:08 p.m., revealed Resident 115 in bed with no pressure reducing boots in place. Clinical record review revealed that Resident 296 was admitted to the facility on [DATE], and had diagnoses that included a dependence on renal dialysis and nontraumatic ischemic infarction (blocked blood flow) of the right lower leg muscle. Review of Resident 115's hospital discharge instructions dated May 4, 2024, revealed he was to receive epoetin alpha (medication that helps your body produce red blood cells) three times a week. On May 4, 14, 17, and 20, 2024, the physician ordered for Resident 115 to receive epoetin alpha three times a week. In an interview on May 20, 2024 at 12:34 p.m., Resident 115's wife stated he had not received the epoetin at all during his stay. There was no documented evidence that Resident 115 had received epoetin alpha as ordered by the physician. In an interview on May 22, 2024 at 9:54 a.m., the Director of Nursing confirmed that Resident 115 did not receive his ordered epoetin alpha in a timely manner. CFR 483.25 Quality of Care. Previously cited 2/12/24 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17709 Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide services and treatment to prevent further limitations in range of motion for one of five sampled residents who had limitations in range of motion. (Resident 41) Findings include: Clinical record review revealed that Resident 41 had a diagnosis of a stroke with hemiplegia, (paralysis), of the non-dominant left side. The Minimum Data Set assessment dated [DATE], indicated that the resident had some memory impairment and had limitations in range of motion on one side of the lower and upper extremities. A review of the care plan revealed that the resident had an activites of daily living deficit due to physician limitations. There was a current intervention for staff to apply a left resting hand splint in the morning and to remove it at night. In addition, there was a current physician order since March 8, 2024, for staff to apply the left resting hand splint every day to prevent contractures. Review of an occupational therapy evaluation dated May 16, 2024, revealed that the left resting hand splint was missing. On May 19, 2020, at 11:30 a.m., 12:10 p.m., 1:21 p.m., and 1:51 p.m., the resident was observed dressed and seated in her reclining broda chair without the left resting hand splint in place. In an interview on May 22, 2024, at 9:49 a.m., the Director of Nursing stated that the left resting hand splint was to be in place as ordered by the physician and that the splint was found to have been missing. CFR 483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility Previously cited 6/1/23. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43883 Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to provide adequate supervision and interventions to prevent accidents for two of five residents at risk for accidents. (Residents 2, 100). Findings include: Clinical record review revealed that Resident 2 had diagnoses that included traumatic brain injury and history of falls. Review of Resident 2's care plan revealed he was at risk for falls with interventions for staff to provide music or YouTube videos and to provide a laptop to watch baseball games. On May 19, 2024, at 9:15 a.m. through 10:45 a.m., and 12:08 p.m. through 12:45 p.m., Resident 2 was observed in his wheelchair in the hallway with no music, videos, or laptop. On May 20, 2024, at 10:05 a.m. through 12:35 p.m., Resident 2 was again observed in his wheelchair in the hallway with no music, videos, or laptop. In an interview on May 22, 2024, at 12:13 p.m., the Director of Nursing confirmed that staff should have provided music, YouTube videos, or a laptop to watch baseball games to Resident 2. Clinical record review revealed that Resident 100 had diagnoses that included hemiparesis (paralysis) to the left side, dysphagia (difficulty swallowing), and pneumonitis (inflammation of lung) due to inhalation of food. On April 6, 2023, the physician ordered for staff to provide supervision during meals for aspiration precautions (guidelines to prevent food or liquid from entering the lungs). On May 19, 2024, at 12:26 p.m. through 12:58 p.m., Resident 100 was observed in bed eating lunch without supervision from staff. On May 20, 2024, at 12:05 p.m. through 12:36 p.m., Resident 100 was again observed in bed eating lunch without supervision from staff. In an interview on May 22, 2024, at 9:58 a.m., the Director of Nursing confirmed that staff should have provided supervision of Resident 100 during meals. CFR 483.25(d)(2) Accidents. Previously cited 4/3/24 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43883 Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to monitor and assess resident weights and weight changes for five of 14 reviewed residents who were at risk for weight loss. (Residents 36, 73, 84, 95, 122) Findings include: Review of the facility policy entitled, Weights and Heights, last reviewed February 1, 2024, revealed that residents were to be weighed upon admission and/or re-admission, then weekly for four weeks and monthly thereafter. Additional weights may be obtained at the discretion of the interdisciplinary care team. In an interview on May 21, 2024, at 1:24 p.m., the Director of Nursing stated that reweighs should be completed the next day. Clinical record review revealed that Resident 36 had diagnoses that included dementia and heart disease. Review of the care plan revealed that the resident had an alteration in nutritional status due to dementia and weight loss with an intervention to review monthly weights and notify the doctor of significant weight loss. Review of the documented weights revealed that on January 1, 2024, the resident's weight was 143.6 pounds (lbs) and on February 1, 2024, her weight was 120 lbs. The resident had a 23.6 pound (lb) weight loss in 30 days. There was no documented evidence that the weight loss was addressed in a timely manner. On March 8, 2024, a dietician noted that the resident had a significant weight loss. In an interview on May 22, 2024, at 12:11 p.m., the Director of Nursing confirmed that the significant weight loss for Residents 36 had not been addressed in a timely manner. Clinical record review revealed that Resident 73 had diagnoses that included dementia and anemia. Review of the care plan revealed the resident was at nutritional risk due to inadequate intake and significant weight loss. There was no evidence that the resident's monthly weight was obtained in January, February, March, or April 2024, per facility policy. Clinical record review revealed that Resident 84 had diagnoses that included dysphagia and aphasia (comprehension and communication disorder). Review of the care plan revealed that the resident was at nutritional risk due to inadequate intake. On January 11, 2024, the resident weighed 198.4 lbs, and on February 1, 2023, the resident weighed 162.8 lbs, which reflected a significant weight loss of 35.6 lbs (17. 9%), in less than 30 days. There was no evidence that a reweigh was obtained in 24 hours or that the significant weight loss was identified or addressed in a timely manner. On March 1, 2024, the resident weighed 159.8 lbs, which confirmed the ongoing weight loss. There was no evidence that the weight loss was addressed or that the resident was assessed until March 12, 2024. Clinical record review revealed that Resident 95 was admitted to the facility on [DATE], and had diagnoses that included hydrocephalus (water on the brain), diabetes, and depression. Review of the care plan revealed that the resident was at risk for alteration in nutrition status. The resident was weighed on April 26, 2024 and May 1, 2024. There was no documented evidence that Resident 95 was weighed weekly after admission per facility policy. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clinical record review revealed that Resident 122 had diagnoses that included end stage renal disease with hemodialysis, legal blindness, and depression. Review of the care plan revealed that the resident was at risk for malnutrition. The resident was admitted to the facility on [DATE], and weighed 143.4 lbs at that time. There was no evidence that the resident was weighed again until February 28, 2024, not weekly per facility policy. In an interview on May 22, 2024, at 9:57 a.m., the Director of Nursing confirmed that the residents had not been weighed or assessed per facility policy. CFR 483.25(g)(1) Maintain acceptable parameters of nutritional status. Previously cited 12/6/23 28 Pa. Code 211.12(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. 43883 Based on policy review, clinical record review, and staff interview, it was determined that the facility failed to provide services consistent with professional standards of practice for one of two residents who received dialysis. (Resident 39) Findings include: A review of the facility policy entitled, Dialysis: Hemodialysis (HD) Provided by a Certified Dialysis Facility, last reviewed February 1, 2024, revealed that professional standards of practice included ongoing communication and collaboration with the dialysis facility regarding HD care and services. The care of the patient who received HD reflected ongoing communication, coordination, and collaboration between the center and dialysis staff. Communication included medication administration and changes, advanced directive and code status, and changes to functional status or falls. Clinical record review revealed that Resident 39 had diagnoses that included hypertension, heart failure, and end stage renal disease. Review of the resident's dialysis communication forms revealed that the pre-treatment report, which included code status, medications administered prior to dialysis, vital signs, falls, and relevant changes since the last treatment, was to be completed by the facility nurse. Further review of the resident's dialysis communication forms from April and May 2024, revealed that the pre-treatment report section of the communication forms was incomplete on April 1, 3, 5, 8, 10, 12, 15, 17, 19, 24, 26, and 29, 2024, and May 1, 6, 3, 8, 10, 15, and 17, 2024. In an interview on May 22, 2024, at 12:46 p.m., the Director of Nursing confirmed that the dialysis pre-treatment report was to be completed and was incomplete on those dates. 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. 43883 Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement a individualized, person-centered plan to render trauma informed care to a resident with a diagnosis of post-traumatic stress disorder (PTSD) for one of 34 sampled residents. (Resident 84) Findings include: Clinical record review revealed that Resident 84 had diagnoses that included bipolar disorder, depression, anxiety, aphasia (impaired ability to understand or form language), and PTSD. Further review of the resident's clinical record revealed that there were no resident specific interventions to meet the resident's needs for minimizing triggers or preventing re-traumatization. In an interview on May 22, 2024, at 11:51 a.m., the Director of Nursing confirmed the resident had a diagnoses of PTSD, and no individualized care plan was developed. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 43883 Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure that pharmacy recommendations were acted upon by the physician for one of 34 sampled residents. (Resident 111) Findings include: A review of the facility policy entitled, Medication Regimen Review, last reviewed February 1, 2024, revealed that the facility was to ensure that the attending physician, Medical Director, and Director of Nursing (DON) were provided with copies of the medication regimen reviews. The attending physician should document in the resident's record that an irregularity was reviewed and what, if any, action had been taken to address it. The attending physician should have addressed the consultant pharmacist's recommendation on their next scheduled visit to the facility to assess the resident, and no later than 60 days. Clinical record review revealed that Resident 111 had diagnoses that included dementia and insomnia. On October 31, 2023, the physician ordered for staff to administer melatonin (a hormone that assisted with sleep) three milligrams (mg) with instructions to provide one mg by mouth once a day for insomnia. On February 22, 2024, the pharmacist noted that the dose of the melatonin was to be clarified by the physician. On May 3, 2024, the pharmacist again noted that the dose of the melatonin was to be clarified by the physician. There was no evidence that Resident 111's physician acknowledged or acted upon the pharmacist's recommendation. In an interview on May 22, 2024, at 9:57 a.m., the Director of Nursing confirmed that the physician did not address the pharmacist's recommendation from February 22, 2024. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395796	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montgomeryville Skilled Nursing and Rehabilitati	640 Bethlehem Pike Montgomeryville, PA 18936

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 0804 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 43883 Based on resident interview, review of facility documentation, observation, and results of a test tray audit, it was determined that the facility failed to provide food that was palatable and at acceptable temperatures on three of three nursing units. (Rehab, First floor, and Second floor nursing units) Findings include: During interviews on May 19, 2024, between 10:22 a.m. and 1:10 p.m., Residents 62, 88, and 144, stated that the food was often served cold. In a group interview conducted on May 20, 2024, at 10:00 a.m., Residents 60, 120, 126, and 134, stated that the food was often served cold. During interviews on May 20, 2024, between 11:00 a.m. and 12:45 p.m., Residents 20 and 66 stated that the food was often served cold. Review of the facility's Food and Nutrition Services Test Tray Evaluation, revealed that the temperature range of hot items should be greater than 140 degrees Fahrenheit (F). A test tray conducted on May 21, 2024, at 12:07 p.m., revealed chicken at a temperature of 120 degrees F, rice at a temperature of 119 degrees F, and corn at a temperature of 118 degrees F. In an interview on May 21, 2024, at 12:56 p.m. the Director of Dietary confirmed that the items did not maintain acceptable temperatures at the point of service. 28 Pa. Code 201.14(a) Responsibility of licensee.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45244 Based on clinical record review, review of facility documentation, observation, and resident interview, it was determined that the facility failed to ensure that a resident's preference at meal times had been accommodated for two of 34 sampled residents. (Residents 49, 126) Findings include: Clinical record review revealed that Resident 49 had diagnoses that included dysphagia (difficulty swallowing) and atrial fibrillation. Reivew of the Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had no cognitive impairment. Review of Resident 49's care plan revealed she had a nutritional risk with an intervention for staff to honor food preferences. In an interview on May 19, 2024, at 12:43 p.m., the resident stated that she often didn't receive the food that she ordered. According to the resident's meal selection sheet (a document completed weekly by the resident to select food choices) she requested spinach, egg, and cheese casserole for lunch that day. When her lunch tray was observed at 12:50 p.m., she received turkey, mashed potatoes, and carrots. The resident stated that she didn't like these items. Clinical record review revealed that Resident 126 was admitted to the facility on [DATE], with diagnoses that included hypertension (high blood pressure) and hyponatremia (low sodium levels). Review of the MDS assessment dated [DATE], revealed that the resident had no cognitive impairment. Review of Resident 126's care plan revealed she had an altered nutrition status with an intervention for staff to honor food preferences. On May 20, 2024, at 12:34 p.m., Resident 126 was observed to receive fish as her meal. At that time, the resident stated she did not like fish and ordered a burger with raw onions. The resident's tray card indicated that the resident was to receive a burger with raw onions. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b) Management.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17709 Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to ensure that a therapeutic diet was provided as recommended by a registered dietician to one of 14 sampled residents who were at risk for weight loss. (Resident 43) Findings include: Clinical record review revealed that Resident 43 had diagnoses that included rhabdomyolysis (breakdown of muscle tissue), diabetes, and anemia. The Minimum Data Set assessment dated [DATE], indicated that the resident was alert and oriented, had weight loss, was not on a prescribed weight loss program, and was on a therapeutic diet. Review of a registered dietician's note dated March 7, 2024, revealed that the resident had a weight loss, had a good appetite, and that the resident stated he feels that breakfast portions can sometimes be too small. At that time, the dietician documented that the resident was to be provided with double portions at meals. Review of the facility master diet guide sheet revealed that on May 20, 2024, the meal served at lunch was three ounces of baked chicken, four ounces of seasoned zucchini, and a half-cup of orzo and fruit ambrosia salad. On May 20, 2024, Resident 43 was observed in his room and he had been served his lunch. Review of his tray card revealed that he was to receive double portions of food at his meals. At that time, he only received one portion each of the lunch items listed above. Resident stated he had a good appetite and liked to eat all of his food. In an interview on May 22, 2024, at 9:51 a.m., the Director of Nursing stated that the resident was to receive double portions of food at his meals. 28 Pa. Code 211.12(d)(3)(5) Nursing services.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 17709 Based on facility documentation review, observation, and family, resident, and staff interview, it was determined that the facility failed to ensure that meals were served at regularly scheduled times, in a timely manner, and in accordance with the residents' needs on one of three the nursing units. (Second floor nursing unit) Findings include: Review of the facility meal times schedule revealed that lunch was to arrive on the nursing units between 11:30 a.m. and 1:00 p.m On May 19, 2024, at 12:45 p.m., confidential staff interviews on the second floor nursing unit revealed that the lunch was being served very late today and had been served late on other occasions. In a confidential interview on May 19, 2024, at 1:09 p.m., a family member of a resident on the second floor stated that meals were frequently served late. Observation at that time revealed that the resident of this family member did not receive lunch until 1:15 p.m., 15 minutes after the latest scheduled time for the meals to arrive on the nursing units. In an interview on May 19, 2024, at 1:00 p.m., Residents 32 and 34 stated that they were waiting for their lunches and that the meals today were very late. In addition, they both stated that they were hungry and were anxiously awaiting their meals. Residents 32 and 34 did not receive their meals until 1:40 p.m., 40 minutes past the latest scheduled time for the meals to arrive on the nursing units. 28 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. 43883 Based on observation and interview, it was determined that the facility failed to store and serve food under sanitary conditions in the kitchen. Findings include: Observation of the kitchen on May 19, 2024, at 9:20 a.m., revealed the following: On a food preparation surface with a microwave, there was an open Pepsi bottle, a staff drink cup, an apron, a mask, crumbs and debris, Styrofoam cups, and plastic lids. The corner of the wall at the entry way was marred and peeling. There was an accumulation of food that remained in the dish machine trap. In an interview, Dietary Aide (DA) 1 stated that the dish machine had not yet been used on that date. On the bottom shelf of a food preparation surface, there was an accumulation of debris that included dust and crumbs on a case of corn starch. There was a rolling cart in the hot food preparation area with a ladle and an open container of powdered potatoes on the cart. In an interview, [NAME] 1 stated that the potatoes had not been used on that date and were left out and uncovered from the previous day. There was an accumulation of a dried, white substance that appeared to have dripped down the front of the oven doors. There was an accumulation of an unidentified substance on the bulk rice and flour bins. There was an open container of peanut butter with a spoon stored in the container. In the walk-in refrigerator, there was a pan of packaged raw beef and pork that were not dated. There were pans of macaroni and cheese and rice that were not dated. There were open packages of hard- boiled eggs and chicken patties that were not sealed and left open to air. In the walk-in freezer, there was a box of frozen potatoes that was stored on the floor. There were open boxes of frozen bread dough and pizzas that were not sealed and left open to air. In dry storage, there was a bag of baking powder that was not sealed and left open to air. Observation of the tray line service on May 21, 2024, at 11:31 a.m., revealed a fan on the counter at the tray line. There was an accumulation of dust on the fan which was blowing onto the plates. [NAME] 2 was wearing gloves and assembling resident plates on the tray line. [NAME] 2 left the tray line, opened and obtained items from the reach-in refrigerator, returned to tray line, and continued to assemble resident plates and handle ready to eat food, without changing gloves or performing hand hygiene. CFR 483.60(i)(1)(2) Food Procurement Store/Prepare/Serve-Sanitary Previously cited 6/1/23. 28 Pa. Code 201.18(b)(3) Management.