STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395865	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplewood Nursing and Rehab Center	125 W Schoolhouse Lane Philadelphia, PA 19144

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48347 Based on clinical record reviews, review of facility policies, and staff interviews, it was determined that the PASRR (Preadmission Screen and Resident Review) was not appropriately revised according to the resident assessment for one of three residents reviewed. (Resident R77) Findings include: Review of facility policy titled Pre-Admission Screening and Resident Review (PASRR) program dated April 1, 2022, reveled the facility work will coordinate assessments with the preadmission screening and resident review program. The coordination includes incorporating the recommendations from the pass our level to determination and pass our evaluation report into a resident assessment care planning and transition of care also to referring all level two residents and all red and all residents with newly evident or possible serious mental disorder intellectual disability or a relation condition for level two resident review upon a significant change in status assessment. Continued review of this policy revealed a nursing facility must notify the state mental health authority or state intellectual disability authority as applicable promptly after a significant change in the mental or physical condition of a resident who is a mental illness or intellectual disability for resident review. The PASRR pre-admission screening resident review was created in 1987 through language in the omnibus budget reconciliation act (OBRA) And it has three goals to identify individuals with mental illness and or intellectual disability, to ensure they are placed appropriately, whether in the community or in a nursing facility, and to ensure they receive the services they require for their mental illness or intellectual disability. The PASRR level I must be completed on all persons who are considering admission to a Medicaid certified nursing facility. A level II PASRR evaluation must be completed at the level 1 PASRR determined that the person is a targeted person with mental illness or intellectual disabilities. The level II PASRR will determine if placement or a continued stay in the requested or carrot nursing facility is appropriate. Review of Resident R77 quarterly MDS dated [DATE], revealed that Resident R77 had diagnosis including Dementia, Depression (mental health disorder characterized by persistently depressed mood and loss of interest), Bipolar disease (a mental illness that causes extreme mood swings, or shifts in energy, thinking, behavior and sleep), and psychotic disorder (mental illness characterized by a disconnection from reality which includes hallucinations, delusions, disorganized thoughts, speech and actions). (continued on next page)

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

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R77's care plan revealed that this resident had the potential to be aggressive related to mental emotional illness, diagnosis of major depression disorder and unspecified delusional disorder, unspecified psychosis and other psychotic disorders dated August 5, 2020. Review of Resident R77's PASRR level I assessment dated [DATE] revealed the resident did not have any serious mental illnesses listed on the assessment continue review revealed that the assessment was signed and completed July 21, 2017, by facility staff. Interview with Nursing Home Administrator, Employee E1 November 5, 2024, revealed that this above PASRR for Resident 77 was the most current PASRR. 28 Pa. Code 201.8(b)(1) Management 28 Pa. Code 201.8 (e) (1) Management

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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** 46508 Based on observations, clinical records reviews, it was determined that the facility failed to develop a baseline care plan within 48 hours of admission that includes the instructions needed to provide effective and person-centered care, ADL (activity of daily living) needs for one of 32 residents reviewed (Resident R362). Findings include: Observation conducted of Resident R362 on November 3, 2024, at 9:10 a.m. revealed that Resident R362's left hand was in a fist. Further, Resident R362 had unkempt facial hair. Review of clinical record revealed that Resident R362 was admitted to the facility on [DATE], with diagnoses of Cerebral Infarction (stroke) due to embolism to the right vertebral artery, aphasia (difficulty speaking and trouble understanding), and cerebral atherosclerosis (thinking and hardening of brain arteries). Review of Resident R362's OSA (OSA- Optional State Assessment, a state required MDS-minimum data set assessment containing the activities of daily living (ADL) functional items) MDS (minimum data set, a federally required resident assessment completed at a specific interval) assessment dated [DATE], section G (Functional Status), G0110. (Activities of Daily Living (ADL) Assistance), Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture was coded 3 for self-performance and 2 for support extensive assistance with 1-person physical assist, Transfer - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing, was coded 3 for self-performance and 2 for support extensive assistance with 1-person physical assist, Toilet use - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes was coded 3 for self-performance and 2 for support extensive assistance with 1-person physical assist, Further review of Resident R362's clinical record revealed that there was no base line care plan for ADL developed within 42 hours of admission. Further a care plan for ADL self-care performance deficit r/t (related to) Impaired balance was developed and initiated on October 23, 2024, five days after Resident R362 was admitted to the facility. 28 Pa. Code 211.5(f)(viii) Medical records 28 Pa. Code 211.12(d)(5) Nursing services

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344 Based on observations, review of facility policies, clinical record review and interviews with staff, it was determined that the facility failed to develop comprehensive person-centered care plans, related to behaviors, nutrition and contractures, for four of 32 residents reviewed (Residents R129, R100, R117 and R38). Findings include: Review of facility policy, Baseline Care Plan, Comprehensive Care Plan and Ongoing Care Plan Updates dated April 1, 2022, revealed, The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Review of Resident R38's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated September 16, 2024, revealed the resident had diagnoses of hemiplegia (paralysis of one side of the body), muscle wasting, and muscle weakness. Further review of Resident R38's quarterly MDS dated [DATE], revealed the resident had impairment in range of motion on one side of the upper extremity. Observations on November 3, 2024, at 12:50 p.m. revealed Resident R38 had a contracture (shortening and tightening of muscle fibers that reduces flexibility and makes movement difficult) of the left-hand. Interview on November 6, 2024, at 9:26 a.m. with licensed nurse, Employee E18, confirmed Resident R38 had a left-hand contracture. Review of Resident R38's entire clinical record revealed no documented evidence that the facility developed and implemented a comprehensive care plan pertaining to the care and treatment of Resident R38's left-hand contracture. Review of Resident R129's Annual MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated September 18, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including depression (mood disorder characterized by low mood, a feeling of sadness, and a general loss of interest in things). Continued review revealed that the resident had a BIMS (Brief Interview for Mental Status) of 11, which indicated that the resident was moderately cognitively impaired. Observation, on November 3, 2024, at 12:35 p.m. revealed that Resident R129 had two containers of a nutritional health shake and four cups of yogurt on his bedside counter. The food items were at room temperature and their labels indicated that they required refrigeration. Interview, at the time of the observation, Resident R129 stated that he keeps these foods in his room for days at a time, refused to discard them and insisted that they do not spoil or go bad at room temperature. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continued observation, on November 4, 2024, at 9:51 a.m. revealed that Resident R129 had several additional containers of nutritional health shake and cups of yogurt on his bedside counter. Further observation, on November 5, 2024, at 10:13 a.m. revealed that Resident R129 continued to have several cups of yogurt on his bedside counter. Review of Resident R129's care plan, dated initiated January 9, 2024, revealed that the resident had a behavior problem related to hoarding food and milk. Listed interventions included to anticipate the resident's needs and educate the resident regarding the potential hazards of hoarding food. No other interventions were listed to address the resident's hoarding behaviors. Interview on November 3, 2024, at 12:39 p.m. Employee E25, licensed nurse, confirmed that nursing staff are aware that Resident R129 has hoarding behaviors including keeping dairy products at room temperature in his room, and that due to this the foods are unsafe to consume. Employee E25, licensed nurse, stated that Resident R129 will not allow staff to remove the food items from his room and that nursing staff don't know what else to do to manage the resident's hoarding behaviors. Observation on Resident R117 conducted on November 3, 2024, at 12:51 p.m. revealed that Resident R117 was in bed. Review of Resident R117's clinical record revealed that Resident R117 was admitted to the facility on [DATE] with diagnoses of Cerebral Infarction (stroke) due to embolism to the right vertebral artery, aphasia, cerebral atherosclerosis. Further review of Resident R117's clinical record revealed a physician's diet order dated August 13, 2024 for: Heart Healthy / CCD (controlled carbohydrate diet) / NAS (no added salt) diet Regular - Level 7 texture, Thin consistency. Review of nutrition assessment dated [DATE] revealed that resident was non-compliant with diet. Interview with regional dietician Employee E19 conducted on November 6, 2024, at 12:18 p.m. confirmed that Resident R117 was non-compliant with her diet. Review of Resident R117's care plans revealed that a care plan was not developed for Resident R117's non-compliance with her diet. Review of Resident R100's annual Minimum Data Set (MDS - federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing facility) completed August 16, 2024, revealed Resident R100 entered the facility on August 28, 2023 with diagnosis' of dementia (progressive degenerative disease of the brain), seizure disorder (neurological disorder that cause brief episodes of spasms, unresponsiveness), and malnutrition. Review of the resident's care plan dated May 29, 2024, revealed that Resident R100 has activities of daily living (ADL) self-care performance deficit related to Alzheimer's, confusion, dementia, and impaired balance. Interventions include: Resident R100 requires setup and assistance with eating, supervision for eating, and assistance by one for eating staff dated August 4, 2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility's grievances revealed a concern report dated September 6, 2024, related to Resident R100 found with ball of foil in mouth. Resident foil was to be removed from juice cups. They staff were educated not to allow resident to have foil from juice cups for safety and all personal items to be stored out of reach related to dementia and confusion. Observation of resident room with large sign of the wall stating Do not leave any paper, and do not leave anything disposable in reach of the resident. Continued review of the resident's care plan revealed that there were no interventions developed in Resident R100's care plan related to staff ensuring that there were no foil from juice cups or paper left in the resident's tray and/or at the reach of the resident. 28 Pa Code 201.18(b)(1) Management 28 Pa Code 211.10(a) Resident care policies 28 Pa Code 211.12(d)(5) Nursing services

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277 Based on observations, review of clinical records, and staff and resident interviews, it was determined that the facility failed to ensure residents with limited range of motion received treatment and services to maintain or improve range of motion/mobility for one of five residents reviewed with limited range of motion (Resident R38). Findings Include: Review of Resident R38's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated September 16, 2024, revealed the resident was cognitively intact and had diagnoses of hemiplegia (paralysis of one side of the body), muscle wasting, and muscle weakness. Further review of Resident R38's quarterly MDS dated [DATE], revealed the resident had impairment in range of motion on one side of the upper extremity. Observations on November 3, 2024, at 12:50 p.m. revealed Resident R38 had a contracture (shortening and tightening of muscle fibers that reduces flexibility and makes movement difficult) of the left-hand and had no splint. Resident R38 reported that he used to have a splint for the left-hand contracture but was unsure what happened to it. Interview on November 6, 2024, at 9:26 a.m. with licensed nurse, Employee E18, confirmed Resident R38 had a left-hand contracture. Further interview with licensed nurse, Employee E18, believed that Resident R38 used to have a splint but was unsure. Interview on November 5, 2024, at 12:45 p.m. with Physical Therapist, Employee E21, revealed the employee started in September of 2024 and did not have access to previous therapy treatment notes for Resident R38. Interview on November 5, 2024, at 12:50 p.m. with Occupational Therapist, Employee E35, revealed the employee's first day was November 4, 2024, and was not familiar with Resident R38 and treatment for the left hand contracture. Interview on November 6, 2024, at 9:26 a.m. with Restorative Nurse Aide, Employee E34, confirmed Resident R38 had a splint at one time but was not put on a restorative nursing program. Review of Resident R38's entire clinical record revealed no documented evidence of the treatment and services Resident R38 received for the left hand contracture. 28 Pa. Code 211.12 (d)(3) Nursing services. 28 Pa. Code 211.12 (d)(5) Nursing services.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 48347 Based on review of clinical records, review of facility policy and staff interview, it was determined that the facility failed to ensure communication with the dialysis provider for one of two residents reviewed on renal dialysis (Resident R22) Findings include: Review of facility policy title Dialysis dated April 1, 2022, revealed that the facility shall provide adequate management of dialysis services to ensure that residents attained or maintain the highest practicable physical mental and psychosocial wellbeing. Further review of this policy reveal the facility will ensure that residents who require dialysis receive such services consistent with professional standards of practice the comprehensive standard care plan and residence goals and preferences. The nursing facility will collaborate with the dialysis facility and assure that residents needs related to dialysis or met. That documentation requirements are met to assure that treatments are provided as ordered and nephrologist attending practitioners and dialysis team. That there is an ongoing communication and collaboration for the development and implementation of dialysis care plan by nursing home and dialysis staff Continued review of this policy revealed the facility must provide ongoing communication and collaboration between the nursing home and the dialysis provided regarding dialysis care and services assessment of the resident's condition. Ongoing monitor from complications before and after dialysis treatments. The facility will utilize the Dialysis Communication from each time a resident attends dialysis as a tool to relay permanent information regarding the residents condition and coordinate care and services with the dialysis provider Review of Resident R22's annual Minimum Data Set (MDS - federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing facility) dated October 16, 2024, revealed Resident R22 entered the facility on November 16, 2023 with the diagnosis of end stage renal disease (a medical condition in which a person's kidney ceases functioning on a permanent basis leading to the need for regular course of long term dialysis or kidney transplant to maintain life), and dependent on dialysis (the process of removing waste products and excess fluid from the body dialysis is necessary when kidneys are not able to adequately filter the blood). Review of Resident R 22's documented dialysis communication binder revealed that the daily documented pages included instructions to record both weights, pre and post treatment. The daily pages also included any instructions, recommendations for care, any access problems, administered medications, lab work or any concerns before, during and after treatment. Review of treatment dates daily communication pages revealed incomplete communication: October 30, 2024, the documented page did not contain any dialysis assessment nor dialysis nurse signature. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	October 23, 2024, the documented page did not include any facility pretreatment documentation and any vitals. Continued review of this document revealed there was no dialysis assessment completed nor dialysis nurse signature. October 21, 2024, the documented page did not include any dialysis assessment completed nor dialysis nurse signature. October 11, 2024, the documented page did not include any pre or post treatment weights and did not include any dialysis assessment completed nor the dialysis nurse signature. October 9, 2024, the documented page did not include any pre or post treatment weights, and did not include any dialysis assessment completed, or the dialysis nurse signature. October 7, 2024, the documented page did not include any dialysis assessment completed or the dialysis nurse signature. October 2, 2024, the documented page did not include any pre or post treatment weights and did not include any dialysis assessment completed or the dialysis nurse signature. September 30, 2024, the documented page did not include any pre or post treatment weights and did not include any dialysis assessment completed, or the dialysis nurse signature. The above observation was confirmed by Licensed nurse, unit manager Employee E32. Employee E 32 stated that she has been in communication with the dialysis staff regarding the incomplete documentation. 28 Pa. Code 211.12(d)(1) Nursing Services 28 Pa. Code 211.12(d)(3) Nursing Services

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 39344 Based on observations, review of facility policies, clinical record reviews and interviews with staff, it was determined that the facility failed to ensure a medication error rate of less than five percent for two of four residents observed during medication administration (Residents R43 and R108). Findings include: The facility's medication error rate was 20.69 percent based on observation of 29 medication administration opportunities with six medication errors observed. Review of facility policy, Administering Medication dated April 17, 2024, revealed, Medications shall be administered in a safe and timely manner, and as prescribed. Review of facility policy, Enteral Feeding dated April 15, 2024, revealed, Prior to crushing tablets for administration through the enteral tube, the Medication Crushing General Guidelines should be reviewed. Continued review revealed, Each medication is administered separately followed by a 5cc [milliliter] flush of water between medications to avoid physical interactions of the medications. Observation of the morning medication pass on November 3, 2024, at 9:51 a.m. Employee E26, licensed nurse, prepared medications for Resident R43. Employee E26, licensed nurse, prepared one tablet of enteric coated 81 m.g (milligrams) of aspirin (a medication to prevent and to treat heart attacks, to prevent strokes, and to treat inflammation), two tablets of delayed release 20 m.g omeprazole (medication used to treat acid reflux) for a total of 40 m.g, one tablet of 50 m.g sertraline (medication used to treat depression), one tablet of 50 m.g topiramate (medication used to treat seizures) and 17 grams of polyethylene glycol powder mixed in a cup of water (laxative medication). Review of physician orders for Resident R43 revealed an order, dated August 11, 2023, for aspirin 81 m.g chewable tablet via PEG tube (percutaneous endoscopic gastrostomy - a surgical opening and placement of a tube though a person's abdominal wall into their stomach). Continued review revealed another order, dated February 2, 2024, for omeprazole suspension give 40 m.g via PEG tube two times a day. Employee E26, licensed nurse, proceeded to crush Resident R43's aspirin, omeprazole, sertraline and topiramate tablets together, then poured the crushed tablets into the polyethylene glycol water solution. Employee E26, licensed nurse, then administered the medications to Resident R43 via her PEG tube. Employee E26, licensed nurse, stated that Resident R43 gets her medications crushed and administered through her PEG tube, that what's in the medication cart are the only medications that she has and that she has to crush some medications even though they aren't supposed to be crushed. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued observation of the morning medication pass on November 3, 2024, at 10:24 a.m. Employee E25, licensed nurse, prepared medications for Resident R108. Employee E25, licensed nurse, prepared 17 grams of polyethylene glycol powder mixed in a cup of water. Employee E25, licensed nurse, prepared the rest of Resident R108's medications and administered them with the prepared polyethylene glycol. Review of physician orders for Resident R108 revealed that there were no orders for polyethylene glycol for the resident. Employee E25, licensed nurse, stated that she administered the polyethylene glycol because Resident R108 requested something to help move his bowels. 28 Pa Code 211.9(a)(1) Pharmacy services 28 Pa Code 211.10(c) Resident care policies 28 Pa Code 211.12(d)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344 Based on observations, review of facility policies and interviews with staff, it was determined that the facility failed to ensure that medications were properly labeled and dated for two of three medication carts reviewed (fourth floor A and B carts), and failed to ensure that a medication cart was kept locked when not in use during medication administration for one of three nursing units observed (third floor nursing unit). Findings include: Review of facility policy, Administering Medication dated April 17, 2024, revealed, During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. Continued review revealed, Medications must be stored per manufacturer/labeled. Review of facility policy, Medication Storage dated April 1, 2022, revealed, Medications will be stored in the original, labeled containers received from the pharmacy. Review of facility policy, Expiration Dates for Open Injectable Diabetes Medications dated July 12, 2023, revealed that lispro (rapid acting) and lantus (long acting) insulin vials (medications used to lower blood sugar levels) expire 28 days after the vials are opened and that aspart (rapid acting) insulin pens also expire 28 days after the pens are opened. Observation on November 3, 2024, at 9:51 a.m. of the fourth floor unit B (high side) medication cart with Employee E26, licensed nurse, revealed a vial of lispro for Resident R44 that was open and undated. Continued observation of the medication cart revealed two vials of lantus insulin that were opened and had no label nor date of when the vials were opened. Employee E26, licensed nurse, confirmed the above findings at the time of the observation. Observation on November 3, 2024, at 10:24 a.m. of the fourth floor unit A (low side) medication cart with Employee E25, licensed nurse, revealed two vials of lantus insulin for Resident R129 that were opened and undated. Continued observation revealed an opened aspart insulin pen for Resident R129 that was open and undated. Continued review revealed a vial of lispro insulin for Resident R98 that was open and undated. Further review revealed two medication cups that were unlabeled, one cup contained one unmarked pill and the other cup contained six unmarked capsules; Employee E25, licensed nurse, stated that the one pill was senna (laxative medication) for a resident and that the six capsules were probiotics for another resident. Employee E25, licensed nurse, confirmed the above findings at the time of the observation. Observation of medication cart B on the third-floor nursing unit on November 4, 2024, at 9:48 a.m. revealed the cart was positioned between rooms [ROOM NUMBERS] with cart drawers facing outward. The medication cart was observed unlocked. Licensed nurse Employee E33, assigned to this cart was in room [ROOM NUMBER] with the room door closed, obstructing any visual of the medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on Licensed nurse, Employee E33 exiting room [ROOM NUMBER] on November 4, 2024, at 9:59 a.m The medication cart was left unlocked and unattended for ten minutes. Interview with Rmployee E33 on November 4, 2024, at 9:59 a.m. confirmed that the facility policy of locking the medication carts is that the medication carts must be locked at all times. Employee E33 stated she was room [ROOM NUMBER] providing care for the resident. 28 Pa Code 211.9(a)(1) Pharmacy services 28 Pa Code 211.12(d)(2) Nursing services

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 43277 Based on review of personnel files, review of facility documentation, and staff interviews, it was determined that the facility failed to employ a qualified Registered Dietitian and Director of Food and Nutrition Services. Findings Include: Review of the job description for the Director of Food and Nutrition Services revealed that job responsibilities included oversight of ordering, receiving, storing, preparation and service of food. Interview on November 4, 2024, at 11:45 a.m. with Registered Dietitian, Employee E8, confirmed the Registered Dietitian only worked at the facility part time. Review of Food Service Directors, Employee E4, personnel file revealed the employee held the position of Dietary Director with a start date of July 17, 2023. Review of the Food Service Directors, Employee E4, personnel file confirmed the employee was not currently a certified dietary manager (CDM); or a certified food manager (CFM); or had a national certification for food service management and safety from a national certifying body; or had an associate's or higher degree in food service management or hospitality from an accredited institution. Review of Food Service Directors, Employee E4's, credentials indicated that Employee E4 did not meet the statutory qualifications of a director of food and nutrition services. Review of the Registered Dietitian, Employee E8, personnel file revealed the employee held the position of Registered Dietitian with a start date of April 3, 2023. Further review of Registered Dietitian, Employee E8, personnel file revealed no documented evidence that the employee was licensed as a dietitian by the State of Pennsylvania (LDN - Licensed dietitian-nutritionist). Interview on November 5, 2024, at 12:05 p.m. with Regional Registered Dietitian, Employee E19, confirmed Registered Dietitian, Employee E8, was not licensed by the State of Pennsylvania, as required, to practice dietetics-nutrition in the Commonwealth of Pennsylvania. 28 Pa. Code 201.14 (a) Responsibility of licensee. 49 Pa. Code 21.701 Definitions.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 43277 Based on observations and staff interviews, it was determined that the facility failed to employ sufficient dietary personnel to carry out the functions of the food and nutrition service for one of one meal observed (Breakfast November 3, 2024). Findings Include: Observation on November 3, 2024, revealed that the posted mealtimes on the fourth-floor nursing unit were: Breakfast 7:40 a.m. to 8:40 a.m. Observations in the main kitchen on November 3, 2024, at 9:00 a.m. revealed dietary staff were preparing for the breakfast meal service and cooking food. Observations revealed there was one dietary personnel cooking the breakfast and three dietary aides preparing the resident beverages and meal trays for service. Interview on November 3, 2024, at 9:00 a.m. with the Assistant Food Service Director, Employee E24, revealed the cook did not show for the breakfast shift. Observations revealed breakfast was still being prepared by the Assistant Food Service Director, Employee E24, at 9:15 a.m. Further observations on November 3, 2024, revealed breakfast tray line (when resident trays began to get plated) started at 9:35 a.m. in the main kitchen. Observations on November 3, 2024, revealed residents did not start receiving breakfast until about 9:50 a.m. Interview on November 3, 2024, at 10:30 a.m. with the Food Service Director, Employee E4, revealed there are usually/supposed to be four dietary aides to work the breakfast meal service but only three were working the breakfast meal. Further observations on November 3, 2024, revealed the last nursing unit to receive breakfast, 4th floor nursing unit, did not get their last truck of breakfast trays until 11:05 a.m. 28 Pa Code 201.18(b)(3) Management

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38735 Based on observations, review of facility documentation, and staff and resident interviews, it was determined that the facility failed to ensure menus were followed for three of three nursing units observed (second, third and fourth floor nursing units). Findings include: Review of the facility menu revealed the planned menu for lunch on November 3, 2024, was crispy ranch chicken, oven browned potatoes, and parslied carrots. The alternate planned lunch items were roast pork, rice pilaf, and brussels sprouts. Observations on November 3, 2024, at 2:00 p.m. in the main kitchen revealed dietary staff was serving beef stew over rice. Interview on November 3, 2024, at 2:00 p.m. with the Food Service Director, Employee E4, confirmed the planned menu was not followed because there was not sufficient time to prepare the meal due to breakfast running so late. Review of the facility menu revealed the planned menu for lunch on November 4, 2024, was fish, orzo, and sauteed mushrooms. The alternate planned lunch items were meatballs with gravy, chateau potatoes, and baked zucchini. Interview on November 4, 2024, at 12:27 p.m. with the Food Service Director, Employee E4, revealed mushrooms would not be served because the residents do not like it. The Food Service Director, Employee E4, reported a California vegetable blend was the substitution. Observations of tray line in the main kitchen on November 4, 2024, at 12:45 p.m. with the Food Service Director, Employee E4, confirmed meatballs with gravy and chateau potatoes was the alternate lunch option. Observations revealed zucchini was not available as a side option per the planned menu. Observations on November 4, 2024, at 12:55 p.m. revealed the residents in room [ROOM NUMBER]-A bed and 210-B bed received meatballs with orzo, not potatoes, per the planned menu. Interview with Resident R309, room [ROOM NUMBER]-B bed, on November 4, 2024, at 12:55 p.m. revealed he would have liked the potatoes instead of the orzo. Observation on November 3, 2024, at 9:11 a.m. of the menu posted on the fourth floor nursing unit revealed that oat cereal, egg of choice, biscuit, margarine, jelly, coffee, tea, milk, orange juice, sugar, salt, pepper and nondairy creamer were on the menu to be served for breakfast. Fried chicken, poultry gravy, mashed potatoes, seasoned cabbage, wheat roll, margarine, cranberry bar, coffee, tea, milk, sugar, salt, pepper, nondairy creamer and a parsley garnish were to be served for lunch. The alternate lunch meal was posted as beef and rice casserole with seasoned zucchini. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued observation revealed that the breakfast meal trays were served on the fourth floor nursing unit on November 3, 2024, at 10:58 a.m. Residents were served pancakes with syrup, scrambled eggs, trix cereal, coffee, sugar, nondairy creamer and milk. Observations of residents' meal tickets revealed that residents were supposed to receive orange juice and bran flakes cereal with their meals; however, no residents received these items. Further observation revealed that Resident R137's meal ticket indicated that the resident was supposed to receive a mighty shake nutritional supplement with her meal but received a snack pack pudding cup instead. Residents R63 and R127 stated that the meal was terrible. Continued observation revealed that the lunch meal trays were served on the fourth floor nursing unit on November 3, 2024, at 2:05 p.m. Residents were served beef stew over rice or chili over rice, carrots, a dessert of either pineapple, pears or pudding, cranberry juice, and coffee. Residents who received the beef stew were also served a dinner roll. Interview with on November 3, 2024, at 11:05 a.m. with Resident R40's daughter revealed that her mother has not been getting her Ensure Clear supplement on her tray, and that she has been buying it because it is one of the only things that she will consume. Review of Resident R40's meal ticket revealed that Ensure Clear was listed on the ticket. Observation of Resident R40's tray revealed that there was not Ensure Clear on her tray. Interview with Employee E27, Nurse Aide, revealed that the Ensure Clear had not been coming up on the meal trays. Interview with Employee E4, Food Service Director (FSD), confirmed that she has been having trouble order enough Ensure Clear in the past few weeks or so, and that they had run out again that morning at breakfast. Interview with Resident R91, on November 3, 2024, at 11:25 a.m. revealed that he does not like the food, and sometimes he does not get what is listed on the ticket, like no orange juice on his breakfast tray today. 28 Pa. Code 211.6(a) Dietary services 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 38735 Based on observations and interviews with residents and staff, it was determined that the facility failed to ensure that food was palatable and served at appetizing temperatures. Findings include: Review of facility food council minutes dated September 25, 2024, revealed old business that was reviewed included cold food temperatures. Further review of the food council minutes revealed 9 out of 11 residents reported the temperature of hot and cold foods at breakfast were not appropriate. Review of facility food council minutes dated October 30, 2024, revealed food temperatures are still served cold for breakfast. Further review of the food council minutes revealed 7 out of 7 residents reported breakfast is served cold. Observation of the breakfast meal served on the fourth floor nursing unit on November 3, 2024, at 10:58 a.m. revealed that residents were served pancakes with syrup, scrambled eggs, trix cereal, coffee, sugar, nondairy creamer and milk. Interview on November 3, 2024, at 10:58 a.m. Resident R63 stated that the pancake was cold, that the coffee was cold, that the eggs were always bad and he refused to eat them. Interview on November 3, 2024, at 11:10 a.m. Resident R127 stated that the breakfast tasted terrible. Interview on November 3, 2024, at 12:12 p.m. Resident R159 stated that the food was terrible. Interview on November 3, 2024, at 12:18 p.m. Resident R111 stated that the food was horrible. Interview on November 4, 2024, at 9:43 a.m. Resident R62 stated that the food sucks. Interview with Resident R91, on November 3, 2024, at 11:25 a.m. revealed that he does not like the food, that it is disgusting, not always hot enough, and he worries about not getting enough to eat. Observations on November 3, 2024, at 10:45 a.m. revealed dietary staff utilized a tray line system to plate resident meals in the kitchen before loading onto a food cart and sending resident meal trays to the designated nursing units. Further observations revealed dietary staff used a steam table to hold the foods while serving on the tray line. Interview on November 3, 2024, at 10:45 a.m. with the Food Service Director, Employee E4, revealed the steam table has been broken for a few months and does not work to help keep foods warm on the steam table while serving. Further interview with the Food Service Director, Employee E4, revealed the plate warmer (used to warm plates to help keep food warm during meal service) was also broken. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A test tray was completed on November 3, 2024, at 11:05 a.m. with Food Service Director, Employee E4, on the fourth-floor nursing unit, during the breakfast meal service. The outcome of the test tray revealed the following: pureed pancakes were 100.8 degrees Fahrenheit (F), minced and moist pancakes were 107.2 degrees F, scrambled eggs were 101.5 degrees F, regular pancakes were 91 degrees F, and the juice was 66.9 degrees F. A taste test of the food items revealed the food was served cold to taste. Interview with the Food Service Director, Employee E4, on November 3, 2024, at 11:05 a.m. confirmed that the hot foods were served too cool to be palatable and that the cold beverage was served too warm. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 211.6(f) Dietary services

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 43277 Based on observations, review of facility documentation, and staff interviews, it was determined that the facility failed to prepared foods in a form that meet resident needs for 8 of 8 residents on a pureed diet (Resident R100, R124, R21, R148, R8, R138, R81, R53). Findings Include: Review of facility diet manual signed by the Medical Director on January 1, 2023, and signed by the Food Service Director on September 1, 2023, revealed the facility follows the International Dysphagia Diet Standardization Initiative (IDDSI - provides a common terminology to describe food textures and drink thickness) Framework for food and beverage consistencies. Continued review of the facility diet manual revealed IDDSI Level 4 -Pureed Diet are foods pureed which are of a smooth, homogenous, and cohesive consistency and keep their shape when on a spoon. Review of a physician diet order report provided by the Food Service Director, Employee E4, on November 3, 2024, at 9:50 a.m. revealed Resident R100, R124, R21, R148, R8, R138, R81, and R53 were ordered a pureed diet. Interview on November 3, 2024, at 9:30 a.m. with the Assistant Food Service Director, Employee E24, revealed the breakfast menu was eggs, pancakes, cold cereal, and hot cereal (oatmeal) for residents on a pureed diet and those who request it. Observations revealed the Assistant Food Service Director, Employee E24, began plating resident breakfast trays on tray line on November 3, 2024, at 9:35 a.m. Further observations revealed there was only one pan of regular scrambled eggs. Subsequent interview with the Assistant Food Service Director, Employee E24, reported the regular scrambled eggs were also for the residents on a pureed diet and that it was the same thing. Observations revealed when the scrambled eggs were plated, they were in a crumbly consistency and did not have a smooth, homogenous, and cohesive consistency. Interview on November 3, 2024, at 9:48 a.m. with the Food Service Director, Employee E4, confirmed the pureed eggs were not prepared in accordance with the diet manual and IDDSI framework. Interview and observations with the Food Service Director, Employee E4, on November 3, 2024, at 10:42 a.m. revealed the hot oatmeal was lumpy and not prepared into a pureed consistency. 28 Pa. Code 201.14(a) Responsibility of licensee.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. 43277 Based on observations, review of clinical record, and staff interview, it was determined that the facility failed to provide beverages consistent with resident needs for two of twenty-seven residents reviewed for dining (Resident R152 and R145). Findings include: Observation of breakfast meal service conducted on November 3, 2024, at 10:20 am revealed that Resident R152 was in the dining room. Further observation revealed that Resident R152's meal ticket indicated No Dairy Products. Observation of Resident R152's breakfast tray revealed that the breakfast tray contained a carton of whole milk. Interview with Resident R152 conducted at the time of the observation revealed that she is lactose intolerant and that she had requested for almond milk or other non-dairy products but has not received any. Observations and review of Resident R145's meal ticket on November 4, 2024, revealed the meal ticket specified to provide the resident with thickened beverages. Review of Resident R145's physician order summary revealed a diet order dated August 6, 2024, which indicated the resident was ordered thin liquids. Interview on November 5, 2024, at 1:00 p.m. with the Speech Therapist, Employee E37, confirmed Resident R145 was ordered thin liquids for beverages. Interview on November 5, 2024, at 9:19 a.m. with Licensed Nurse, Employee E18, confirmed Resident R145's meal ticket had the wrong beverage consistency listed. Further interview with the Licensed Nurse, Employee E18, confirmed the kitchen still sends thickened beverages even though the physician ordered thin liquids for Resident R145. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (d)(5) Nursing services.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 39344 Based on observations, review of facility documentation and interviews with residents and staff, it was determined that the facility failed to ensure that meals were served timely on three of three nursing units observed (second, third and fourth floor nursing units) and failed to ensure that residents were provided snacks for two of 32 residents reviewed (Residents R68 and R34) Findings include: Observation on November 3, 2024, at 9:11 a.m. revealed that posted meal times on the fourth floor nursing unit were: Breakfast 7:40 a.m. to 8:40 a.m.; Lunch 12:15 p.m. to 1:15 p.m.; Dinner 5:50 p.m. to 6:50 p.m. Review of facility food council minutes dated September 25, 2024, revealed 11 out of 11 residents reported breakfast is usually served late. Review of facility food council minutes dated October 30, 2024, revealed 7 out of 7 residents reported breakfast is usually served late. Observations in the main kitchen on November 3, 2024, at 9:00 a.m. revealed dietary staff were preparing for the breakfast meal service and cooking food. Observations revealed there was one dietary personnel cooking the breakfast and three dietary aides preparing the resident beverages and meal trays for service. Interview on November 3, 2024, at 9:00 a.m. with the Assistant Food Service Director, Employee E24, revealed the cook did not show for the breakfast shift. Observations revealed breakfast was still being prepared by the Assistant Food Service Director, Employee E24, at 9:15 a.m. Further observations on November 3, 2024, revealed breakfast tray line (when resident trays began to get plated) started at 9:35 a.m. in the main kitchen. Observations on November 3, 2024, revealed residents did not start receiving breakfast until about 9:50 a.m. Further observations on November 3, 2024, revealed the last nursing unit to receive breakfast, 4th floor nursing unit, did not get their last truck of breakfast trays until 11:05 a.m. Interview on November 3, 2024, at 9:27 a.m. Resident R104 stated that she was hungry and that she was upset because breakfast had not been served yet. Interview on November 3, 2024, at 10:35 a.m. Resident R5 stated that she was hungry and asked when breakfast would be served. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued observation revealed that the breakfast meal was delivered to the fourth floor nursing unit on November 3, 2024, at 10:58 a.m. Further observation revealed that the lunch meal was delivered to the fourth floor nursing unit on November 3, 2024, at 2:05 p.m. Clinical record review for Resident R68 revealed a nutrition assessment, dated June 21, 2024, which indicated that the resident should receive snacks twice per day. Review of Resident R68's care plan, dated February 27, 2023, revealed that the resident has a nutritional problem and for the resident to receive snacks at 10 a.m., 2 p.m. and at bedtime. Clinical record review for Resident R34 revealed a nutrition assessment, dated September 17, 2024, which indicated that the resident should receive snacks three times per day. Review of Resident R34's care plan, dated February 12, 2023, revealed that the resident has a nutritional problem and for the resident to receive snacks at 10 a.m., 2 p.m. and at bedtime. Interview on November 4, 2024, at 10:20 a.m. Employee E28, unit clerk, confirmed that none of the residents on the fourth floor nursing unit received their 10:00 a.m. and 2:00 p.m. snacks on November 3, 2024, because snacks were never sent up from the kitchen. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa.Code 201.18(b)(3) Management

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39344 Based on observations, review of facility policies and interviews with staff, it was determined that the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Findings include: An initial tour of the main kitchen on November 3, 2024, at 9:45 a.m. with the Food Service Director, Employee E4, revealed the following: Observations revealed boxes of dry cereal placed directly on floor next to tray line while waiting for service to start. Observations in the freezer revealed a tray of premade meatballs that was not sealed, raw burger patties on the shelf not in any packaging, waffles not in their original packaging with no date, open vegetable blend with no date. Observations revealed an industrial fan facing the dish machine where clean dishes come out with a thick layer of dust build-up on the fan. Observations revealed a small red bucket with dirty water/cleanser and a cloth on the shelf beneath the coffee maker. Observations in the dry storage room revealed a plastic bin filled with condiment packets and a red liquid build-up in the bottom of the bin. Further observations revealed an open bag of grits with no date and was not sealed shut. Observations of the cooking equipment such as the fryer, stove, and tilt skillet, revealed they were dirty with significant grease build up on the front of the equipment. Observations behind the ice machine revealed a pool of water on the floor with fruit flies present around the ice machine. Interview with the Food Service Director, Employee E4, revealed the floor drain backs up causing an overflow of water onto the floor. Observations of the three-compartment prep sink revealed a black bin with water pooled at the bottom and shelf stable milks in the bin. Fruit flies were observed hovering the bin. The above observations were confirmed on November 3, 2024, by the Food Service Director, Employee E4, throughout the duration of the tour. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on November 6, 2024, at 12:05 p.m. with the Food Service Director, Employee E4, revealed the dishwasher becomes backed up due to a plumbing issue, causing water to pour out from underneath the dishwasher and onto the floor, subsequently causing the floor to become flooded with inches of water during use of the dishwasher. Further interview and observations also revealed the sink in the dishwasher area has a large crack in it, causing water to leak and further contributing to a flooded floor. Observation, on November 3, 2024, at 12:35 p.m. revealed that Resident R129 had two containers of a nutritional health shake and four cups of yogurt on his bedside counter. The food items were at room temperature and their labels indicated that they required refrigeration. Interview, at the time of the observation, Resident R129 stated that he keeps these foods in his room for days at a time, refused to discard them and insisted that they do not spoil or go bad at room temperature. Continued observation, on November 4, 2024, at 9:51 a.m. revealed that Resident R129 had several additional containers of nutritional health shake and cups of yogurt on his bedside counter. Further observation, on November 5, 2024, at 10:13 a.m. Revealed that Resident R129 continued to have several cups of yogurt on his bedside counter. Interview on November 3, 2024, at 12:39 p.m. Employee E25, licensed nurse, confirmed that nursing staff are aware that Resident R129 has hoarding behaviors including keeping dairy products at room temperature in his room, and that due to this the foods are unsafe to consume. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa.Code 201.18(b)(3) Management 43277

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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. 38735 Based on review of facility documentation, review of clinical records, and staff interview, it was determined that the facility failed to submit complete records related to rehabilitation services for three of 32 residents reviewed (Resident R110, R113, R38). Findings include: Request for rehab documents for Resident R113 on November 6, 2024, at 1:10 pm for Resident R113 revealed that the facility was not able to provide surveyors with rehab notes as requested for Residents Resident R133. Request for rehab documents for Resident R110 on November 6, 2024, at 1:10pm for Resident R110 revealed that the facility was not able to provide surveyors with rehab notes as requested for Residents Resident R110. Interview with Employee E1 conducted on November 6, 2024, at 1:11pm revealed that the facility changed rehab company and that they were not able to access the rehab therapy notes from the previous company. A request for Resident R38's most recent physical and occupational therapy notes and discharge summary was made to the Nursing Home Administrator, Employee E1, on November 6, 2024, at 9:30 a.m. Interview on November 6, 2024, at 12:45 a.m. with Physical Therapist, Employee E21, revealed the employee started in September 2024 and did not have access to any previous therapy notes for Resident R38 due to a change in ownership. Interview on November 6, 2024, at 1:00 p.m. with the Nursing Home Administrator, Employee E1, confirmed the facility was unable to obtain and provide physical and occupational therapy notes for Resident R38 as requested. 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38735 Based on a review of facility documents and resident clinical records and interviews with staff, it was determined that the facility failed to ensure that residents had the capacity to understand the terms of a binding arbitration agreement for one of nine residents reviewed (Resident R259). Findings include: Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of admission record indicated Resident R259 was admitted to the facility on [DATE]. Review of Resident R259's Minimum Data Set (MDS - a periodic assessment of care needs) dated January 17, 2021, indicated the diagnoses of cognitive communication deficit (problem with one or more cognitive skills involved in communication, such as attention, memory, or reasoning). Further review revealed a BIMS score of 3, indicating severe cognitive impairment. Review of Resident R259's Binding Arbitration Agreement (a binding agreement by the parties to submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship, whether contractual or not. The decision is final, can be enforced by a court, and can only be appealed on very narrow grounds) indicated that he signed the document on admission on January 13, 2021. Interview on November 5, 2024, with the Nursing Home Administrator (NHA) revealed that the Arbitration Agreement is part of the admission packet, and that the Admission Director gets the signatures at admission. The NHA further stated that the facility did not currently have an Admission Director, and that there have been four admission directors since 2021. The NHA confirmed that a resident with a BIMS of 3 should not have been signing this document as they did not have the capacity to understand the terms of a binding arbitration agreement. 28 Pa. Code: 201.14(a)(c)(d)(e) Responsibility of licensee. 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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39344 Based on observations, review of facility policies and interviews with staff, it was determined that the facility failed to maintain effective infection control practices related to barrier precautions and personal protective equipment for three of 32 residents reviewed (Residents R43, R81, and R52) and proper disposal of PPE by staff prior to leaving room for 4 out of 17 rooms observed. Findings include: Review of facility policy titled Isolation Steps Categories of Transmission Based Precautions revised August 1, 2023, revealed the facility shall make every effort to use the least restrictive approach to managing individuals with potentially communicable infections enhanced barrier precautions expands the use of PPE (personal protective equipment) beyond situations in which exposure to blood and bodily fluids is anticipated and referred to the use of donning gloves during high contact resident care activities that provide opportunities for the transfer of multi drug resistant organisms (MDRO) to staff hands and clothing. All residents with any of the following conditions should use enhanced barrier precautions infection or colonization with a novel or targeted MDRO when contact precautions do not apply and or open wounds in our dwelling medical devices examples are central line, urinary catheter, feeding tube, and tracheostomy regardless of MDRO colonization status. Examples of infections requiring Enhanced Barrier Precautions, but are not limited to: MRSA - Methicillin-Resistant Staphylococcus Aureus VRE - Vancomycin-Resistant Enterococci CRE - Carbapenem-resistant Enterobacteriaceae Carbapenem-resistant Pseudomonas Carbapenem-resistant Acinetobacter baumanni Candida auris Multidrug-resistant Pseudomonas aeruginosa Drug-resistant Streptococcus pneumoniae GNB - Multidrug-Resistant Gram-Negative Bacilli (also known as Extended Spectrum Beta Lactamase (ESBL) which may include: o Escherichia coli (Ecoli) o Klebsiella pneumoniae o Acinetobacter baumannii (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o Pseudomonas aeruginosa All residents with any of the following conditions should use enhanced barrier precautions: Infection or colonization with a novel or targeted MDRO when Contact Precautions do not apply. Open wounds and/ or indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy) regardless of MDRO colonization status who reside on a unit or wing where a resident known to be infected or colonized with a novel or targeted MDRO resides. Review of facility policy, Administering Medication dated April 17, 2024, revealed, Staff shall follow established facility infection control procedures (e.g., hand washing, antiseptic technique, gloves, isolation precautions, etc.) when these apply to the administration of medications. Review of physician orders for Resident R43 revealed an order, dated September 13, 2024, which indicated that the resident required Enhance Barrier Precautions due to having an indwelling PEG tube (percutaneous endoscopic gastrostomy - a surgical opening and placement of a tube though a person's abdominal wall into their stomach). Observation of the morning medication pass on November 3, 2024, at 9:51 a.m. Employee E26, licensed nurse, prepared medications for Resident R43. A sign was posted on Resident R43's door indicating that the resident required Enhanced Barrier Precautions. Employee E26, licensed nurse, crushed Resident R43's medications and administered them via the resident's PEG tube. Throughout the administration of Resident R43's medications, Employee E26, licensed nurse, only wore a pair of gloves. Interview, at the time of the observation, Employee E26, licensed nurse, stated that she didn't know where any other PPE were located. Observation of the breakfast meal served on the fourth floor nursing unit on November 3, 2024, at 10:58 a.m. revealed that residents were served pancakes with syrup, scrambled eggs, trix cereal, coffee, sugar, nondairy creamer and milk. Continued observation revealed that Employee E29, nurse aide, while assisting a resident with their meal, picked up the resident's pancake with her bare hands and ripped the pancake apart, then placed the pancake pieces back on the resident's plate. Observation of wound care for Resident R81 on November 3, 2024, at 1:45 p.m. revealed Employees E10 and E12, licensed nurses, perform wound care on the resident's right foot. Employees E10 and E12, licensed nurses, worn gowns and gloves during the procedure. After the treatment was completed, there was no container or place to properly dispose of the used PPE within the vicinity of the resident's room. Employee E12, revealed that the gowns were washable and stated that there was a bin in the resident shower room to put the used gowns in. Employee E12, licensed nurse, then proceeded to walk all the way down the hall to the resident shower room. Observation of the resident shower room with Employee E12, licensed nurse, revealed that there was no designated container for used gowns; Employee E12, licensed nurse, obtained a trash bag and placed the used gowns in it. Observation conducted on November 4, 2024, at 10:22 am during a follow-up observation of the second-floor unit revealed that there were no bins to discard used PPE's (protective personal equipment) in room [ROOM NUMBER] observation of the second-floor hallway conducted on November 4, 2024 at 11:40 AM revealed that there was no bin outside the resident's room to discard used PPE's (protective personal equipment). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Nurse aide, Employee E17 conducted at the time of the observation revealed that after taking care of residents who are on ABP (enhanced barrier precaution), she takes the used PPE out of the room and take them in the soiled utility room where they throw it on the bin. Follow-up observation of the second floor conducted on November 5, 2024, at 11:03 am with Employee E18 revealed that room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] had Enhanced Barrier Precaution signage posted outside the rooms. Observation of room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] revealed that there were no bins to discard used PPEs inside room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]. Interview with licensed nurse, Employee E18 conducted at the time of the observation revealed that staff must wear PPE's before entering room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] due to the facility's Enhanced Barrier Precaution policy. Further, Employee E18 confirmed that room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] did not have bins to discard used PPE. Interview with DON Employee E2 conducted on November 5, 2024 at 10:10 am revealed that there should be bins in the resident's rooms with enhanced barrier precaution for staff to discard their PPE's prior to leaving the room. Observations conducted on November 3, 2024, time on the third-floor nursing unit revealed signs posted on the door or wall outside the resident rooms indicating a high contact resident care activities that require use of gown and gloves. Observations conducted on November 3, 2024, at 1:15 p.m. the third-floor nursing unit revealed no PPE stationed on the floor for access to use. This observation confirmed by Employee E12 Interview with unit manager confirmed that there was no PPE on the floor. Observation of Resident R52's door revealed a sign on the door stating the resident in the room is on enhanced barrier precautions. Review of Resident 52's quarterly Minimum Data Set (MDS - federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing facility) dated October 1, 2024 revealed that Resident R52 was admitted into the facility April 6, 2022 with diagnoses of respiratory failure (condition which results from inadequate gas exchange)and Crohn's disease (an inflammatory bowel disease). Resident required a colostomy bag (a surgical procedure that creates an opening in the abdominal wall, to allow waste to exit the body) and a tracheostomy (a surgical procedure that create an opening in the neck and trachea to help a person breath). Observation of Resident R52 on November 3, 2024, at 1:07 p.m. revealed Nurse aide, Employee E11 and Nurse aide, Employee E16 providing colostomy care to Resident R52. Further observation revealed that Employee E11 and Employee E16 were not wearing proper PPE, only gloves. Interview with Employee E11 at time of observation, revealed that she did to need to wear PPE. Interview with Licensed nurse unit manager, Employee E12 confirmed that there was no PPE on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Licenses nurse, Employee E10 during the above observation, when questioned how she administered medications to the residents on the floor that were ordered tube feeding, Employee E10 confirmed that she did not wear any PPE. Observation on November 5, 2024 at 10:28 a.m. of Licensed nurse, Employee E25 on providing care to Resident R52, revealed that Licensed nurse Employee E25 was not practicing proper infection control by not adhering to wearing required PPE. Interview with Licensed nurse, Employee E25 at time of observation, she believed that the PPE was only for toileting the resident. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(c)(d)(1)(5) Nursing Services

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 39344 Based on observations and interviews with residents and staff, it was determined that the facility failed to ensure that essential dining equipment in the kitchen and essential resident equipment was maintained in proper working order for two of 32 residents reviewed (Residents R26 and R38). Findings include: Interview on November 3, 2024, at 12:50 a.m. with Resident R38 revealed the head rest of the wheelchair fell off and now there is no where to put his head when leaning back. Interview on November 5, 2024, at 12:45 a.m. with Physical Therapist, Employee E21, confirmed Resident R38's head rest fell off the wheelchair and a maintenance request was sent to the Nursing Home Administrator, Employee E1, on November 1, 2024. Interview on November 6, 2024, at 9:47 a.m. with the Nursing Home Administrator, Employee E1, confirmed Resident R38's headrest on the wheelchair was broken and that maintenance has not yet looked at the wheelchair for repair. Observations on November 3, 2024, at 10:45 a.m. revealed dietary staff utilized a tray line system to plate resident meals in the kitchen before loading onto a food cart and sending resident meal trays to the designated nursing units. Further observations revealed dietary staff used a steam table to hold the foods while serving on the tray line. Interview on November 3, 2024, at 10:45 a.m. with the Food Service Director, Employee E4, revealed the steam table has been broken for a few months and does not work to help keep foods warm on the steam table while serving. Further interview with the Food Service Director, Employee E4, revealed the plate warmer (used to warm plates to help keep food warm during meal service) was also broken. Continued interview on November 3, 2024, at 10:45 a.m. with the Food Service Director, Employee E4, revealed the slicer in the kitchen was broken. Continued observations on November 3, 2024, at 11:00 a.m. during a tour of the main kitchen with the Food Service Director, Employee E4, revealed the front panel of the fryer was broken, exposing the inside of the fryer. Observations of the dish machine on November 3, 2024, at 11:15 a.m. revealed a significant amount of water was spraying through the curtain during use of the dishwasher. Interview on November 6, 2024, at 12:05 p.m. with the Food Service Director, Employee E4, revealed the dishwasher becomes backed up due to a plumbing issue, causing water to pour out from underneath the dishwasher and onto the floor, subsequently causing the floor to become flooded with inches of water during use of the dishwasher. Further interview and observations also revealed the sink in the dishwasher area has a large crack in it, causing water to leak and further contributing to a flooded floor. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued interview on November 6, 2024, at 12:05 p.m. with the Food Service Director, Employee E4, revealed the garbage disposal in the sink is also broken causing water to back up and needing to be plunged frequently. Observation on November 3, 2024, at 10:40 a.m. revealed Resident R26 had an air mattress that was alarming low pressure. Upon touching the mattress, the metal base under the mattress could be felt. Employee E25, licensed nurse, confirmed that the air mattress was alarming for low pressure and stated that she would recheck the mattress again later. Continued observation, on November 3, 2024, at 12:25 p.m. revealed that Resident R26's air mattress was still alarming for low pressure. Resident R26 stated that she felt like she was lying on a metal frame and stated that her rear end and back really hurts me. Continued observation, on November 4, 2024, at 9:47 a.m. revealed that Resident R26's air mattress was still alarming for low pressure. Resident R26 stated that her mattress felt very uncomfortable. Continued observation, on November 5, 2024, at 10:09 a.m. revealed that Resident R26's air mattress was still alarming for low pressure and the mattress appeared deflated under the resident. Resident R26 stated that her bed felt uncomfortable. Interview on November 6, 2024, at 9:00 a.m. Employee E30, licensed nurse, confirmed that Resident R26's air mattress has been malfunctioning for the past few days. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management

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F 0922 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have enough backup water supply for essential areas of the nursing home. 38735 Based on observation of the facility's physical environment and interviews with staff, it was determined that the facility failed to ensure that a supply of potable (safe for drinking) water on hand at the facility in the event that there was a loss of normal water supply. Findings Include: Interview on November 6, 2024, at 11:15 a.m. with the Food Service Director, Employee E4, revealed based on a census of 156 residents, the facility should have 3-gallons of water per resident for emergency purposes. Further interview revealed based on the above information the facility should have a total of 468 gallons of emergency water. Observations of the emergency water storage on November 6, 2024, at 11:30 a.m. with the Food Service Director, Employee E4, revealed the facility only had 294 gallons of emergency water on hand. Interview with the Food Service Director, Employee E4, confirmed the facility did not have sufficient emergency water to meet the needs of the residents in case of an emergency. 28 Pa. Code 201.18(b)(3) Management

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 39344 Based on observations, review of facility documentation and interviews with staff, it was determined that the facility failed to maintain an effective pest control program in the kitchen and for two of 32 residents reviewed (Resident R81 and R309). Findings include: Review of the facility pest control report dated October 28, 2024, revealed the pest control company Observed live roach activity in the dishwasher area coming out of wheel carts that carry dishes after they are done being washed. Observed carts with old food on them as well. Subsequently the pest control company recommended for better sanitation practices throughout the kitchen, especially behind the cooking area such as stoves, and for trash to be thrown out in a timely manner. The pest control company also recommend for leaks under dishwasher area to be fixed as the water washes away chemicals after being treated. Review of the facility pest control report dated November 4, 2024, revealed the pest control copy observed positive roach acceptance on monitor placed under dishwasher area in the main kitchen. The pest control company further recommend better sanitation practices in kitchen and for trash to be thrown out in a timely manner. Observations during a tour of the main kitchen on November 3, 2024, with the Food Service Director, Employee E4, at 9:45 a.m. revealed the following: Observations of the cooking equipment such as the fryer, stove, and tilt skillet, revealed they were dirty with significant grease build up on the front of the equipment. Observations in the dry storage room revealed a plastic bin filled with condiment packets and a red liquid build-up in the bottom of the bin. Observations behind the ice machine revealed a pool of water on the floor with fruit flies present around the ice machine. Interview with the Food Service Director, Employee E4, revealed the floor drain backs up causing an overflow of water onto the floor. Observations of the three-compartment prep sink revealed a black bin with water pooled at the bottom and shelf stable milks in the bin. Fruit flies were observed hovering the bin. The above observations were confirmed by the Food Service Director, Employee E4, during the duration of the tour. (continued on next page)

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Maplewood Nursing and Rehab Center	125 W Schoolhouse Lane Philadelphia, PA 19144

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on November 6, 2024, at 12:05 p.m. with the Food Service Director, Employee E4, revealed the dishwasher becomes backed up due to a plumbing issue, causing water to pour out from underneath the dishwasher and onto the floor, subsequently causing the floor to become flooded with inches of water during use of the dishwasher. Further interview and observations also revealed the sink in the dishwasher area has a large crack in it, causing water to leak and further contributing to a flooded floor. Although the pest control company recommended for leaks under dishwasher area to be fixed as the water washes away chemicals after being treated, the dishwasher is still broken and subsequently flooding the floors. Observation of wound care for Resident R81 on November 3, 2024, at 1:45 p.m. revealed Employees E10 and E12, licensed nurses, perform wound care on the resident's right foot. The resident was also observed to have an indwelling feeding tube. Continued observation during the treatment revealed multiple flies were in the room and on the resident. Employee E12, licensed nurse, confirmed that there were flies in the room and on Resident R81, and stated that she was unsure when pest management services are provided in the facility and that resident rooms are only treated upon request. Employee E12, licensed nurse, agreed that flies in the room and on the resident puts Resident R81 at greater risk for infection due to having the wound and feeding tube. Continued observation on November 4, 2024, at 9:55 a.m. revealed that there were multiple flies on Resident R81 and in the resident's room. Further observation on November 5, 2024, at 10:15 a.m. revealed that there were multiple flies on Resident R81 and in the resident's room. Review of facility pest logs revealed that no flies were reported on the log for Resident R81. Observations on November 4, 2024, at 12:57 p.m. revealed Resident R309's bilateral lower extremities were wrapped with gauze and scabs were present on the uncovered areas. Flies were observed in the room at this time. Resident R309 reported that the flies were bothersome. Interview on November 4, 2024, at 12:59 p.m. with licensed nurse, Employee E36, confirmed Resident R309 had open areas of the bilateral lower extremities and further confirmed the presence of flies in Resident R309's room. Review of pest control reports revealed that during pest management services that were provided on November 4, 2024, that no resident rooms were treated due to no list of rooms needing treatment were provided to the pest management company. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management