STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395819	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caring Heart Rehabilitation and Nursing Center	6445 Germantown Avenue Philadelphia, PA 19119

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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 - Few	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** Based on observations, resident interviews, staff interview, and review of facility policies, it was determined that the facility failed to maintain a clean, comfortable, and homelike environment on one of four nursing units (Fourth floor). Findings Include: Review of facility policy titled, The Dining Experience undated states, Policy: The dining experience will be person centered with the purpose of enhancing each individual's quality of life and being supportive of each individual's needs during dining. Individuals will be provided nourishing, palatable, attractive meals that meet daily nutritional, and/or special dietary needs and food preferences and are served at a safe and appetizing temperature. Further review of the policy states, Procedure: 4. Tables will be properly set (forks on the left, knives and spoons on the right). Review of facility policy titled, Reheating Foods in Microwave with a revision date on October 1, 2024 states, Policy Interpretation and Implementation- 1. Meal trays will not be held on the nursing units for re-heating at a later time. Fresh trays will be prepared by the kitchen when the resident is available to eat or requests a particular item at a higher temperature or hot beverages between meals. Interview on June 9, 2025, at 1:15 p.m. with Resident R502 revealed about two weeks ago there was a leak in the bedroom from the unit above and water was pouring from the ceiling. Observations on June 9, 2025, at 1:17 p.m. of Resident R502's bathroom confirmed the ceiling tiles above the sink in the room and in bathroom had water damage and had a brown/yellow discoloration. Interview held with Resident R183 on June 11, 2025 at 10:10 a.m. and resident stated he gets back from dialysis sometimes not until 3:45 p.m. and his lunch tray is sitting at his bedside cold. Resident R183 stated, I do not eat or will eat the food cold because staff says they are not allowed to heat it up for me. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview held with licensed nurse, Employee E16 on June 11, 2025 at 1:13 p.m. Employee E16 was seen assisting a nurse aide with passing out lunch trays to residents eating in their rooms. A lunch tray was observed sitting on a tray table bedside for Resident R183. Employee E16 was asked what they do for residents that have a dialysis chair time of 11:00 a.m. and are not back in time for lunch. Employee E16 stated, we set their lunch tray in the room and then when they get back we can reheat it for them if they want. When asked who heats up the lunch, Employee E16 stated, well we have a microwave on the unit, but that's usually just for employees so we send it back down to the kitchen. Observations on June 12, 2025, at 12:23 p.m. in room [ROOM NUMBER] revealed the panel on the wall was peeling off. Observation was made on June 12, 2025 at 12:43 p.m. of dining on the fourth floor. The residents were seated in the dining/activities room waiting for lunch starting around 12:40 p.m. Residents began being served their lunch at 1:18 p.m. by the nurse aides. All residents observed in the dining room were served their food on trays. All residents observed in the dining room were provided plastic silverware. There was no explanation of why the residents were given plastic silverware. 28 Pa Code 201.14 (a) Responsibility of licensee.

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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, review of clinical records, observations, and staff interviews, it was determined that the facility did not complete a comprehensive care plan for three of 38 residents reviewed (Residents R90, R204, R541). Findings Include: Review of Resident R90's clinical record revealed that the resident was admitted to the facility on [DATE]. Diagnoses included difficulty in walking, weakness, age related and osteoporosis (a condition that weakens bones, making them more likely to break). Review of physician order dated May 14, 2025, for Resident R90, indicated an order stating, left buttock: cleanse with 0.125% Dakin's, lightly pack with 0.125% Dakin's moistened fluffed gauze, zinc oxide to peri wound cover with bordered foam, two times a day for wound care, and as needed for soiled/dislodged/incontinence care. Observation conducted on June 11, 2025, at 10:03 a.m., of pressure ulcer treatment to Resident R90, revealed that the resident had a pressure wound at left buttocks. Review of the care plan for Resident R90, June 11, 2025, at 10:23 a.m., revealed that there were no focus, interventions, and outcomes (goals) care- planned for the care and treatment of the pressure wound at left buttocks of Resident R90. On June 11, 2025, at 10:27 a.m., interview with Employee E5, a Licensed Nurse, confirmed the above findings. Interview was held with Resident R204 on June 9, 2025 at 1:11 p.m. The resident discussed having wounds and being in pain. Observation of the resident's bed area revealed the resident had urinary catheter bag. Review of Resident R204's clinical record revealed the resident was admitted to the facility on [DATE]. Further review of Resident R204's record revealed the following diagnoses: Quadriplegia (dysfunction or loss of motor and/or sensory function in the cervical area of the spinal cord), Pressure-Induced Deep Tissue Damage of Left Hip, Pressure Ulcer of Right Upper Back, Pressure Ulcer of Left Buttock Unstageable, and Non-Pressure Chronic Ulcer of Other Part of Right Foot. Review of Residents R204's clinical record revealed the resident did not currently have an order for Enhanced Barrier Precautions. Further review of the resident's clinical order revealed the resident had an indwelling urinary catheter as of December 4, 2024. Further review of Resident R204's clinical record revealed the resident had a care plan dated March 4, 2025 revealed the resident did not have a baseline care plan in place for Enhanced Barrier Precautions related to the resident's pressure ulcers and urinary catheter care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Safety and Supervision dated October 1st, 2021, revealed resident safety and supervision and assistance to prevent accidents are facility wide priorities. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accent hazards or risks for individual residents the team then shall target in our interventions to reduce individual risks implementing interventions to reduce accents or risk shall include communication specific interventions to all relevant staff, assigning responsibility, providing training, ensuring that interventions are implemented and documenting interventions. Review of Resident R541's Minimum Data Set (MDS- a federal mandated assessment tool for all residents) revealed admission assessment dated [DATE], revealed that the resident entered the facility on May 17, 2025, with diagnosis including hemiplegia (paralysis of one side of the body), respiratory failure and malnutrition. Resident R541 with a brief interview of mental status revealed that this resident scored 9, indicating moderately cognitively deficit. This resident required continuous oxygen therapy, a urinary indwelling catheter, and a feeding tube. Review of resident R541's nurses note dated June 5, 2025, revealed the resident in bed awake, alert, and oriented. and remained on 1:1 supervisor. Further review of clinical record nursing notes dated June 11, 2025, revealed resident continues on 1:1 for safety Review of resident's care plan revealed no plan of care for resident's need for one-to-one supervision for safety. Interview with Director of Nursing, Employee E3 on June 11, 2025, at 02:00 p.m. confirmed that the resident does not have a physician order for one-to-one supervision and there is no current care plan for the resident to be supervised. Employee E3 stated that the resident required supervision for safety. The resident had behaviors of pulling on tubing of feeding tube, oxygen, and catheter. This employee continued to describe the resident's safety precaution as evolving on the determination of the resident's mood daily, sometimes requiring one to one, sometimes monitored at nurses' station, or determining the resident's moods the resident can be left alone. 28 Pa. Code 211.10 (c)(d) Resident care policies 28 Pa. Code 211.11(d) Resident care plan 28 Pa. Code 211.12(d) Nursing services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observations, clinical record review, review of facility documents and staff interviews, it was determined that the facility failed to revise residents' care plan related to fall prevention, smoking supervision, and oxygen treatment for two of 38 residents reviewed. (Residents R111, and R150) Findings include: A review of the facility's policy titled comprehensive care plans dated October 1, 2024 revealed that the facility was responsible for the development and implementation of a comprehensive care plan for each resident. The care plan was developed and implemented to meet the medical, nursing and mental and psychosocial needs identified in the resident's comprehensive assessment. The policy indicated that an interdisiplinary care team was to participate in the development, implementation and revision of the care plan as needed to reflect measurable objectives and timeframes to meet the residents needs. Clinical record review for Resident R111 revealed a quarterly Minimun Data Set (MDS- assessment of resident's needs) dated May 2, 2025 that indicated this resident was cognitively intact and had a diagnosis of cerebralvascular accident with hemiparesis (weakness to one side of the body). The assessment indicated that this resident uses a wheelchair to ambulate and required the assistance of one staff member for transfers. On May 22, 2025 the nursing note indicated that Resident R111 was found on the floor next to the bed. Resident R111 had fallen from the bed. The resident sustained a laceration to her forehead from the fall. The physician had given orders to send the resident to the hospital post fall. The resident received dermabond (skin adhesive to hold wound edges together) to her forehead at the hospital. Observation of Resident R111 at 11:30 on June 9, 2025 revealed that the resident had a scoop mattress on her bed. Interview with Resident R111 at 11:30 a.m., on June 9, 2025 confirmed a fall in May, 2025. Clinical record review for Resident R111 revealed that the use of adaptive equipment (scoop mattress) to help prevent falls from bed. There care plan was not revised to reflect the use of a perimeter mattress to prevent falls. Interview with the licensed nurse, Employee E8 at 1:00 p.m., on June 9, 2025 confirmed that the use of a perimeter mattress as resident care equipment to prevent falls for Resident R111 had not been revised and documented on the care plan for Resident R111. Review of clinical records revealed that Resident R150 was admitted in the facility on May 6, 2025 with the diagnoses of Chronic Obstructive Pulmonary Disease (COPD- long-term lung disease that makes it difficult to breathe), and adjustment disorder with mixed anxiety and depressed mood. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R150's care plan revealed as follows under its focus area: The resident has, COPD. Date Initiated: May 7, 2025. Continued review of the reisdent's care plan revealed the following interventions area: Identify and eliminate sources of respiratory irritation such as cigarette smoke, pollen, perfumes, etc. Further review of Resident R150's car plan revealed the following focus area: Resident wishes to smoke and is designated as safe Smoker; Date Initiated: May 14, 2025; . Resident will smoke safely in designated area and at scheduled times through next review; Date Initiated: 05/14/2025. Resident R150's care plan denoted a conflict between the resident's preference, and the outlined care interventions. 28 PA. Code 211.12(d)(1) 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. Based on clinical record review, interviews with staff and residents, reviews of policies and procedures and hospital record review, it was determined that the nursing staff failed to clarify and obtain physician's orders for treatment of skin impairments for one of six residents reviewed. (Resident R88) Findings include: A review of the facility policy titled treatment and medication administration dated October 1, 2024 revealed that the licensed nurse was responsible for administration of treats and medication administration for the residents. The nurse was responsible for verfiying resident name and physician's order on the medication or treatment administration record. The nurse was responsible for identifying the route of administration to the resident as ordered by the physician. The nurse was responsible for documenting adverse side effects or refusals of a treatment or medication that was ordered by the physician. The license nurse was responsible for correcting and discrepancies with the physician and nurse supervisor. Clinical record review for Resident R88 revealed a quarterly Minimun Data Set (MDS- assessment of resident care needs) dated April 11, 2025 that revealed this resident was cognitively intact. The assessment also indicated that this resident was at risk for pressure ulcer development. The assessment also said that Resident R88 was receiving application of dressings and ointments to areas of the body/skin other than the feet. Observations of Resident R88 at 11:00 a.m., on June 9, 2025 revealed that the resident was seated in the wheel chair with uncovered feet directly on the floor. Resident R8 was observed with uncovered lower extremities. Observations at this time with the licensed nurse, Employee E8, confirmed that the resident had a right lower extremity wound that was weaping onto the floor. Interview with Resident R88 at 10:30 a.m., on June 10, 2025 revealed that his lower extremities do itch at times. The resident said that he was not sure if the current treatment was preventing or releaving the dry skin itching. Resident R88 reported that he was willing to be on a nap schedule to elevate his legs throughout the day to help prevent the swelling of the lower extremities. Clinical record review revealed a hospital record that indicated Resident R88 had lymphedema (swelling cause by fluid buildup in the body) of the lower extremities. The hospital discharge record indicated that compression wrapping was the care plan and manual lymph drainage was also a consideration for lymphedema. Clinical record review revealed a wound specialist note dated April 16, 2025 that indicated that Resident R88 had a right leg lymphatic ulcer. The wound specialist's plan of care was to cleanse the right leg with soap and water, apply ammonia lactate, abd (sterile pad), kerlix (dressing) and compression wrapping (bandages for the legs) to the right lower extremity. Clinical record review revealed a physician's progress note dated April 29, 2025 that indicated Resident R88 had chronic lower extremity wounds. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clinical record review revealed that the podiatrist evaluated Resident R88 on May 1, 2025 and indicated that this resident had lymphedema. The podiatrist's plan of care for Resident R88 was to elevate legs and consider compression socks or teds. Clinical record review revealed that the licensed nurse failed to clarify the physician's orders for treatment of the right lower extremity. The treatment order for the right lower leg for June, 2025 indicated that the licensed nurse was to apply ammonia lactate 12% one time a day for dryness. The licensed nurse, Employee E8 confirmed at 11:15 a.m., on June 9, 2025 that the order did not specify a cleaning with soap and water, applying sterile pads, dressings or leaving open to air. Clinical record review revealed that the licensed nurse failed to clarify the podiatrist treatment plan to elevate the bilateral lower extremities. Interview with the licensed practical nurse, Employee E8, at 11:15 a.m, on June 9, 2025 confirmed that Resident R88 had no leg rests attached to the wheelchair and/or care planned for naps during the day so that the resident could elevate the lower extremities in bed. Clinical record review for Resident R88 revealed documentation on the medication administration record that lac-hydrin lotion(ammonium lactate) 5% was ordered to be applied three times a day to dry skin for Resident R88. Interview with licensed practical nurse, Employee E8 at 11:15 a.m., on June 9, 2025 confirmed the order for this skin treatment was not clarified. The licensed nurse failed to clarify this order (apply lac-hydrin (ammonium lactate) 5%) for Resident R88. Upon interview the nursing staff were unaware of how where to apply the treatment or if it could be applied concurrently with other skin treatments, in accordance with manufacturer's specifications for dry skin care for Resident R88. 28 PA. Code 211.10(c) Resident care policies 28 PA. Code 211.12(d)(1) Nursing services

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, interviews with staff and reviews of policies and procedures, it was determined that the facility failed to obtain weights and notify the physician or a weight gain as ordered for one of seven residents reviewed. (Resident R288) Findings include: A review of the facility policy titled weight and weight management dated October 1, 2024 indicated that the facility was responsible for obtaining an ongoing record of each resident's body weight. The policy indicated that body weight was an indicator of each resident's nutritional status and medical condition. That each resident will be weighed monthly or more frequently as deemed necessary by the physician. The policy also indicated that the physician ordered daily weights were to be documented by the nursing staff in the clinical record. The dietitian was responsible to reassess the nutritional needs and food and fluid intakes of each resident following a significant weight change. The nursing staff were to notify the physician of any significant weight changes. Clinical record review for Resident R288 revealed an admission Minimum Data Set (MDS- assessment of resident's needs) dated April 30, 2025 that indicated the resident was admitted to the facility on [DATE]. Continued review of the MDS revealed that the resident was cognitively intact and had a diagnosis of congestive heart failure (excessive body fluid caused by a weakened heart muscle). The assessment indicated that this resident was 67 inches in height and weighed 251 pounds and was not on a physician prescribed diet for weight-gain. Clinical record review revealed that Resident R288 was ordered daily weights by the physician, upon admission to the facility. The physician gave paramaters for the daily weights indicating that if the weight gain was greater than two pounds a day or five pounds a week that the physician was to be notified about the weight. Clinical record review revealed a weight record documented by the nursing staff. The weights for Resident R288 were not being recorded daily for April 25, 26, 27, 29, 30, 2025, and May 1, 2, 3, 4, 5, 2025. A significant weight gain of three pounds for May 8, 2025 at 307 pounds to May 9, 2025 at 310 pounds was recorded for Resident R288; however the physician was not notified of the weight gain as requested. There was no evidence that the dietitian was also notified by the nursing staff about the weight gain. Clinical record review revealed a daily weight of 302 pounds for Resident R288 on April 28, 2025. The next weight was not taken and recorded until May 6, 2025 for Resident R288 at 307 pounds. The physician was not notified of this five pound weight gain. The dietitian was not notified of the five pound weight gain documented on May 6, 2025 for Resident R288. Interview with the Director of Nursing, Employee E2, at 9:30 a.m., on June 11, 2025 confirmed that lack of documentation related to resident R288 weights record. The Director of Nursing also confirmed that the physician had not been notified of the weight gain on May 5, 2025 and the significant weight gain on May 9, 2025. 28 PA. Code 211.10(c) Resident care policies (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 PA. Code 211.12(d)(1)(3) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, clinical record review, review of facility policy and staff interview, it was determined that the facility failed to provide appropriate respiratory care and services for one of 38 residents reviewed (R191). Findings include: Review of the facility policy and guidelines for implementation of oxygen administration indicated that the nurse should review and follow the physician's orders while administering oxygen via nasal canula. Review of clinical records revealed that Resident R191 was admitted in the facility on July 9, 2024. R191 had diagnoses that included Chronic Obstructive Pulmonary Disease ((COPD), and Pulmonary Hypertension due to Lung Disease and Hypoxia (Pulmonary hypertension (PH) due to lung disease and hypoxia is a condition where high blood pressure develops in the pulmonary arteries (blood vessels in the lungs) as a result of lung damage and/or low blood oxygen levels (hypoxia). This high blood pressure makes it harder for the heart to pump blood through the lungs, potentially leading to right heart failure). Review of physician order for Resident R191 indicated an order dated August 30, 2024; Oxygen Continuous 3 L(liters)/min, via Nasal Canula, every shift for Shortness of Breath. On June 10, 2025, at 12:03 p.m., during interview, Resident R 191 stated that the humidifier chamber of Oxygen Concentrator was not filled with water. observation conducted at the time of the interview confirmed that the humidifier chamber of the oxygen concentrator was not filled with water. Also, observed that the tubing of the oxygen was not dated. At the time of the finding the same was confirmed with the Unit Manager, a Registered Nurse, Employee E17. 28 Pa Code 211.12(d)(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. Based on observation, interview with staff, clinical record review and reviews of facility policy, it was determined that the facility failed to ensure complete communication between the facility and the dialysis care provider for two of three residents reviewed. (Residents R8 and R539) Findings include: Review of facility policy titled Dialysis revised October 1, 2024, revealed that the facility will provide the necessary care and treatment, consistent with professional standards of practice . the comprehensive person-centered care plan and the residence goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis. Continued review of this policy revealed that a licensed nurse will communicate to the dialysis facility via telephone communication or written format such as the dialysis communication form that will include but not limited to physician laboratory values and vital signs and changes or decline in condition on related to dialysis. Review of facility dialysis long term care facility agreement with renal dialysis affiliation dated March 23, 2023, revealed the dialysis staff and facility will maintain communication, and ensure each record is properly documented and completed with information to provide supportive care of each resident. This joint communication consists of ongoing care interventions such as vitals, monitoring fluid gain or loss, monitor nutrition needs, medications, assessment of labs, and symptoms of infections. Review of Resident 539's care plan revealed this resident is care planned to receive dialysis services related to renal failure initiated June 9, 2025 with interventions included: to monitor dialysis fistula for bruit and thrill, monitor document, report to doctor as needed any signs or symptoms of infection to access site examples redness, swelling, warmth or drainage, obtain vital signs and weight per protocol, report significant changes in pulse respirations and blood pressure immediately. Review of a Dialysis binder (a shared communication between dialysis staff and facility staff relation to resident's health status before treatment, during treatment and after treatment, such as any medication change, recent lab results, vitals, fluids, sign and symptom of infection, resident site evaluation and if any adverse reaction) revealed communication sheets divided into three parts consisting of 1) information to be completed by facility staff to be completed prior to leaving the floor for treatment including information such as resident room/ date, code status, mental status, vital signs, current diet/ fluids, medications, medical problems, labs, location of access site, assessment of bruit, thrill, sign or symptoms of infection, and nurse's signature. Part 2) to be completed by dialysis nurse including pre dialysis weight/ post weight, amount of fluid removed, post treatment vitals, labs, dietician recommendations, fluid recommendation. Part 3) of the communication sheet is to be completed by the facility including information to be recorded and documents such as sign and symptoms of infection, bruit and thrill presence, additional comments and nurse's signature. Review of Resident R8's dialysis communication binder revealed that communication between the facility nursing staff and dialysis staff was determined to be incomplete, missing vital information on the following dates: May 23, May 26, May 28, May 30, June 2, June 4, June 6, and June 19,2025. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review or Resident R 539's dialysis communication binder revealed that communication between the facility nursing staff and dialysis staff was determined to be incomplete, missing vital information on the following dates: June 2, June 4, June 6, and June 9, 2025. Interview with Licensed nurse, Employee E18 on June 10, 2025 at 11:31p.m. revealed that the facility nurses sometimes just call the dialysis nurse and communicate all information, confirm verbally but it is not documented. Interview with Licensed dialysis nurse, Employee E 19 on June 11, 2025, 9:55 a.m. revealed that the proper protocol of the dialysis procedure is that the patient comes to the dialysis den (special room of treatment) with the dialysis communication binder, it is then reviewed prior to treatment. This employee stated that sometimes verbal communication is necessary for any irregular concerns of the resident. 28 Pa. Code 211.12 (d)(1)(5) Nursing Services

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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. Based on clincial record review and staff interview, it was determined that the faciltiy failed to ensure that a plan of care and assessment was completed for one of one resident with a diagnosis of post traumatic stress disorder (PTSD) . (Resident R50) Findings include: Review of facility policy title Trauma Informed Care dated October 2nd, 2022, revealed it is the policy of the facility to provide care and services are delivered using approaches which are culturally competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and or traumatization. Ensuring the residents choice and preferences are honor and the residents are empowered to be active participants in their care. An emphasis on partnering between residents, representative, and all staff and disciplines involved in the residence care in developing the plan of care. The facility will identify triggers which may be traumatized residents with a history of trauma, and update care plans to include interventions provided by the resident, family members, mental health professionals and observations during groups, socials and outings. In situations where trauma survivor is reluctant to share their history, the facility still tried to identify triggers which may retraumatize the resident and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident. Review of Resident R50's clinical record revealed resident had diagnosis' including major depressive disorder (persistent feelings of sadness and or loss of interest) vascular dementia (decline of thinking skills) and posts traumatic stress disorder (PTSD-a mental disorder that develops after experiencing a traumatic event). Review of Resident R50's care plan revealed no indication that this resident's diagnosis of PTSD has been defined and no plan has been developed and or documented for the specific diagnosis and needs of this resident. Resident R50's care plan dated December 16, 2029 has identified a risk for change in mood related to depressions, anxiety, and PTSD with no interventions specific to resident's diagnosis of PTSD. Interview with Social Service, Employee E14 on June 12, 2025, at 2:11 p.m. confirmed the care plan had no specific focus of the diagnosis PTSD. This employee stated that once the resident has the diagnosis then they are referred to psychiatric consult to then determine the resident triggers, moods, and changes which then would be included in the care plan. The facility now presents each resident with a trauma assessment to determine the residents needs and then included in the care plan. Resident R50 was not given the trauma assessment to complete. 28 Pa. Code 211.10 (c)(d) Resident care policies 28 Pa. Code 211.11(d) Resident care plan 28 Pa. Code 211.12(d) Nursing services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and review of resident records, it was determined the facility failed to maintain complete and accurate records for restorative therapy for one of 38 resident records reviewed (Resident R162) Findings include: Review of Resident R162's clinical record revealed that the resident was admitted to the facility on [DATE], with the diagnoses of osteoarthritis (degeneration of joint cartilage), dementia (a progressive cognitive disease with a loss of daily functions), abnormalities of gait and mobility. Review of Resident R162 's care meeting notes dated, February 4, 2025, indicated the resident was currently on physical therapy able to walk 180 feet using a rolling walker with one person assisting. Review of Resident R162's therapy Discharge summary dated , February 10, 2025, recommended the restorative nursing program (RNP) to facilitate the resident maintaining current level of performance and in order to prevent decline. The same discharge summary indicated the development of and instruction in the RNP has been completed with the interdisciplinary team that included ambulation and range of motion therapy. Resident R162 current care plan for limited physical mobility related to weakness included that the resident required one person assist to ambulate using a rolling walker. Further review of Resident R162's clinical record revealed no documented evidence the RNP was being completed with staff. On June 12, 2025, at 10:00 a.m. during an interview with the Assistant Director of Nursing (ADON) confirmed Resident R162 and residents on the RNP program fail to have a designated area for documentation when the RNP has been completed for the residents. 28 Pa Code 211.5(f)(ix) Medical records 28 Pa Code 211.12(d)(1) Nursing services

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, review of the clinical record and facility documentation, it was determined that the facility failed to ensure that a communication process was utilized for communication between the facility and the hospice care agencies for one out of three residents review receiving hospice care (Resident R204). Findings Include: Review of the facility's policy titled, Hospice with a revision date on October 1, 2024 states, Policy: When a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental, and psychosocial well-being. Further review of the facility policy revealed, Guidelines: 1. The facility maintains written agreements with hospice providers that specify the care and services to be provided and the process for hospice and nursing home communication of necessary information regarding the resident's care. 2. The facility and hospice provider will coordinate a plan of care and will implement interventions in accordance with the resident's needs, goals, and recognized standards of practice in consultation with the resident's attending physician/practitioner and resident's representative, to the extent possible. 3. The plan of care will identify the care and services that each entity will provide in order to meet the needs of the resident and his/her expressed desire for hospice care. 5. The facility will monitor and evaluate the resident's response to the plan of care. 6. The facility will maintain communication with hospice as it relates to the resident's plan of care and services. Review of Resident R204's clinical record revealed the resident was admitted to the facility on [DATE]. Further review of Resident R204's clinical record revealed the following diagnoses: Quadriplegia (dysfunction or loss of motor and/or sensory function in the cervical area of the spinal cord), Depression (a mood disorder characterized by persistent feelings of sadness, loss of interest in activities, and a range of other symptoms that interfere with daily life), and Dysphagia (Difficulty swallowing foods or liquids). (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's hospital discharge paperwork from February 15, 2025 revealed, Hospital Course/Treatment by Problem: admitted to the hospital for sepsis secondary to infected sacral decubitus, patient was also treated for multilobar community-acquired pneumonia and influenza A infection. He was seen by surgery and underwent debridement of his infected sacral decubitus. He was noted to have E coli bacteremia and was seen by infection doctor who recommended 14 days of IV (intravenous) antibiotics. Due to patient's poor quality of life and risk of recurrent infections as well as morbidity/mortality in the near future, palliative care was involved in patient's care. After discussions with patient and his brother, who was his medical Power of Attorney, it was decided that hospice services would be best suited for him with plans to do not hospitalize in the future. Patient was not interested in getting a PICC line for IV antibiotics and after discussion with infection doctor, decision was made regarding completing his antibiotic course with medication that can be administered through his PEG tube. Patient's pain was controlled with his usual medication he was discharged back to his long-term facility with hospice care. Further review of Resident R204's record revealed the resident signed onto hospice services on February 23, 2025. Review of the facility's hospice communication log (a communication book for hospice providers to utilize when they enter the facility by ensuring that the provide a summary to the facility of what services they provided to the resident) indicated that Resident R204 from February 23, 2025 when he signed onto hospice till current date of June 12, 2025 (11 weeks) the resident only had progress note entries for the following dates 2/24, 3/4, 3/12, 3/18, 3/26, 4/1, 4/4, 4/10, 4/16, 4/22, 5/7, 5/22, 5/29, 6/4/2025. Review of the communcation log progress notes revealed the hospice provider did not provide any documented information to the facility on what services the hospice nurse and/or nurse aide provided to the resident during the visits. Continued review of the hospice communication log did not include any information as to what occurred during the visits that were logged in the book by the hospice staff who visits Resident R204 (e.g. licensed nurse, nurse aides) to ensure ongoing communication between the facility and hospice agency. Interview held on June 11, 2025 at 10:01 a.m. with licensed nurse, Employee E16 who stated that hospice comes in really early in the morning for Resident R204. When asked about the frequency of visits Employee E16 stated the visits were daily. When asked about communcation with the hospice provider and the missing progress notes for a large amount of dates from February through June, Employee E16 stated there were no other notes provided by the hospice provider. 28 Pa Code 201.18(b)(1) Management

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policies, review of facility documentation, clinical record review and interviews with staff, it was determined that the facility failed to maintain an effective infection control program related with Enhanced Barrier Precautions for two of 10 residents reviewed (R90 and R541) Findings include: Review of literature revealed that Enhanced Barrier Precautions are infection control Intervention designed to reduce the transmission of novel or Multi-Drug-Resistant Organisms. Enhanced Barrier Precautions require to employ the use of targeted personal protective equipment (PPE) during high contact patient/resident activities. Review of Resident R90's clinical record revealed that the resident was admitted to the facility on [DATE]. Diagnoses included difficulty in Walking, Weakness, Age related and Osteoporosis (condition that weakens bones, making them more likely to break), and Methicillin Resistant Staphylococcus Aureus Infection (MRSA- is a type of bacterial infection that has developed resistance to several common antibiotics, including methicillin and other beta-lactam drugs. MRSA can cause a range of infections, from mild skin issues to more serious bloodstream infections. It is spread through skin-to-skin contact or contact with contaminated surfaces). Review of physician order dated May 14, 2025, for R90, indicated an order stating, left buttock: cleanse with 0.125% Dakin's, lightly pack with 0.125% Dakin's moistened fluffed gauze, zinc oxide to peri wound cover with bordered foam, two times a day for wound care, and as needed for soiled/dislodged/incontinence care. Review of Resident R90's care plan indicated; Enhanced Barrier Precautions: Resident is at increased risk for infection related to wound and foley catheter, date initiated: May 29, 2025. On June 12, 2025, at 10:03 a.m., observed wound treatment administered by a Licensed Nurse, Employee E6; the nurse did follow physician order for left buttock wound treatment, except the Enhanced Barrier Precaution Procedure. After the wound treatment, Employee E6, could not discard the used gown in a protective bag, but carried the used gown exposed, outside the resident room. Employee E5, the Licensed Nurse who was assisting Employee E6, also could not discard the used gown in a protective bag, but carried the used gown exposed, outside the resident room and placed in an open trash box attached with the treatment cart. At the time of the finding, the above finding was confirmed with Employees E5, and E6. Review of Resident R541's Minimum Data Set (MDS- a federal mandated assessment tool for all residents) revealed admission assessment dated [DATE], revealed that the resident entered the facility on May 17, 2025, with diagnosis including hemiplegia (paralysis of one side of the body), respiratory failure and malnutrition. Resident R 541 with a brief interview of mental status revealed that this resident scored 9, indication of a moderately cognitively deficit. This resident required continuous oxygen therapy, indwelling urinary catheter, and a feeding tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Resident 541 on June 10, 2025, at 12:02 p.m. revealed that this resident was receiving personal care by a nurse aide, Employee E20. This employee was observed not wearing the proper personal protection equipment (PPE) required for this task. Interview with Employee E20 at time of the above observation revealed that she was unaware that the gown was required unless actually performing wound care or urinary catheter care. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(d) Management

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observations of the food and nutrition services department, interviews with residents and staff, it was determined that essential equipment used to operate the food service was not being maintained in safe operating condition. Findings include: Observations of the main kitchen at 11:30 a.m., on June 9, 2025 revealed a tray line, steamtable and plating of foods. Observations of the main kitchen at 12:00 a.m., on June 9, 2025 revealed that the kitchen was not equipped with an operating plate warmer. The food service director, Employee E12 reported that the food service department was waiting for repairs for this essential piece of food service equipment to be fully operational. Observations of the main kitchen at 11:30 a.m., on June 10, 2025 revealed that the dinnerware (plates) did not fit inside the plate warmer and were stacked on top of each other two feet above the warming mechanisms of the plate warmer after being repaired. The plates were not warm or hot to touch. Interview with the food service director, Employee E12 at 11:30 a.m., on June 10, 2025 revealed that a facility this size needed two plate warming units to operate and accommodate all the china (plates) used for the residents meals. Interview with the food service director, Employee E12, at 11:30 a.m., on June 11, 2025 revealed that two wells inside the steamtable unit were not fully functioning. The food service director reported that a work order had been placed for repair of the steam table wells. The food service director reported that the maintenance department was waiting on a mechanical part to replace the broken wells of the steam table located in the main kitchen. 28 PA. Code 201.14(a) Responsibility of licensee