STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395828	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Heights Health & Rehab Center, LLC	429 Manor Drive Ebensburg, PA 15931

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 31760 Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure that assistance with hygiene was given in a manner that maintained dignity for one of 66 residents reviewed (Resident 84). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 84, dated December 17, 2024, revealed that the resident was understood and could understand others. A care plan for the resident, dated January 20, 2025, revealed that the resident had an activity of daily living (ADL - refer to basic tasks necessary for self-care and independent living) self-care performance deficit and staff was to help with morning and evening care. The facility's bath schedule indicated that Resident 84 was to receive a shower during the evening shift on Tuesdays and Fridays. The resident's clinical record revealed that the resident refused the shower and accepted a bed bath on January 24, 2025. However, there was no documented evidence that staff had asked the resident and/or that the resident had refused to have her facial hair removed. Observations of Resident 84 on January 27, 2025, at 1:24 p.m. and on January 28, 2025, at 11:51 a.m. revealed that the resident was lying in bed and she had multiple visible hairs on her chin approximately one-half to three-quarters of an inch long. Interview with the Director of Nursing on January 29, 2025, at 8:29 a.m. revealed that she had the staff go back to Resident 84 during the evening shift on January 28, 2025, and the resident allowed the staff to shave her facial hair. She indicated that they do not have a policy regarding facial hair preferences for females. She indicated that staff are to ask at the time of their shower, and that it would depend on the resident's response at that time if the staff would or would not remove the facial hair. 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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 31760 Based on review of residents' clinical records and facility's grievance/complaint logs, as well as staff interviews, it was determined that the facility failed to honor the resident's right to make informed choices and participate in his/her treatment for one of 66 residents reviewed (Resident 79). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 79, dated November 21, 2024, revealed that the resident was understood and could understand others. Physician's orders for Resident 79, dated November 14, 2024, included an order to inform the resident of his treatment plan. A concern form for Resident 79, dated September 4, 2024, revealed that the resident presented a concern that he is not being informed of when his appointments are, and he wants to know his appointments in advance. The results of the action that were taken after the investigation indicated that the resident would be given at least a week's notice. Interview with Resident 79 on January 27, 2025, at 11:46 a.m. revealed that he was sent out to a procedure last Thursday and was never notified prior to the person transporting him to the procedure showed up in his room. Nursing notes for Resident 79, dated January 16, 2025, at 8:00 a.m. revealed that the resident left at this time via power wheelchair. A nursing note, dated January 16, 2025, at 7:12 p.m., revealed that the resident went to a vascular appointment this morning and was awaiting transport back to facility. A nursing note, dated January 16, 2025, at 7:58 p.m., revealed that the resident returned from the hospital via stretcher after having his suprapubic catheter (a thin, flexible tube inserted into the bladder through a small incision in the lower abdomen to drain urine) reinserted. A nursing note for Resident 79, dated January 28, 2025, revealed that the writer spoke with the resident's sister at this time and explained to her about an appointment he had on January 16, 2025, as well as informed her that he had an appointment this Thursday at 1:45 p.m. There was no documented evidence in Resident 79's clinical record to indicate that the resident was notified of his appointments on January 16 and January 30, 2025. Interview with Resident 79 on January 29, 2025, at 12:30 p.m. revealed that he was looking on his patient portal (online access to your medical records) for his physician and found out that he has an appointment for this coming Thursday and that he was never informed from the facility staff that he had this appointment. Interview with the Director of Nursing on January 30, 2025, at 11:10 a.m. confirmed that there was no documented evidence that Resident 79 was informed of the January 16 and 30, 2025, appointments. She indicated that she notified the resident's sister because she wanted to be notified. She indicated that she would have to check with the resident and the resident's sister again to see what they want regarding the notification process. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.29(a) Resident Rights.

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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. 19102 Based on review of policies, clinical records, and facility grievance forms, as well as resident and staff interviews, it was determined that the facility failed to make ongoing efforts to resolve the grievances of residents for one of 66 residents reviewed (Resident 18). Findings include: The facility's grievance policy, revised October 19, 2018, indicated that the facility's grievance review would be completed in a reasonable time frame consistent with the type of grievance, but in no event would the review exceed 30 days. If the Grievance Committee/Grievance Official determined that a resident rights violation had occurred, the violation was to be corrected within 10 days. Upon completion of the review, the Grievance Official would complete a written grievance decision that included the following: the date the grievance was received, a summary of the statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns, a statement as to whether the grievance was confirmed or not confirmed, whether any corrective action was or would be taken, and if the corrective action was or would be taken, and a summary of the corrective action. If corrective actions would not be taken, then an explanation of why such action was not necessary. The Grievance Official would meet with the resident and inform the resident of the results of the investigation and how the resident's grievance was resolved or would be resolved, if applicable. A copy of the written grievance decision would be provided to the resident upon request. A quarterly Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 18, dated December 16, 2024, revealed that the resident could make her needs known, was cognitively intact, and required assistance from staff for care. An interview with Resident 18 on January 27, 2025, at 10:26 a.m. revealed that she filed a grievance on December 25, 2024 and did not hear anything about it. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A grievance form for Resident 18, dated December 25, 2024, revealed that the resident had concerns about not receiving her gas pill and that she was still not washed up for the day. She asked a nurse aide and licensed practical nurse at 1:00 p.m. to help her, and after she called the desk, she was washed up by 3:00 p. m. by two unknown nurse aides. The grievance was assigned on January 7, 2025, and the results of the action taken was that nursing was to review medication changes with Resident 18. There was no documented evidence that the resident's complaint/grievance was thoroughly investigated, including interviews and/or written statements from the staff who worked during the shift in question, whether or not there was proper care provided at that time or not, and did not include a statement as to whether the grievance was confirmed or not confirmed. There was also no documented evidence regarding ongoing efforts to resolve Resident 18's concerns until January 28, 2025, when the Nursing Home Administrator met with Resident 18, and it was decided that he would review in the morning clinical meeting changes to Resident 18's care regarding medication changes, including pharmacy delivery of her medications that were changed, outstanding laboratory tests, and other pertinent care issues. The Nursing Home Administrator would confirm with nursing that Resident 18 was made aware of those changes and would follow up with Resident 18 weekly with room visits to see how the mentioned issues were being addressed and discuss any other needs or questions she may have. There was no documented evidence that Resident 18 signed that she was informed of the grievance resolution until January 29, 2025. Interview with the Nursing Home Administrator on January 29, 2025, at 12:44 p.m. confirmed that there was no documented evidence that ongoing efforts were made to resolve Resident 18's grievance from December 25, 2024, and that the resident was not informed of the resolution until January 29, 2025. 28 Pa. Code 201.29(i) Resident Rights.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43856 Based on review of facility policies, investigation reports, and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from abuse or neglect for three of 66 residents reviewed (Residents 58, 130, 134). This deficiency is being cited as past non-compliance. Findings include: The facility's policy regarding abuse, neglect, and exploitation, dated December 30, 2024, indicated that the facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, or misappropriation of resident property by anyone. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual including a caretaker of goods or services that are necessary to attain or maintain physical, mental, and psychological well-being. Neglect was defined as the failure of the facility, its employees, or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 58, dated October 25, 2024, revealed that the resident was understood and could understand others, was dependent on staff for toileting needs, was occasionally incontinent of urine, and had a diagnosis of dementia. A nursing note for Resident 58, dated November 21, 2024, revealed that Licensed Practical Nurse 2 reported to Registered Nurse 1 that Resident 58 was crying and stated, she pulled my call bell out. Licensed Practical Nurse 2 observed the call bell on the floor, plugged it back into the wall, and alerted the registered nurse. The resident reported to Registered Nurse 1 that she had her call bell on last night to use the bed pan, the girl came in, pulled her call bell out and left, shutting the door without assisting her to the bedpan. A witness statement from Licensed Practical Nurse 2, dated November 21, 2024, revealed that when she went into Resident 58's room at 8:30 a.m. to administer the resident's medication, she observed the resident crying. When she asked the resident what was wrong, Resident 58 stated she pulled my call bell out. Licensed Practical Nurse 2 observed the call bell lying on the floor and immediately plugged it back into the wall and notified the registered nurse. The facility's investigation, completed on November 22, 2024, revealed that the nurse aide accused of abuse/neglect by Resident 58 was identified as Nurse Aide 3. The allegation of abuse/neglect made by Resident 58 of Nurse Aide 3 was substantiated and Nurse Aide 3 was terminated. An interview with the Director of Nursing on January 29, 2025, at 11:10 a.m. confirmed that Resident 58's allegation of abuse/neglect was substantiated. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly MDS assessment for Resident 130, dated August 7, 2024, revealed that the resident was cognitively impaired, required extensive assistance for daily care needs, and had a diagnosis of severe dementia with anxiety. A care plan for Resident 130, dated May 31, 2024, revealed that the resident had physical and behavioral symptoms toward others and has tried to push and hit staff when attempting to redirect. The resident can become aggressive with other residents. Approach and interventions included maintaining a calm environment; promptly provide incontinence care after bowel movements; provide care, activities, and a daily schedule that resembles the resident's prior lifestyle; and remove the resident from other resident rooms and unsafe situations. Resident 130 is currently being followed by psychiatry services since June 12, 2024, for behavior, mood and medication management. A nursing note for Resident 130, dated October 21, 2024, at 4:50 p.m., revealed that Registered Nurse 5 was called to room [ROOM NUMBER], where Resident 28 resides. Resident 130 entered the room and flipped Resident 28's supper tray on her from the bedside table while she was seated in her wheelchair. Resident 28 picked up the tray and hit Resident 130 on the top of the head. The residents were immediately separated and assessed, and no injuries were noted. Resident 130 was placed on one-on-one observation. Resident representatives, providers, and local police were notified of the incident. Resident 130 had no recollection of the incident and was placed on 15-minute checks. A statement from Resident 28, dated October 21, 2024, revealed that a lady came in my room while I was eating supper and said that I was with her man. I said something back to her and she threw food all over me. I tried to scare her out by using my tray, I hit her on the head, but not hard I just wanted to scare her. A statement from Registered Nurse 5, dated October 21, 2024, revealed that she was called to Resident 28's room by her roommate stating that something is wrong. Upon entering the room Resident 28 was observed sitting in her wheelchair with food on her and holding her dietary tray over Resident 130's head. Resident 28 was hitting resident 130 on the head with the tray. Resident 130 was removed from the room and Resident 28 stated that Resident 130 came in to her room and flipped the tray on her and she was hitting her with the tray to scare her out of the room. A psychiatry note for Resident 130, dated October 22, 2024, revealed that the visit was an emergent televisit (a visit via telecommunication) requested by the facility after a resident-to-resident altercation. Resident 130's mood was improved but continues to have intermittent episodes of agitation. Medications were reviewed and changes were 0.5 mg Ativan three times a day for five days then 0.25 mg Ativan at bedtime for 5 days then discontinue, 5 mg Hydroxyzine four times a day for 5 days then 10 mg Hydroxyzine four times a day, 5 mg Hydroxyzine 5 mg/0.1 ml gel topically every eight hours for 10 days. Resident to be followed up on October 25, 2024. An interview with the Director of Nursing on January 28, 2025, at 1:35 p.m. confirmed that the facility's investigation was completed on October 22, 2024, and resident-to-resident abuse was substantiated. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note for Resident 130, dated October 25, 2024, at 2:15 p.m. revealed that Nurse Aide 6 was walking down the South shoe hall and when she turned the corner, she witnessed an altercation with Resident 130 and Resident 350. Resident 130 was wandering in the hall and was attempting to enter the room of Resident 350 when Resident 350 kicked her in the groin and leg. The residents were redirected away from each other and safety was maintained. An assessment was attempted on Resident 130 and she refused repeatedly. She was agitated and was yelling and swearing. She was uncooperative and unable to be redirected. There were no visible signs of trauma or injury. The provider was notified of the resident-to-resident altercation, increased behaviors, and altered mental status. The order to transfer Resident 130 to the hospital was given and family was agreeable. Resident 130 was admitted to the Behavioral Health Unit at the hospital. A nursing note for Resident 130, dated October 28, 2024, at 11:42 a. m. revealed that a hearing was held regarding a 302 petition (an involuntary commitment process to provide immediate emergency treatment for individuals experiencing a mental health crisis). An interview with the Director of Nursing on January 28, 2025, at 1:35 p.m. confirmed that the facility's investigation was completed on October 25, 2024, and the resident-to-resident abuse was substantiated. A quarterly MDS assessment for Resident 134, dated November 4, 2024, revealed that the resident was cognitively impaired, required assistance for daily care needs, and had a diagnoses of Rhabdomyolysis (the breakdown of muscle tissue) and Parkinsonism (a brain condition that causes slowed movements, stiffness and tremors). A care plan for Resident 134, dated June 10, 2024, revealed that the resident had physical behavioral symptoms toward others, hitting, kicking, pushing, scratching and abusing other sexually. Approach and interventions included avoiding over stimulation, noise, crowding and aggressive residents, avoid power struggles with resident, offer one-step instructions and allow resident time to process information, when resident becomes aggressive keep distance between resident and others, leg rests for wheelchair during transport only. When not in use leg rests were to be placed in the bag on the back of the wheelchair. Resident 134 was currently being followed by psychiatry services since June 12, 2024 for behavior, mood, and medication management. A nursing note for Resident 134, dated December 17, 2024, at 1:50 p.m., revealed that the resident was involved in a resident-to-resident altercation after an activity. Resident 134 was propelling in the hallway in his wheelchair and was trying to get past Resident 92. When Resident 92 stated, hang on a minute, Resident 134 took the footrest off of his wheelchair and hit Resident 92 in the head with it. The residents were immediately separated and Resident 92 was assessed and was noted to have a small laceration on the top of his head. Resident 92 stated, it's not a big deal. Resident 92 was also assessed by the nurse practitioner on the unit. Responsible parties and local police were notified of the incident. Resident 134 was interviewed by social services and revealed that he did remember hitting someone and he did it because the man was going to unlock the main line and shut off all the power to the building. Resident 134 was to be evaluated by psychology the following day. A statement from Nurse Aide 7, dated December 17, 2024, revealed that she was pushing Resident 134 through a door that Resident 92 was holding open, and Resident 134 took the footrest off of his wheelchair and hit Resident 92 on the top of the when he bent over. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A psychiatry note for Resident 134, dated December 18, 2024, revealed that the resident was involved in a resident -to-resident altercation and the facility requested a visit. The altercation appears to be a misunderstanding due to the resident's mentation. Resident 134 thought that the other resident was going to cause harm. No medication changes were made and staff was to monitor mood and behavior. An interview with the Director of Nursing on January 30, 2025, at 12:30 p.m. confirmed that the facility's investigation was completed on December 17, 2024, an that resident-to-resident abuse was substantiated. Following the incident/investigation on December 17, 2024, the facility's corrective actions included: Nursing staff were educated on abuse and education was completed December 17, 2024. Audits to monitor and maintain ongoing compliance with abuse prevention were conducted weekly for four weeks then monthly for two months. The results of these audits will be brought to Quality Assurance Performance Improvement committee for further analysis and corrective actions if necessary. A review of the facility's corrective actions revealed that they were in compliance with F600 on December 18, 2024. Interview with the Director of Nursing on January 30, 2025, at 12:30 p.m. revealed staff education was completed and ongoing audits are to be discussed during the monthly Quality Assurance (QA) meeting. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.10(c)(d) Resident Care Policies. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 19102 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that a written notice was provided to the resident's responsible party regarding the reason for transfer to the hospital for three of 66 residents reviewed (Residents 12, 32, 84). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 12, dated December 10, 2024, indicated that the resident was understood, could understand others, and was cognitively intact. A nursing note, dated November 2, 2024, at 11:50 a.m., revealed that Resident 12 was observed lying on her left side on the floor between her bed and wheelchair. The resident was confused, had a tremor to her right hand, and stated that she had pain in her lower extremities. She was observed to be hyperventilating, staring blankly into the corner of the room, and had a nonproductive, moist cough. The resident's responsible party was notified and requested she be transferred to the hospital. Interview with the Social Service Director on January 30, 2025, at 2:37 p.m. confirmed that there was no documented evidence that a written notice of Resident 12's transfer to the hospital was provided to the resident's responsible party regarding the reason for transfer to the hospital on November 2, 2024. An annual MDS assessment for Resident 32, dated December 2, 2024, revealed that the resident was understood and could understand others. Nursing notes for Resident 32, dated December 29, 2024, at 7:05 a.m. revealed that the resident was checked at the bedside at the request of a licensed practical nurse due to change in the resident's condition. The resident was lying in bed awake but disoriented. The resident was lethargic (feeling tired, sluggish, or lacking in energy) and nodding head to answer some questions. The physician was contacted and a order was obtained to send the resident to the emergency department for further evaluation. A nursing note at 11:59 a.m. revealed that the resident was admitted with a diagnosis of septic shock (a life-threatening condition that occurs when an infection spreads throughout the body and causes a dangerously low blood pressure). Nursing notes for Resident 32, dated January 9, 2025, at 12:51 a.m. revealed that the resident was requesting to go to the emergency department for a complaint of shortness of breath. Verbal orders were obtained from the physician to send resident to emergency department for further treatment and evaluation. A nursing note at 5:48 p.m. revealed that the resident was admitted with a diagnosis of shortness of breath. There was no documented evidence that a written notice of Resident 32's transfer to the hospital was provided to the resident's responsible party regarding the reason for transfer to the hospital on December 29, 2024, and on January 9, 2025. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Nursing Home Administrator on January 29, 2025, at 12:08 p.m. confirmed that there was no documented evidence that a written notice of Resident 32's transfers to the hospital was provided to the resident's responsible party regarding the reason for transfer to the hospital on December 29, 2024, and on January 9, 2025. A quarterly MDS assessment for Resident 84, dated December 17, 2024, revealed that the resident was understood and could understand others. A nursing note for Resident 84, dated January 16, 2025, revealed that a roommate's family member approached the nurses' station stating that this resident was on the floor. Upon entering the resident's room, the resident was observed on the floor next to the bed on her right side. Blood was noted on the resident's face, upper body, and floor next to the resident. A large laceration was noted above her left eyebrow. The left nostril was noted to have blood coming from it, and a large blood clot was noted. The resident was unable to state what she was doing prior to the fall. The Certified Registered Nurse Practitioner (CRNP - a registered nurse (RN) who has obtained advanced education and training allowing them to diagnose illnesses, prescribe medication, and provide patient care in a specialized area of healthcare) was updated, and orders were received to send the resident to the hospital for evaluation. A nursing note for Resident 84, dated January 17, 2025, revealed that the resident was admitted to the hospital at this time. There was no documented evidence that a written notice of Resident 84's transfer to the hospital was provided to the resident's responsible party regarding the reason for transfer to the hospital on January 16, 2025. Interview with the Director of Nursing on January 29, 2025, at 10:15 a.m. confirmed that there was no documented evidence that a written notice of Resident 84's transfers to the hospital was provided to the resident's responsible party regarding the reason for transfer to the hospital on January 16, 2025. 28 Pa. Code 201.14(a) Responsibility of Licensee.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19102 Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that comprehensive admission Minimum Data Set assessments were completed in the required time frame for five of 66 residents reviewed (Residents 141, 143, 147, 152, 165). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, indicated that an admission MDS assessment was to be completed no later than 14 days (admitted + 13 calendar days) following admission. A comprehensive admission MDS assessment for Resident 141, dated October 28, 2024, revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on November 5, 2024, which was 16 days after admission. A comprehensive admission MDS assessment for Resident 143, dated November 13, 2024, revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on November 26, 2024, which was 20 days after admission. A comprehensive admission MDS assessment for Resident 147, dated November 7, 2024, revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on November 15, 2024, which was 15 days after admission. A comprehensive admission MDS assessment for Resident 152, dated November 25, 2024, revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on December 4, 2024, which was 16 days after admission. A comprehensive admission MDS assessment for Resident 165, dated January 2, 2025, revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on January 10, 2025, which was 15 days after admission. An interview with Nursing Home Administrator on January 30, 2025, at 3:10 p.m. confirmed that the admission MDS assessments listed above were not completed within the required time frames. 28 Pa. Code 211.5(f) Clinical Records.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19102 Based on a review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for seven of 66 residents reviewed (Residents 12, 17, 18, 25, 41, 93, 122). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of MDS assessments, dated October 2024, indicated that the intent of Section N was to record the number of days, during the seven-day assessment period, that any type of injection, insulin, and/or select medications were received by the resident. Section N0415B was to be coded if the resident received an antianxiety medication during the seven-day assessment period, Section N0415G1 Diuretic Medications (medications that promote the excretion of urine by the kidneys) was to be coded if the resident took the medication during the seven-day assessment period, Section N0451H was to be coded if the resident received an opioid (narcotic) medication during the seven-day assessment period, and Section N0451K was to be coded if the resident received an anti-convulsant during the seven-day assessment period. Section O0100J2 was to be coded for residents who received hemodialysis services (mechanical cleansing of the blood for a person whose kidneys are not functioning normally) while a resident within a 14-day look-back period. Section O0250A (Influenza Vaccine) was to be coded (0) if the resident did not receive the influenza vaccine, and (1) if the resident did receive the influenza vaccine, Section O0250B was to be completed with the date the influenza vaccine was received, and Section O0250C was to be coded with the reason why the influenza vaccine was not received; (1) if the resident was not in the facility during the flu season; (2) if received outside the facility; (3) if not eligible; (4) if offered and declined; (5) if not offered; (6) inability to obtain influenza vaccine due to a declared shortage; and (9) none of the above. A quarterly MDS assessment for Resident 12, dated December 10, 2024, revealed that the resident was not offered the influenza vaccine. However, a nursing note, dated September 26, 2024, revealed that Resident 12 refused the influenza vaccine despite education. Physician's orders for Resident 17, dated June 10, 2024, included an order for the resident to receive 300 milligrams (mg) of gabapentin (anticonvulsant medication) twice a day for neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet). Medication Administration Records (MAR's) for Resident 17, dated December 2024, revealed that staff administered 300 mg of gabapentin twice a day from November 1 through 30, 2024. However, Section N0415K1 of Resident 17's quarterly MDS assessment, dated November 20, 2024, was coded to indicate that the resident did not receive an anti-convulsant medication during the seven-day assessment. Physician's orders for Resident 18, dated May 30, 2024, included an order for the resident to receive 2 mg of bumetanide (a diuretic medication) daily for lymphedema (chronic condition that causes swelling in the body's tissues, typically in the arms or legs) of the lower extremities. Medication Administration Records (MAR's) for Resident 18, dated December 2024, revealed that staff administered 2 mg of bumetanide daily from December 1 through 16, 2024. However, Section N0415G1 of Resident 18's quarterly MDS assessment, dated December 16, 2024, was coded to indicate that the resident did not receive a diuretic medication during the seven-day assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan for Resident 25, dated January 3, 2025, revealed diagnoses that included kidney failure and required hemodialysis treatments three times a week. A nursing note for Resident 25, dated January 4, 2025, revealed that she was out of the facility for hemodialysis treatment. However, Section O0100J2 of Resident 25's admission MDS, dated [DATE], revealed that the section was not checked, indicating that the resident did not receive dialysis treatments during the assessment's 14-day look-back period. Interview with the Licensed Practical Nurse Assessment Coordinator 4 on January 30, 2025, at 2:10 p.m. confirmed that Section O0100J2 of Resident 25's admission MDS assessment of January 6, 2025, should have been coded to reflect that the resident received hemodialysis treatments during the assessment period. Physician's orders for Resident 41, dated December 26, 2024, included an order for the resident to receive 5 milligrams (mg) diazepam (anti-anxiety medication) every day. Review of the MAR for Resident 41, for December 2024 and January 2025 revealed that the resident received 5 mg of diazepam daily as ordered. However, a quarterly MDS assessment for Resident 41, dated January 8, 2025, revealed that Section N0415B was coded to indicate that the resident had not received an anti-anxiety medication. An influenza declination form for Resident 93, dated September 26, 2024, indicated that the resident refused the influenza vaccine. A pneumococcal vaccine declination form for Resident 93, dated March 12, 2024, indicated that the resident refused the pneumococcal vaccine. However, a quarterly MDS assessment for Resident 93, dated November 28, 2024, revealed that Section O0250C was coded 5 indicating that the flu vaccine was not offered and Section O0300B was coded 3 indicating that the pneumococcal vaccine was not offered. Physician's orders for Resident 122, dated June 25, 2024, included orders for the resident to receive 50 mg Tramadol (opioid) every six hours as needed for pain. Physician's orders dated August 9, 2024, included an order for the resident to receive 75 mg Topiramate (anti-convulsant) at bedtime and 50 mg twice a day. Review of the October and November 2024 MAR for Resident 122 revealed that the resident received Tramadol and Topiramate during the assessment period. However, a quarterly MDS assessment for Resident 122, dated November 4, 2024, revealed that Sections N0415H and N0415K were coded to indicate that the resident had not received the opioid and the anti-convulsant. Interview with the Licensed Practical Nurse Assessment Coordinator 4 (LPNAC - a licensed practical nurse who assists the Registered Nurse Assessment Coordinator with the completion of MDS assessments) on January 30, 2025, at 11:35 a.m. confirmed that MDS assessments for Residents 12, 17, 18, 41, 93, and 122 were coded inaccurately. 28 Pa. Code 211.5(f) Clinical Records.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 31760 Based on a review of facility policies, clinical record reviews, and staff interviews, it was determined that the facility failed to ensure that a resident's baseline care plan included information regarding the resident's immediate care needs for one of 66 residents reviewed (Resident 94). Findings include: A facility policy for interim/baseline care plans, dated December 30, 2024, revealed that within 48 hours of admission, the facility will develop and implement an interim/baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident until a comprehensive assessment can be completed, leading to a comprehensive care plan. The base line care plan will be used until the comprehensive assessment and care plan is developed by the interdisciplinary team. The base line care plan will include the minimum healthcare information necessary to care for a resident. A nursing note for Resident 94, dated December 14, 2024, revealed that the resident was a new admission to the facility from the hospital; that the resident receives hemodialysis services (mechanical cleansing of the blood for a person whose kidneys are not functioning normally) three time per week on Tuesday, Thursday, and Saturday; and the resident has an arteriovenous (AV) fistula (a procedure that connects an artery to a vein in preparation for dialysis). Physician's orders for Resident 94, dated December 15, 2024, included orders for staff to check the AV fistula site daily for bleeding; notify provider as needed; if bleeding occurs from the AV fistula site, apply pressure and if bleeding does not stop, call 911, and notify provider; and to check for a bruit (an audible vascular sound associated with turbulent blood flow) and thrill (a palpable vibration or sensation felt on the skin overlying a blood vessel) to the resident's left upper arm AV fistula site. There was no documented evidence that a baseline care plan was developed for Resident 25's care and treatment needs related to hemodialysis. Interview with the Licensed Practical Nurse Assessment Coordinator 4 (LPNAC - a licensed practical nurse who assists the Registered Nurse Assessment Coordinator with the completion of MDS assessments) on January 30, 2025, at 2:16 p.m. confirmed that a baseline care plan was not developed for Resident 25's care and treatment needs related to hemodialysis. 28 Pa. Code 211.12(d)(1) Nursing 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. 19102 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included specific and individualized interventions for one of 66 residents reviewed (Resident 44). Findings include: The facility's policy regarding care plans, dated December 30, 2024, revealed that the facility was to develop a comprehensive, person-centered care plan for each resident that included measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessments. The comprehensive care plan was to be reviewed and updated at least every 90 days by the interdisciplinary team, and in cases of significant changes in the resident's condition, the care plan was to be updated within seven days of the new full assessment. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 44, dated November 20, 2024 revealed that the resident was cognitively impaired, received an anti-convulsant medication, and had diagnoses that included a seizure disorder. Physician's orders for Resident 44, dated November 14 and December 30, 2024, included orders for the resident to receive 500 milligrams (mg) of valproic acid (anticonvulsant) two times a day for seizures and 1500 mg of levetiracetam (anticonvulsant) twice a day for seizures. The Medication Administration Record (MAR) for January 2025 revealed that Resident 44 was receiving valproic acid and levetiracetam two times a day. Review of the resident's current care plan revealed that there was no documented evidence that a care plan was developed to address Resident 44's care needs related to receiving anticonvulsant medications or having a seizure disorder. Interview with the Director of Nursing on January 28, 2025, at 1:32 p.m. confirmed that Resident 44's care plan did not include the use of anticonvulsant medications or a seizure disorder and should have. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31760 Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that care plans were updated to reflect changes in residents' care needs for seven of 66 residents reviewed (Residents 2, 25, 41, 64, 79, 106, 130). Findings include: The facility's policy regarding care plans, dated [DATE], revealed that the facility was to develop a comprehensive, person-centered care plan for each resident that included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessments. The comprehensive care plan was to be reviewed and updated at least every 90 days by the interdisciplinary team, and in cases of significant changes in the resident's condition, the care plan was to be updated within seven days of the new full assessment. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated [DATE], indicated that the resident was cognitively intact and that she required assistance from staff for her daily care needs. Physician's order for Resident 2, dated [DATE], indicated that the resident was a Do Not Resuscitate (DNR - do not provide Cardio-Pulmonary Resuscitation - CPR). Resident 2's care plan, most recently updated [DATE], revealed that the resident was a full code (wanted CPR). There was no documented evidence that Resident 2's care plan was updated to reflect her change in code status to reflect that she no longer wanted CPR. Interview with the Director of Nursing on [DATE], at 1:35 p.m. confirmed that Resident 2's care plan was not updated to reflect the change in her code status and that it should have been. Physician's orders for Resident 25, dated [DATE], included an order for the resident to be on Enhanced Barrier Precautions (EBP - a set of infection control measures that use personal protective equipment (PPE) to reduce the spread of multidrug-resistant organisms (MDROs). Observations of Resident 25's room on [DATE], at 12:32 p.m. revealed that there was signage on the resident's door indicating that the resident was on contact isolation (a set of precautions that healthcare workers and visitors take to prevent the spread of germs from a patient to others) and droplet precautions (a set of guidelines for caring for patients with respiratory infections). As of [DATE], there was no documented evidence that Resident 25's care plan was revised/updated to include the EBP/Contact/Droplet precautions. Interview with the Licensed Practical Nurse Assessment Coordinator 4 (LPNAC - a licensed practical nurse who assists the Registered Nurse Assessment Coordinator with the completion of MDS assessments) on [DATE], at 2:16 p.m. confirmed that there was no documented evidence that Resident 25's care plan was revised/updated to include the EBP/Contact/Droplet precautions. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly MDS assessment for Resident 41, dated [DATE], indicated that the resident was cognitively intact and that she required assistance from staff with daily care needs. Physician's orders for Resident 41, dated [DATE], included an order for the resident to receive 500 milligrams (mg) Levaquin (antibiotic) daily for five days, after which time the medication would be discontinued. Resident 41's care plan, dated [DATE], revealed that the resident had an active infection and was medicated with an antibiotic. There was no documented evidence that Resident 41's care plan was updated to reflect the discontinuation of the antibiotic. Interview with the Director of Nursing on [DATE], at 1:47 p.m. confirmed that Resident 41's care plan was not updated after the discontinuation of the antibiotic and it should have been. A quarterly MDS assessment for Resident 64, dated [DATE], indicated that the resident was cognitively impaired, required assistance from staff with daily care needs, and had diagnosis that included dementia. Physician's orders for Resident 64, dated [DATE], included an order for the resident to be out of bed to an evolution chair in upright position with pressure redistribution cushion and bilateral standard leg rests for transport and outside only. Resident 64's care plan, dated [DATE], revealed that the resident was a fall risk and included an intervention, dated [DATE], that the resident be out of bed in a wheelchair with an Equagel seat cushion (used to distribute weight across a seat evenly) with antisling (helps prevent sliding and provides support) under the Equagel cushion, Dycem (Non-slip material keeps objects from sliding or rolling) under and on top of the antisling, a Posey pad (designed to alert caregivers when a fall-risk patient attempts to get up from a chair unassisted) on the back rest with lumbar (lower back) support behind the Posey pad, and lamb's wool on the armrests and leg rests for transport only. There was no documented evidence that Resident 64's care plan was updated to reflect that the resident was to be in an evolution chair as ordered. Interview with the Director of Nursing on [DATE], at 11:10 a.m. confirmed that Resident 64's care plan was not updated when her out-of-bed to chair orders were changed. Physician's orders for Resident 79, dated [DATE], included an order for the resident to be on EBP's. Observations of Resident 79's room on [DATE], at 10:29 a.m. revealed that there was signage on the resident's door indicating that the resident was on EBP's. As of [DATE], there was no documented evidence that the resident's care plan was revised/updated to include the EBP. Interview with Licensed Practical Nurse/Infection Control Preventionist on [DATE], at 1:27 p.m. confirmed that there was no documented evidence to indicate that Resident 79's care plan was revised/updated to include the EBP's. A significant change MDS assessment for Resident 106, dated [DATE], indicated that the resident was cognitively impaired, required assistance from staff with daily care needs, and had diagnosis that included Alzheimer's disease. Physician's orders for Resident 106, dated [DATE], included an order for the resident to be admitted to hospice services with a diagnosis of Alzheimer's disease; however, Resident 106's care plan, dated [DATE], indicated that the resident required comfort care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence that Resident 106's care plan was updated to reflect that the resident was receiving hospice services. Interview with the Director of Nursing on [DATE], at 8:43 a.m. confirmed that Resident 106's care plan was not updated when she started receiving hospice services. A quarterly MDS assessment for Resident 130, dated [DATE], indicated that the resident was cognitively impaired, required assistance from staff with daily care needs, and had diagnoses that included respiratory failure. Physician's orders for Resident 130, dated [DATE], included an order for the resident to receive 20 mg of Furosemide (diuretic) one time a day. An order to discontinue the Furosemide 20 mg was obtained on [DATE]; however, Resident 130's care plan, dated [DATE], included the use of a diuretic. There was no documented evidence that Resident 130's care plan was updated to reflect the discontinuation of the diuretic. Interview with the Director of Nursing on [DATE], at 1:35 p.m. confirmed that Resident 130's care plan was not updated after the discontinuation of the diuretic, and it should have been. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 38012 Based on review of Pennsylvania's Nursing Practice Act and clinical records, as well as staff interviews, it was determined that the facility failed to clarify an order for treatment for one of 66 residents reviewed (Resident 69). Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain and restore the well-being of individuals. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs), dated November 2, 2024, indicated that Resident 69 was alert and oriented, required assistance from staff with care, and had a non-healing surgical wound. A wound consult report for Resident 69, dated December 24, 2024, recommended that the resident's wound was to be cleansed with VASHE (a wound cleanser intended for cleansing, irrigating, moistening, debridement and removal of foreign material), medi-honey applied to alginate that was cut to fit the wound and covered with a foam dressing. However, the resident's Treatment Administration Record (TAR), dated December 2024, revealed that the staff were not using VASHE wound cleanser and were not applying alginate to the wound. A wound consult report for Resident 69, dated December 31, 2024, and January 7, 2025, recommended that the resident's wound was to soak in VASHE for 15 minutes, then be cleansed with VASHE, and to apply medihoney with biofilm dressing. However, the resident's TAR, dated December 2024 and January 2025, indicated that staff were not soaking the resident's wound with VASHE and were not using VASHE cleanser. Interview with the Director of Nursing on January 29, 2025, at 3:00 p.m. revealed that the Wound Nurse Practitioner wrote orders that did not match the wound consultant's recommendations and nursing staff did not read the wound consultant's notes in order to compare his dictation with the orders. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 46994 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that discharge instructions that included post-discharge medications and a post-discharge plan of care was completed for one of three discharged residents reviewed (Resident 149). Findings include: A nursing note for Resident 149, dated October 31, 2024, at 7:31 p.m. revealed that the resident was picked up by a transport company to discharge to another facility. As of October 30, 2024, there was no documented evidence that Resident 149 was provided discharge instructions that included post-discharge medications or a post-discharge plan of care. Interview with the Assistant Nursing Home Administrator on January 30, 2025, at 3:25 p.m. confirmed that there was no documented evidence that Resident 149 was provided discharge instructions that included post-discharge medications or a post-discharge plan of care. 28 Pa. Code 211.5(d) Clinical Records. 28 Pa. Code 211.9(j.1)(4) Pharmacy Services.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 31760 Based on a review of facility policies and clinical records, as well as resident family and staff interviews, it was determined that the facility failed to provide adequate, ongoing activities designed to meet the needs of residents for one of 66 residents reviewed (Resident 9). Findings include: The facility's life enrichment programming policy, dated December 30, 2024, indicated that an ongoing resident-centered life enrichment program, based on comprehensive assessments and care plans, will be provided. The program will be designed to meet the interests (including hobbies and cultural preferences) and the abilities of each resident including their physical, mental, emotional, social, spiritual, psychological, and leisure needs. Programs will be scheduled and offered seven days a week, including evening and weekend programs. Adaptations will be made as necessary to enhance the resident's enjoyment of, or participation in, programming. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 9, dated November 4, 2024, revealed that the resident was understood, could understand others, and had a diagnosis which included hemiplegia (paralysis to one side of the body) and dysphagia (swallowing difficulties) following a cerebral vascular accident (CVA - commonly known as a stroke). A care plan for the resident, dated February 20, 2024, revealed that the resident may be at risk for reduced activity involvement related to his diagnosis, and that the resident needs one-to-one bedside/in-room visits and activities if he is unable to attend out-of-room events. Review of Resident 9's activity documentation, dated November and December 2024 and January 2025, revealed that there was no documented evidence that the resident was involved in or refused involvement in an activity or one-to-one during the week of November 10 through 16, 2024; during the week of November 17 through 23, 2024; during the week of November 24 through 30, 2024; during the week of December 1 through 7, 2024; during the week of January 5 through 11, 2025; during the week of January 12 through 18, 2025; and during the week of January 19 through 25, 2025. Interview with Resident 9's spouse/POA on January 27, 2025, at 10:10 a.m. revealed that Resident 9 does not like to get out of bed and that the facility does not provide the resident with any in-room activities. She indicated that all he has to do is watch TV. Interview with the Activities Director on January 30, 2025, at 2:45 p.m. revealed that they will assess residents' activities preferences at least quarterly. If there is a noted change that is brought to her attention, she will also assess the resident. She indicated that Resident 9 was scheduled to have one-to-one bedside/in-room visits and activities weekly and confirmed that there was no documented evidence that the resident received one-to-one bedside/in-room visits and activities weekly on the above weeks. 28 Pa. Code 211.12(d)(3)(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. 19102 Based on review of clinical records and personnel files, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders were followed for one of 66 residents reviewed (Resident 44), and failed to follow recommendations from a interventional radiology consultation for one of 66 residents reviewed (Resident 79). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 44, dated November 20, 2024, indicated that the resident was cognitively impaired, received pain medication routinely, and received an opioid. Physician's orders, dated November 25, 2024, included an order for the resident to receive 12 micrograms per hour (mcg/hr) of fentanyl (a narcotic pain patch) patch to be applied every 72 hours for pain. A physician's order, dated December 19, 2024, included an order to hold the fentanyl patch until December 20, 2024. A controlled drug accountability record (tracks each dose of a controlled medication) for Resident 44's 12 mcg/hr fentanyl patches revealed that one patch was signed out on the controlled drug log as being applied on December 20, 2024, at 8:00 a.m. and the next patch was applied on December 22, 2024, at 8:00 a.m. (48 hours). Interview with the Director of Nursing on January 29, 2025, at 1:16 p.m. confirmed that staff applied the resident's fentanyl patch in 48 hours, instead of the ordered 72 hours. The date the fentanyl patch should have been applied after December 20, 2024, was on December 23, 2024. Physician's orders for Resident 79, dated November 15, 2024, included an order for the resident to receive one 75 milligram (mg) tablet of clopidogrel (Plavix - an antiplatelet drug to prevent blood clots) once a day. An Interventional Radiology (a medical specialty that uses minimally invasive procedures to diagnose and treat patients) Consult for Resident 79, dated December 30, 2024, revealed that the resident was scheduled for a procedure on January 16, 2025, at 9:00 a.m. for a suprapubic catheter (a thin, flexible tube that is inserted through the abdominal wall into the bladder to drain urine) exchange. The resident was to stop the Plavix five days before the procedure on January 16, 2025. Review of Resident 79's MAR's, dated January 2025, revealed that the resident was administered the 75 mg tablet of clopidogrel (Plavix) on January 11 through 16, 2025. Interview with the Director of Nursing on January 30, 2025, at 11:10 a.m. confirmed that the clopidogrel (Plavix) was not stopped five days before the procedure on January 16, 2025. 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. 46994 Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure that each resident received assistance devices to prevent accidents for two of 66 residents reviewed (Residents 64, 120). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 64, dated November 6, 2024, revealed that the resident was cognitively impaired, required assistance from staff for personal care needs, and had diagnoses that included dementia. Physician's orders for Resident 64, dated January 20, 2025, included an order for the resident to be out of bed to an evolution chair in the upright position with bilateral standard leg rests for transport and outside only. Review of the care plan for Resident 64, dated July 11, 2023, revealed that the resident was at risk for falls and that bilateral leg rests were to be used for transport only and outside. Observations of Resident 64 on January 27, 2025, at 10:35 a.m. revealed that the resident was transported in her chair by Nurse Aide 8 from her bedroom to the small activity room on the fourth floor with no footrests on her chair. An interview with Nurse Aide 8 at the time of the observation revealed that she did not apply leg rests to Resident 64's chair prior to transporting the resident and she should have. A quarterly MDS assessment for Resident 120, dated November 13, 2024, revealed that the resident was cognitively impaired, required assistance from staff for personal care needs, and had diagnoses that included dementia. Physician's orders for Resident 120, dated October 11, 2024, included for the resident to be out of bed in a scoot chair with standard leg rests for transport and outside. Review of the care plan for Resident 120, dated September 23, 2023, revealed that the resident was at risk for falls and that standard leg rests were to be used for transport and outside. Observations of Resident 120 on January 27, 2025, at 10:05 a.m. revealed that the resident was transported on her chair from the activity room at the end of the hall to the area in front of the nurses' station by Licensed Practical Nurse 9 with no leg rests on her chair. An interview with Licensed Practical Nurse 9 at the time of the observation revealed that she transported the resident because she was being disruptive to other residents and that she did not apply leg rests prior to transporting her. An interview with the Director of Nursing on January 28, 2025, at 1:37 p.m. confirmed that footrests should have been used as ordered when transporting Residents 64 and 120. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.10(c)(d) Resident Care Policies. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 31760 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that the physician and the Certified Registered Nurse Practitioner (CRNP - a registered nurse with advanced training) wrote, signed, and dated progress notes with each visit for two of 66 residents reviewed (Residents 79, 84). Findings include: A nursing note for Resident 79, dated December 31, 2024, revealed that the resident was seen at the bedside by the physician. New verbal orders were received. As of January 30, 2025, there was no documented evidence in Resident 79's clinical record that the physician completed a progress note for his visit on December 31, 2024. Interview with the Director of Nursing on January 30, 2025, 11:10 a.m. confirmed that there was no documented evidence in Resident 79's clinical record that the physician completed a progress note for his visit on December 31, 2024, until today when he faxed the progress note to the facility. A nursing note for Resident 84, dated November 2, 2024, revealed that the resident was a new admit to the facility from the hospital. As of January 29, 2025, there was no documented evidence in Resident 84's clinical record that the physician completed a progress note for his initial admission visit for the resident's admission to the facility. Interview with the Director of Nursing on January 29, 2024, at 8:29 a.m. confirmed that there was no documented evidence in Resident 84's clinical record that the physician completed a progress note for his initial admission visit for the resident's admission to the facility. She indicated that she spoke with the physician, and he recalls seeing the resident, but she is unable to locate a progress note for the resident. Hospital discharge instructions for Resident 84, dated January 18, 2025, revealed that the resident was to have the sutures removed from her left eyebrow on January 23, 2025. As of January 28, 2025, there was no documented evidence in Resident 84's clinical record that the CRNP completed a progress note regarding the removal of the resident's sutures to her left eyebrow. Interview with Licensed Practical Nurse/Infection Control Preventionist on January 28, 2025, at 12:29 p.m. confirmed that there was no documented evidence in Resident 84's clinical record that the CRNP completed a progress note regarding the removal of the resident's sutures to her left eyebrow. She indicated that she spoke with the CRNP, and she advised her that she was only able to remove a few of the sutures at that time and that she was behind putting her progress notes in the residents' clinical records. 28 Pa. Code 211.5(f) Clinical Records.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 19102 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain accountability for controlled medications (drugs with the potential to be abused) for two of 66 residents reviewed (Residents 44, 149). Findings include: The facility's policy/procedure regarding fentanyl patch destruction, dated December 30, 2024, indicated that licensed nurses would remove fentanyl patches, when appropriate, using gloved hands and fold the patch in half so that the adhesive side adhered to itself. With a witness, the patch would be disposed of in the sharps container (a puncture-resistant container used to safely dispose of sharp objects like needles and syringes). Two licensed nurses were to witness and document the disposal of all fentanyl patches. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 44, dated November 20, 2024, indicated that the resident was cognitively impaired, received pain medication routinely, and received an opioid. Physician's orders, dated November 25, 2024, included an order for the resident to receive 12 micrograms per hour (mcg/hr) of fentanyl (a narcotic pain patch) patch to be applied every 72 hours for pain. A controlled drug accountability record (tracks each dose of a controlled medication) for Resident 44's 12 mcg/hr fentanyl patches revealed that one patch was signed out on the controlled drug log on December 31, 2024, at 8:00 a.m.; January 3, 2025, at 8:00 a.m.; January 6, 2025, at 8:00 a.m.; January 9, 2025, at 8:00 a.m.; January 12, 2025, at 8:00 a.m.; and January 27, 2025, at 8:00 a.m. However, there was no documented evidence that two staff members signed that the old patch was destroyed after removal. Interview with the Director of Nursing on January 29, 2025, at 1:16 p.m. revealed that two nurses were to sign when a fentanyl patch was removed and destroyed, and confirmed that there was no documented evidence that two nurses destroyed Resident 44's old fentanyl patch on the dates above. A discharge Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 149, dated October 31, 2024, revealed that the resident was discharged to a nursing facility on October 31, 2024, with a return not anticipated. Current physician's orders for Resident 149 included an order for the resident to receive one milligram (mg) of Ativan (a controlled drug used to treat anxiety) every six hours. A nursing note for Resident 149, dated October 31, 2024, at 1:47 p.m. revealed that the family was updated on new orders for Ativan prior to departure and for discharge. A nursing note, dated October 31, 2024, at 7:31 p.m., revealed that Resident 149 was picked up by a transport company for her discharge to a nursing facility in another state. There was no documented evidence that the disposition of Ativan was completed for Resident 149 on discharge. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Assistant Nursing Home Administrator on January 20, 2025, confirmed that there was no documented evidence of the medication disposition of Resident 149's Ativan upon discharge. 28 Pa. Code 211.9(a)(j.1)(4) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(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. 31760 Based on a review of facility policies, manufacturer's instructions, and clinical records, as well as observations and staff interviews, it was determined that the facility failed to label multi-dose containers of medications with the date they were opened in one of four medication carts observed (First-Floor Southeast medication cart). Findings include: The facility's policy regarding storage and expiration dating of medications, dated December 30, 2024, revealed that once any medication or biological package is opened, the facility should follow manufacture/supplier guidelines with respect expiration dates for opened medications. Facility staff should record the date opened on the primary medication container when the medication has a shortened expiration date once opened. Manufacturer's directions on the container for use of fluticasone propion-salmeterol (used to control and prevent symptoms (wheezing and shortness of breath) caused by asthma or ongoing lung disease) inhaler revealed that the inhaler was to be discarded one month after being removed from the foil pouch. Physician's orders for Resident 32, dated January 12, 2025, included an order for the resident to receive one 250-50 microgram (mcg) puff from the fluticasone propion-salmeterol inhaler twice a day. Physician's orders for Resident 135, dated December 31, 2024, included an order for the resident to receive one 500-50 mcg puff from the fluticasone propion-salmeterol inhaler twice a day. Manufacturer's directions on the container for use of umeclidinium-vilanterol (used to treat chronic obstructive pulmonary disease (COPD), a condition that causes inflammation and narrowing of the airways) inhaler revealed that the inhaler was to be discarded six weeks after being removed from the foil pouch. Physician's orders for Resident 48, dated December 31, 2024, included an order for the resident to receive one 62.5-25 mcg puff from the umeclidinium-vilanterol inhaler once a day. Manufacturer's directions on the container for use of fluticasone-umeclidinium-vilanterol (a combination medication used to treat COPD and asthma) inhaler revealed that the inhaler was to be discarded six weeks after being removed from the foil pouch. Physician's orders for Resident 95, dated June 26, 2024, included an order for the resident to receive one 200-62.5-25 mcg puff from the fluticasone-umeclidinium-vilanterol inhaler once a day. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations of the First-Floor Southeast medication cart on January 29, 2025, at 1:35 p.m. revealed that the 250-50 mcg fluticasone propion-salmeterol inhaler for Resident 32, the 62.5-25 mcg umeclidinium-vilanterol inhaler for Resident 48, the 200-62.5-25 mcg fluticasone-umeclidinium-vilanterol inhaler for Resident 95, and the 500-50 mcg puff from the fluticasone propion-salmeterol inhaler for Resident 135 were opened and not dated with the dates that they were opened. Interview with Licensed Practical Nurse 10 at the time of observation confirmed that the inhalers for Residents 32, 48, 95, and 135's were opened and not dated with the date they were opened, and they should have been dated. 28 Pa. Code 211.9(h) Pharmacy Services. 28 Pa. Code 211.12(d)(1) Nursing Services.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 46994 Based on clinical record review and staff interview, it was determined the facility failed to ensure timely completion of prescribed laboratory services for two of 66 residents reviewed (Residents 58, 120). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 58, dated October 25, 2024, revealed that the resident was understood and could understand others, required assistance from staff for daily care needs, and had a diagnosis of dementia. Physician's orders for Resident 58, dated October 8, 2024, included an order for staff to obtain a urinalysis (lab test that can detect a urinary tract infection) and culture and sensitivity (identifies the specific microorganism causing an infection). May straight catherize (use a small, flexible tube to drain urine from the bladder) the resident to obtain. Once obtained, place specimen in laboratory refrigerator and call the lab for pick up. A nurse's note for Resident 58, dated October 8, 2024, at 2:05 p.m., revealed that a urine for a urinalysis was obtained via straight cath. The lab did not pick up the specimen. Physician's orders for Resident 58, dated October 10, 2024, included an order for staff to obtain a urinalysis and culture and sensitivity. May straight cath the resident to obtain. Once obtained, place specimen in laboratory refrigerator and call the lab for pick up. A nurse's note for Resident 58, dated October 10, 2024, at 2:56 p.m., revealed that a urine for a urinalysis was obtained via straight cath, and that the lab was called and made aware of specimen. A nurse's note for Resident 58, dated October 11, 2024, at 3:57 p.m., revealed that the preliminary results of the urinalysis were reviewed by the Certified Registered Nurse Practitioner (registered nurse with additional education and training that allows them to work under a wider scope of practice) and new orders were received for Keflex (an antibiotic) twice a day for five days. A quarterly MDS assessment for Resident 120, dated November 13, 2024, revealed that the resident was cognitively impaired, required assistance from staff for personal care needs, and had diagnoses that included dementia. A nurse's note for Resident 120, dated January 22, 2025, at 4:10 p.m. revealed that orders were received to obtain a urinalysis related recent falls and agitation. A nurse's note, dated January 23, 2025, at 4:05 p.m. revealed that a urinalysis sample was obtained that morning and the lab was notified to pick it up. A nurse's note for Resident 120, dated January 24, 2025, at 12:18 p.m. revealed that the resident's urine sample was found in the refrigerator and was not picked up by the lab. The Certified Registered Nurse Practitioner ordered to prophylactically treat the resident for a urinary tract infection. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of urinalysis results for Resident 120, dated January 25, 2025, indicated that the resident did not have a urinary infection. Interview with the Director of Nursing on January 30, 2025, at 8:43 a.m. revealed that Resident 58 was straight catherized twice for a urinalysis two days apart because the lab never picked up the urine that was obtained on October 8, 2024. The Director of Nursing further revealed that the hospital lab is responsible for picking up lab specimens and that staff were unaware when labs were not picked up timely. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. 19102 Based on clinical record reviews and staff interviews, it was determined that the facility failed to obtain laboratory studies as ordered by the physician for one of 66 residents reviewed (Resident 18) and failed to obtain a physician's order for an invasive procedure to collect a specimen for a laboratory test for one of 66 residents reviewed (Resident 84). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 18, dated December 16, 2024, revealed that the resident was cognitively intact and had diagnoses that included hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone). Physician's orders for Resident 44, dated June 2, 2024, included an order for staff to obtain a TSH (Thyroid Stimulating Hormone - test used to identify the amount of hormones secreted by the thyroid) on the first Monday of March, June, September, and December. There was no documented evidence that staff obtained Resident 18's TSH for September and December 2024. Interview with Director of Nursing on January 29, 2025, at 4:36 p.m. confirmed that there was no evidence that Resident 18's TSH was obtained for September and December 2024. A quarterly MDS assessment for Resident 84, dated December 17, 2024, revealed that the resident was understood, could understand others, and had diagnoses that included End-Stage Renal Disease (ESRD - a severe and permanent condition where the kidneys have lost most of their function and can no longer adequately filter waste products and excess fluid from the blood) with dependence on hemodialysis (mechanical cleansing of the blood for a person whose kidneys are not functioning normally). Physician's orders for Resident 84, dated January 16, 2025, included an order for staff to obtain a urine specimen and call the hospital's laboratory when obtained. A progress note for Resident 84, dated January 16, 2025, revealed that the writer attempted to straight cath (the insertion of a plastic tube into the bladder) the resident at this time to obtain a urinalysis and culture and sensitivity (UA C&S - urine tests to check for the presence of bacteria and determine which antibiotics the bacteria is sensitive to). There was no documented evidence that staff obtained a physician's order to obtain Resident 84's urine specimen via catheterization. Interview with the Licensed Practical Nurse/Infection Control Preventionist on January 28, 2025, at 12:29 p. m. confirmed that there was no evidence that a physician's order was obtained for Resident 84 to be catheterized to obtain the urine specimen on January 16, 2025. (continued on next page)

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	395828	A. Building B. Wing	01/30/2025

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 19102 Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to maintain compliance with nursing home regulations and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plans of corrections for State Survey and Certification (Department of Health) surveys ending February 14, 2024; June 4, 2024; June 20, 2024; and August 1, 2024, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending January 30, 2025, identified repeated deficiencies related to a failure to prevent resident abuse/neglect; timely completion of comprehensive assessments; accuracy of Minimum Data Set (MDS) assessments (mandated assessment of a resident's abilities and care needs); development of comprehensive care plans; failure to provide professional nursing services; failure to provide safety/prevent accidents; failure to ensure the physician and the certified registered nurse practitioner wrote, signed, and dated progress notes with each visit; preventing issues with the accountability of controlled medications (drugs with the potential to be abused); properly store and label medications; and to ensure proper infection control practices were followed. The facility's plan of correction for a deficiency regarding compliance with preventing resident abuse/neglect, cited during the survey ending June 4, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F600, revealed that the facility's QAPI committee was ineffective in maintaining compliance with preventing resident abuse/neglect. The facility's plan of correction for a deficiency regarding timely completion of comprehensive assessments, cited during the survey ending February 14, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F636, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding timely completion of comprehensive assessments. The facility's plan of correction for a deficiency regarding a failure to ensure that MDS assessments were accurate upon submission, cited during the survey ending February 14, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F641, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to accurate MDS assessments. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's plan of correction for a deficiency regarding the development of a comprehensive person-centered care plan, cited during a survey ending February 14, 2024, revealed that audits would be completed. The results of the current survey, cited under F656, revealed that the QAPI committee was ineffective in correcting deficient practices related to the development of a comprehensive person-centered care plan. The facility's plan of correction for a deficiency regarding professional nursing services, cited during the survey ending February 14, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F658, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding professional nursing services. The facility's plans of correction for deficiencies regarding providing a safe environment free of accident hazards, cited during the surveys ending February 14 and August 1, 2024 revealed that the facility developed plans of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F689, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to safety and accident-free environments. The facility's plans of correction for deficiencies regarding the failure to account for the physician and certified registered nurse practitioner (CRNP) writing progress notes with each visit, cited during the surveys ending February 14, 2024, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F711, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to the physician and the CRNP writing progress notes with each visit. The facility's plans of correction for deficiencies regarding the failure to account for controlled medications, cited during the surveys ending February 14, 2024, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F755, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to the accountability of controlled medications. The facility's plan of correction for a deficiency regarding storing/labeling medications properly, cited during the survey ending February 14, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F761, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to storing/labeling medications properly. The facility's plans of correction for deficiencies regarding infection control practices, cited during the surveys ending February 14 and June 20, 2024, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F880, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to infection control. Refer to F600, F636, F641, F656, F658, F689, F711, F755, F761, F880. 28 Pa. Code 201.14(a) Responsibility of Licensee. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.18(e)(1) Management.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 31760 Based on review of established infection control guidelines, facility policy, and residents' clinical records, as well as observations and staff interviews, it was determined that the facility failed to follow infection control guidelines from the Centers for Medicare/Medicaid Services (CMS) and the Centers for Disease Control (CDC) to reduce the spread of infections and prevent cross-contamination for one of 66 residents reviewed (Resident 79). Findings include: CDC guidance on isolation precautions and Implementation of Personal Protective Equipment (PPE) use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDRO's - bacteria that have become resistant to certain antibiotics, and these antibiotics can no longer be used to control or kill the bacteria), dated July 12, 2022, indicates that MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP's) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. CMS updated its infection prevention and control guidance effective April 1, 2024. The recommendations now include the use of EBP's during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, in addition to residents who have an infection or colonization with a CDC-targeted or other epidemiologically important MDRO when contact precautions do not apply. The facility's policy regarding EBP's, dated December 30, 2024, indicated that EBP's are infection control interventions designed to reduce the transmission of MDRO's through gown and glove use by HCP in the long-term care settings in accordance with CDC's consideration for use of EBP in skilled nursing facilities. EBP are recommended during high contact care (e.g. dressing, bathing, transferring, changing brief or assisting with toileting, device care, wound care, ect.) activities with residents who are at high risk of acquiring or spreading an MDRO (e.g. residents with indwelling medical devices or wounds). A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 79, dated November 21, 2024, revealed that the resident was understood, could understand others, had a indwelling catheter (a thin, flexible tube inserted into the urinary bladder to collect and drain urine), and had a diagnosis of quadriplegia (a condition characterized by the partial or complete loss of motor function, sensation, and autonomic control in all four limbs (arms and legs)). Physician's orders for Resident 79, dated December 29, 2024, included an order for the resident to be on EBP's. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations of Resident 79's room on January 27, 2025, at 10:29 a.m. revealed that there was signage on the resident's door indicating that the resident was on EBP's and that staff was to wear gloves and gown for the following high contact resident care activities: dressing, bathing showering, transferring, changing linens, changing briefs or assisting with toileting, direct care or use central line (a flexible tube inserted into a large vein near the heart), urinary catheter, feeding tube, tracheostomy (a surgical procedure that creates an opening (stoma) in the front of the neck into the trachea (windpipe)), wound care, and any skin opening requiring a dressing. Observations on January 28, 2025, at 11:54 a.m. revealed that Nurse Aide 11 was at Resident 79's bedside emptying the resident's indwelling catheter drainage bag into a clear plastic container. However, while emptying the resident's indwelling catheter drainage bag, she only wore gloves and did not wear a gown. She then performed hand hygiene, placed gloves on, and then assisted the resident to reposition in bed. Interview with Licensed Practical Nurse/Infection Control Preventionist on January 28, 2025, at 12:17 p.m. confirmed that Resident 79 was on EBP, and that Nurse Aide 11 should have been wearing a gown and gloves while emptying the resident's indwelling catheter drainage bag and while assisting the resident to reposition in bed. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 46994 Based on observations and staff interviews, it was determined that the facility failed to ensure that essential equipment was in safe operating condition in the facility's kitchen. Findings include: Observations in the facility's kitchen on January 29, 2025, at 9:38 a.m. revealed that the first rinse cycle on the dishwashing machine was not registering a temperature during dishwashing and that water was leaking onto the floor from underneath the dishwasher. A steam kettle with a plastic bucket underneath it was catching water that was leaking. Interview with the Dietary Manager on January 30, 2024, at 11:15 a.m. revealed that the dishwasher was washing dishes correctly and providing the final sanitizing rinse that was required; however, it had been leaking water and not properly functioning to full capacity since September 2024. The Dietary Manager also revealed that the steam kettle has been broken since June 2024 and needs a new seal; an upright cooler has been out of service since May 2024; the garbage disposal was not being used because it was making a loud noise when turning it on; one oven was not in use since March 2024 because the door pin snapped off; the second oven had a broken on/off switch but was able to be used; one of the two pressure cookers has been out of service because of a bad element since August 2024; and the second pressure cooker has been broken and unable to be repaired since September 2024. Alternate cooking equipment was being used in place of the steamers, and there has been no adverse effects on the meal service related to the broken equipment. Interview with the Nursing Home Administrator on January 30, 2025, at 12:36 p.m. confirmed that the above-mentioned kitchen equipment was not operating properly or not operating at all, and that the facility was in the process of repairing or replacing the kitchen equipment that was not operating correctly. 28 Pa. Code 201.18(b)(3) Administrator's Responsibility.