STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395840	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Patriot, A Choice Community The	495 West Patriot Street Somerset, PA 15501

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 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 complete accurate comprehensive Minimum Data Set assessments for two of 45 residents reviewed (Residents 30, 72). Findings include: The RAI User's Manual, dated October, 2023, indicated that Sections P0100A-P0100H were to capture physical restraint use, Section E0100A-H was to be coded (0) when restraints are not used, (1) when a restraint was used less than daily, and (2) when a restraint was used daily. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) (for Resident 30, dated November 24, 2023, revealed that section P0100F (limb restraint) was coded (1) used less than daily. Observations of Resident 30 in the dining room on February 26, 2024, at 12:29 p.m. revealed the resident was sitting in her broda chair with no restraints. Interview with Licenced Practical Nurse 1 on February 28, 2024, at 1:55 p.m. revealed that Resident 30 does not have a limb restraint. Interview with Licenced Practical Nurse 2, who assisted with the MDS assessment, on February 29, 2024, at 10:25 a.m. indicated that Resident 30 does not have a limb restraint and that the assessment was inaccurate. The RAI User's Manual, dated October 2023, indicated that Section E0200A was to capture physical behavioral symptoms directed towards others, Section E0200B was to capture verbal behavioral symptoms directed towards others, and Section E0200C was to capture other behavioral symptoms not directed towards others. The sections were to be coded zero (0) behavior not exhibited, one (1) behaviors of this type occurred one to three days, two (2) behaviors of this type occurred four to six days, but less than daily, and (3) behavior of this type occurred daily. A nursing note, dated February 17, 2024, at 11:50 p.m., revealed that Resident 72 was standing in his doorway, wet with urine, and when the nurse aide went to help him change socks, the resident kicked her right knee. He then started swearing mother f***ing leave me alone. He refused to have his socks changed and was agitated with staff. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note, dated February 18, 2024, at 3:26 p.m., revealed that Resident 72 walked into another resident's room and the resident in the room did not want him in there. Resident 72 exited the room with staff and then attempted to enter the room again. He was told by staff the lady in that room does not want you in there. The resident was told again he could not go into the room and the resident stated, I don't care, and grabbed the nurse by the arms and brought them up to her chest and shook them, and said, F**k you, I don't care. A nursing note, dated February 19, 2024, at 10:15 p.m., revealed that Resident 72 was combative and aggressive with care at times and swatted his hands at staff three times. A nursing note, dated February 21, 2024, at 8:16 a.m., revealed that Resident 72 walked up to the licensed practical nurse (LPN) and grabbed her shirt and breast. He told the nurse to get the f**k away from him. When the LPN stepped back from him he followed her as she quickly walked away. Resident 72 reapproached her again and told her to get away from him. The LPN quickly walked away; however, the resident increased his pace to a jog to keep up with her and had clenched fists and bared his teeth during the incident. A nursing note, dated February 21, 2024, at 8:45 a.m., revealed that Resident 72 attempted to go out the exit door and told staff to keep the f**k away from me. The resident entered another resident's room and then left the room, then walked towards staff with clenched fists and grabbed a staff member's arm and would not let go. An admission MDS assessment for Resident 72, dated February 23, 2024, revealed that Sections E0200A, E0200B, and E0200C were coded as zero (0), indicating that the resident did not display any behaviors during the seven-day assessment period. Interview with the Social Service Director (who was responsible for the completion of Section E) on February 29, 2024, at 10:45 a.m. confirmed that the above MDS assessment for Resident 72 was not accurate. 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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19102 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that baseline care plans included the information and instructions needed to provide person-centered care for one of 37 residents reviewed (Resident 80). Findings include: The facility's policy regarding baseline care plans, dated January 31, 2024, indicated that within 24-48 hours of admission the facility was to coordinate the gathering, assessment, and evaluation of information from all sources (hospital, facility assessments and notes, resident/resident representative interview) and initiate the resident's care plan. No later than 48 hours after admission the Registered Nurse Assessment Coordinator (RNAC- a registered nurse who is often involved in the development of residents' care plans) or designated person would ensure that the baseline care plan was in place and all required items were addressed. Admission information for Resident 80 revealed that he was admitted to the facility on [DATE], with diagnoses that included dementia and psychotic disturbances, and a colostomy (an opening for the colon, or large intestine, through the abdomen). Physician's orders, dated February 24, 2024, included orders for the resident to receive 15 milligrams (mg) of aripiprazole (an antipsychotic medication) in the morning and colostomy care every shift and the removal and replacment of the face plate and bag every seven days. Resident 80's baseline care plan (developed within 48 hours of a resident's admission and must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission), dated February 24, 2024, did not include information regarding the care or services the resident required for the treatment with an an antipsychotic medication or regarding the care and services required for the use of a colostomy. Interview with Director of Nursing on February 28, 2024, at 11:25 a.m. confirmed that she could not find any information on Resident 80's baseline care plan regarding the treatment with an anti-psychotic medication or the use of a colostomy. 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 - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 42079 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that residents' care plans were reviewed and revised to reflect their current care needs for two of 37 residents reviewed (Residents 35, 42). Findings include: A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 35, dated December 18, 2023, revealed that the resident was cognitively intact and required extensive assistance for daily care tasks. The resident's care plan, dated November 14, 2023, revealed that the resident was medicated with an anticoagulant (blood thinner); however, the resident's anticoagulant was discontinued on December 13, 2023. There was no documented evidence that Resident 35's care plan was updated to reflect the discontinuation of the anticoagulant. Interview with the Director of Nursing on February 28, 2024, at 3:42 p.m. confirmed that Resident 35's care plan should have been updated to reflect the discontinuation of the anticoagulant and it was not. A significant change MDS assessment for Resident 42, dated December 15, 2023, revealed that the resident was cognitively intact, required extensive assistance for bed mobility, was dependent on staff for transfers and toileting, and had diabetic foot ulcer and a fall with a fracture. The resident's care plan regarding skin integrity, dated September 28, 2023, revealed that the resident had a pressure-reducing mattress. Physician's order for Resident 42, dated January 20, 2024, revealed that the resident was ordered a bariatric alternating air mattress, at comfort level three. Observations of Resident 42 on February 26, 2024, at 11:29 a.m. and February 28, 2024, at 2:26 p.m. revealed that she was lying in bed on an air mattress. Interview with the Registered Nurse Assessment Coordinator (RNAC - the nurse responsible for completing the mandated assessment) on February 28, 2024, at 12:01 p.m. confirmed that a pressure-reducing mattress would meet the needs of the care plan, but the care plan was not individualized to reflect Resident 42's care needs. 28 Pa. Code 201.24(e)(4) Admission Policy.

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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 clinical record reviews and staff interviews, it was determined that the facility failed to complete treatments as ordered by the physician for one of 37 residents reviewed (Resident 78). Findings include: An admission skin assessment, dated February 24, 2024, revealed that Resident 78 had scabs on his second, fourth, and fifth toes of the left foot. Physician's orders, dated February 25, 2024, included an order to apply skin prep (protective film) to the second, fourth, and fifth toe of the left foot every day shift. A comprehensive admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated June 26, 2021, revealed that the resident was able to make himself understood and could understand others, required supervision with daily care activities, had a surgical wound that required treatments, and had diagnoses that included a wound infection. Physician's orders, dated June 20, 2021, included an order to clean the resident's abdominal wounds with normal saline solution (medical grade salt water) and pack the openings with wet-to-dry dressings each day and evening shift. The resident's care plan, dated June 21, 2021, included that staff were to provide treatments according to physician's orders. Review of Resident 78's Treatment Administration Records (TAR's) for February 2024 revealed that there was no documented evidence that skin prep was applied to Resident 78's second, fourth, and fifth toe as ordered from February 25 to 28, 2024. Interview with the Director of Nursing on September 29, 2024, at 8:10 a.m. confirmed that there was no documented evidence that skin prep was applied to Resident 78's second, fourth, and fifth toe as ordered from February 25 to 28, 2024. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 42079 Based on review of 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 one of 37 residents reviewed (Residents 42). Findings include: The facility's policy regarding controlled substances, dated January 31, 2024, indicated that accurate accountability of the inventory of all controlled drugs is maintained at all times. When a controlled substance was administered, the licensed nurse administering the medication was to immediately enter the following information on the accountability record and Medication Administration Record (MAR): date and time of administration, amount administered, remaining quantity, and the initials of the nurse administering the dose, completed after the medication is actually administered. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 42, dated December 15, 2023, revealed that the resident was cognitively intact, required extensive assistance for bed mobility, was dependent on staff for transfers and toileting, had a fall with a major injury, and received opiod medication. Current physician's orders for Resident 42 included an order for the resident to receive 5-325 mg of Norco (narcotic pain reliever) every four hours as needed for moderate to severe pain. The resident's controlled drug record (a form that accounts for each tablet/pill/dose of a controlled drug) for October, November and December 2023 indicated that one dose of Norco was signed-out for administration to the resident on October 28 at 6:00 p.m., November 23 at 9:00 p.m., December 14 at 7:30 a.m., and December 19 at 8:00 a.m. However, the resident's clinical record, including the Medication Administration Records (MAR's) and nursing notes, contained no documented evidence that the signed-out doses of Norco were actually administered to the resident on these dates and times. Interview with the Director of Nursing on February 29, 2024, at 10:02 a.m. confirmed that there was no documented evidence that staff administered signed-out doses of Norco to Resident 42 on the above dates and times. 28 Pa. Code 211.9(a)(h) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 19102 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that non-pharmacological (non-medication) interventions were attempted prior to the administration of anti-anxiety medications for one of 37 residents reviewed (Resident 53). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 53, dated January 30, 2024, indicated that the resident was cognitively impaired and had diagnoses that included anxiety. Physician's orders for Resident 53, dated January 28, 2024, included an order for the resident to receive 0.5 milligrams (mg) of Ativan (an antianxiety medication) every six hours as needed for anxiety. Resident 53's care plan, dated January 28, 2024, revealed that the resident used an antianxiety medication related to anxiety. Resident 53's Medication Administration Records (MAR's) for February 2024 revealed that staff administered as needed Ativan to the resident on February 1 at 12:41 a.m. and 9:30 p.m., February 2 at 5:21 a.m., February 5 at 9:00 p.m., February 6 at 7:27 a.m., February 8 at 7:50 p.m., and February 9, 2024 at 7:19 p.m. There was no documented evidence in Resident 53's clinical record regarding any non-medication interventions that were attempted prior to the administration of Ativan on the above days. Interview with the Director of Nursing on February 27, 2024, at 2:30 p.m. confirmed that there was no documention of any non-medication interventions prior to the administration of Ativan, and staff were to document the attempts at non-medication interventions. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 19102 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to provide medication as ordered by the physician, resulting in significant medication errors for one of 37 residents reviewed (Resident 7). Findings include: The facility's policy regarding medication administration, dated January 1, 2024, indicated that residents were to receive all medications as per the physician's order meeting the requirements of the right dose, right route, at the right rate, at the right time, and for the right resident. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 7, dated December 19, 2023, indicated that the resident was alert and oriented, received insulin, and had diagnoses that included diabetes. Physician's orders for Resident 7, dated December 14, 2023, included an order for the resident to receive 5 units of Insulin Lispro (fast acting insulin) subcutaneously (beneath the skin) twice a day for diabetes and to hold the insulin if the resident's blood sugar was less than 150 milligrams/deciliter (mg/dL). Resident 7's Medication Administration Record (MAR) for December 2023 and January 2024 revealed that the resident's blood sugar at 11:30 a.m. on December 21 was 116 mg/dL, December 27 was 149 mg/dL, December 28 was 123 mg/dL, December 29 was 133 mg/dL, December 30 was 146 mg/dL, December 31 was 140 mg/dL, January 9 was 125 mg/dL, and January 19 was 145 mg/dL; and the resident's blood sugar at 4:45 p.m. on December 30 was 120 mg/dL, January 9 was 112 mg/dL, January 10 was 130 mg/dL, January 12 was 104 mg/dL, January 15 was 108 mg/dL, and January 25 was 131 mg/dL. There was no documented evidence that Resident 7's insulin was held according to the physician-ordered parameters on the dates and times above. Interview with the Director of Nursing on February 29, 2024, at 8:10 a.m. confirmed that the Insulin Lispro was not held as ordered on the dates and times above. 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 - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31760 Based on review of manufacturer's instructions and clinical records, as well as observations and staff interviews, it was determined that the facility failed to store unopened (unused) multi-dose containers of insulin according to manufacturer's instructions for one of 37 residents reviewed (Resident 22), and failed to ensure that controlled refrigerated medications were stored in a separately-locked, permanently-affixed container in one of two medication refrigerators reviewed (third-floor east medication room refrigerator). Findings include: Manufacturer's directions for Insulin Lispro (Humalog - a fast-acting insulin used to lower blood sugar levels), dated July 2023, indicated to store unused pens in the refrigerator at 36 degrees Fahrenheit (F) to 46 degrees F. Unused pens may be used until the expiration date printed on the label if the pen has been kept in the refrigerator. Physician's orders for Resident 22, dated January 30, 2024, included an order for the resident to receive Insulin Lispro as per a sliding scale (the amount of Insulin given was determined by the blood sugar level) three times per day. Observations of the 3rd floor central 2 medication cart on February 29, 2024, at 8:42 a.m. revealed that Resident 29's Insulin Lispro Pen Injector was unopened and not in use in the top drawer of the medication cart. The medication label indicated that the Insulin Lispro Pen was dispensed by the pharmacy to the facility on [DATE]. Interview with Licensed Practical Nurse 3 at the time of observation confirmed that Resident 22's Insulin Lispro Pen was not opened, not in use, and should not have been in the medication cart but should have been stored in the refrigerator until ready for use. Observations of the third-floor east medication room refrigerator on February 29, 2024, at 9:38 a.m. revealed that there was a clear plastic box attached to the shelf in the refrigerator that contained three boxes of Ativan Intensol (an antianxiety medication that is a controlled drug); however, the shelf that the clear plastic box was attached to could be removed from the refrigerator. Interview with Licensed Practical Nurse 4 at the time of observation confirmed that the clear plastic box containing the Ativan Intensol was not permanently affixed to the refrigerator and could be removed. 28 Pa. Code 211.9(a)(1) Pharmacy Services. 28 Pa. Code 211.12(d)(1) Nursing Services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31760 Based on review of facility policies, as well as observations and staff interviews, it was determined that the facility failed to store food in accordance with professional standards for food service safety by failing to store food under sanitary conditions, failing to ensure that dietary staff wore appropriate hair coverings, and failing to ensure that a microwave was clean and free of deterioration, for one of three microwaves reviewed (first-floor pantry) Findings include: The facility's policy regarding uniform dress code, dated January 31, 2024, revealed to restrain all facial hair with a beard net/restraint. Observations in the outside walk-in freezer on February 26, 2024, at 8:53 a.m. and February 27, 2024, at 1:15 p.m. revealed that there was an accumulation of ice on the ceiling and floor, as well as on a plastic jug that contained water, a case of ham, and a case of roast beef that were stored on the shelves below the freezer condenser. Interview with the Dietary Manager on February 27, 2024, at 1:15 p.m. confirmed that there was an accumulation of ice on the food products stored below the freezer condensers in the outside walk-in freezer. Observations in the main kitchen during service for the lunch meal on February 28, 2024, at 11:25 p.m. revealed that Dietary Aide 5 was placing the silverware and obtaining coffee, as well as taking the residents' prepared plates from the cook and placing them into the cart to be delivered to the residents. Dietary Aide 5 had a beard that was not covered with a beard net/restraint. Interview with the Registered Dietitian on February 28, 2024, at 12:00 p.m. confirmed that Dietary Aide ([NAME]) should have had his beard covered when working around food in the kitchen. Observations of the microwave in the first-floor pantry February 28, 2024, at 2:41 p.m. revealed that there were food splatters on the top, sides, and back inside walls of the microwave. The paint was worn off and rusty to the frame area below the floor of the microwave. Interview with the Registered Nurse 6 on February 28, 2024, at the time of the observation confirmed that the microwave needed to be cleaned. 28 Pa. Code 211.6(f) Dietary Services.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 19102 Based on clinical records reviews, observations, and staff interviews, it was determined that the facility failed to maintain clinical records that were complete and accurately documented for two of 37 residents reviewed (Residents 7, 42). Findings include: An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 7, dated December 19, 2024, revealed that the resident was cognitively intact, had pressure ulcers (skin impairment caused by pressure), and received pressure ulcer care. Physician's orders, dated December 18, 2023, included an order for collagen (promotes wound healing, silver alginate (prevents infection) and a bordered foam covering be applied to the left heel every day shift. A wound note, dated February 20, 2024, revealed the resident had a Stage 3 pressure ulcer (a full thickness tissue loss where subcutaneous fat may be visible) on the left heel that measured 1.3 x 0.6 x 0.3 centimeters (cm). Resident 7's Treatment Administration Records (TAR's) for February 2024 revealed that there was no documented evidence that a treatment was applied to the resident's left heel on February 8, 12, 14, 18, and 23, 2024. Interview with the Director of Nursing on February 29, 2024, at 8:10 a.m. confirmed that staff did not document when they completed the resident's treatment to the left heel as ordered. A significant change MDS assessment for Resident 42, dated December 15, 2023, revealed that the resident was cognitively intact and required extensive assistance for bed mobility and dependent on staff for transfers and toileting, had a fall with a major injury, and was received opiod medication. Physician's orders for Resident 42, dated January 20, 2024, included an order for the resident to have boot on the right ankle, to be kept in place and removed for hygiene and wound treatment. An orthopedic consult for Resident 42, dated February 2, 2024, indicated that the benefits of any type of immobilization outweighs the risk so offloading the heel was recommended. Observations of Resident 42 on February 26, 2024, at 11:29 a.m. revealed that she was lying in bed on an air mattress with no boot. Interview with Resident 42 on February 28, 2024, at 2:26 p.m. revealed that her husband got rid of it at the doctor's appointment. He said if it is not going to work then throw it away. Review of Resident 42's Treatment Administration Record (TAR) for February 26, 2024, revealed that staff documented that the resident had the boot in place. Interview with the Director of Nursing on February 29, 2024, at 11:42 a.m. confirmed that documentation was incorrect. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1)(5) Nursing Services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395840	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Patriot, A Choice Community The	495 West Patriot Street Somerset, PA 15501

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 31760 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 correct quality deficiencies 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 correction for the State Survey and Certification (Department of Health) survey ending March 2, 2023, revealed that the facility developed plans of corrections that included quality assurance systems to ensure that the facility-maintained compliance with cited nursing home regulations. The results of the current survey, ending February 29, 2024, identified repeated deficiencies related to a failure to complete Minimum Data Set (MDS) assessments (mandated assessments of residents' abilities and care needs) accurately, revision of care plans, following physician's orders, to prepare and store food under sanitary conditions, and to maintain complete and accurate clinical records. The facility's plan of correction for a deficiency regarding completing accurate MDS assessments, cited during the survey ending March 2, 2023, 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 F641, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding completing accurate MDS assessments. The facility's plan of correction for a deficiency regarding revising care plans, cited during the survey ending March 2, 2023, 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 F657, revealed that the QAPI committee was ineffective in correcting deficient practices related to revising care plans. The facility's plan of correction for a deficiency regarding following physician's orders, cited during the survey ending March 2, 2023, 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 F684, revealed that the QAPI committee was ineffective in correcting deficient practices related to following physician's orders. The facility's plan of correction for a deficiency regarding labeling and storing food under sanitary conditions, cited during the survey ending March 2, 2023, 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 F812, revealed that the QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding preparing and storing food under sanitary conditions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395840	A. Building B. Wing	02/29/2024

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's plan of correction for a deficiency regarding clinical records that were not complete and accurate, cited during the survey ending March 2, 2023, indicated that audits of documentation would be completed, and the results of the audits would be presented at the QAPI committee. The results of the current survey, cited under F842, revealed that the QAPI committee was ineffective in correcting deficient practices related to ensuring that residents' clinical records were complete and accurately documented. Refer to F641, F657, F684, F812, F842. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.