STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395868	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Hearthside	450 Waupelani Drive State College, PA 16801

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20725 Based on a review of select facility policies and procedures, employee personnel record review, and staff interview, it was determined that the facility failed to obtain attestation of Pennsylvania residency or criminal background checks as required for four of five personnel records reviewed (Employees 3, 4, 5, and 6); and failed to ensure the completion of abuse training for one of five newly hired employees reviewed (Employee 5). Findings include: In accordance with Act 13 Elder Abuse Mandatory Reporting and Act 169 Criminal Background Checks, nursing facilities are required to obtain a criminal background check on all newly hired employees. Facilities are required to obtain the Pennsylvania State Police (PSP) background check within 30 days of hire on all prospective employees. If the applicant has not been a Pennsylvania resident for the two years before application, they will need to have a PSP criminal history background check completed and an FBI Background Check. The applicant will obtain an FBI fingerprint card either from their prospective employer or by contacting Pennsylvania Department of Aging (PDA). The applicant will go to the police to be fingerprinted. The completed card (fingerprints and requested information) will be forwarded to PDA along with payment. The fingerprints will be forwarded to the FBI for processing by the PDA. The normal processing time is between 60 and 90 days. The facility policy entitled, Abuse, Neglect, Exploitation, and Misappropriation of Resident Property, last reviewed without changes on March 29, 2024, revealed that screening procedures include that the facility will undertake background checks of all employees and to retain on file applicable records of current employees regarding such checks. The facility will conduct a criminal background check in accordance with Pennsylvania law and facility policy and verify that the applicant is not excluded from any Federally funded health care programs. Training procedures include that the facility will educate its staff upon hire and annually thereafter regarding the facility's policy concerning abuse, neglect, exploitation of residents, and misappropriation of resident property; and how to handle resident-to-resident abuse and injuries of unknown origin. The policy did not include how the facility will have an employee attest to two consecutive years of Pennsylvania residency before application for employment. The policy did not include how the facility would check information from previous and/or current employers (obtain reference checks). (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Employee 3's (nurse aide) personnel file revealed that the facility hired him on December 11, 2023. A Pennsylvania Resident Verification for Waiver of FBI Report (form included in the facility's personnel records that require an employee to list all addresses for the past [AGE] years) revealed that Employee 3 did not provide a signature to attest to the addresses he lived at for the previous [AGE] years. Employee 3's file did not include an FBI Background Check. Employee 3's personnel file included a Pennsylvania State Police criminal record check with a date of request of April 24, 2024 (the day after the surveyor requested his personnel record, more than four months after his hire date). Review of Employee 4's (dietary aide) personnel file revealed that the facility hired her on January 8, 2024. Employee 4 did not sign a Pennsylvania Resident Verification for Waiver of FBI Report until January 23, 2024 (15 days after her hire date). The Pennsylvania State Police criminal record check, dated as requested January 12, 2024, was still pending. The facility did not have a completed criminal record check within 30 days of Employee 4's hire date. Review of Employee 4's timecard revealed that she worked paid hours starting January 11, 2024. Review of Employee 5's (registered nurse) personnel file revealed that the facility hired her on February 22, 2024. Employee 5's personnel record did not contain a Pennsylvania Resident Verification for Waiver of FBI Report form to attest to Pennsylvania residency for two years before hire. Employee 5's file did not include an FBI Background Check. Employee 5's personnel file included a Pennsylvania State Police criminal record check with a date of request of April 24, 2024 (the day after the surveyor requested her personnel record, more than two months after her hire date). Employee 5 did not sign to attest to receipt of education regarding the facility's abuse policies until March 4, 2024. Review of Employee 5's timecard revealed that she worked paid hours on March 2 and 3, 2024 (before her orientation to the facility's abuse prevention program). Review of Employee 6's (activities aide) personnel file revealed that the facility hired her on March 1, 2024. Employee 6 did not sign a Pennsylvania Resident Verification for Waiver of FBI Report form to attest to Pennsylvania residency for two years until April 25, 2024 (after the surveyor reviewed her personnel record). Employee 6's personnel file included a Pennsylvania State Police criminal record check with a date of request of March 13, 2024 (12 days after her hire date). A review of Employee 6's timecard revealed that she worked paid hours on March 2, 3, 4, 6, 7, 8, 11, 12, and 13, 2024. Employee 6's personnel file did not indicate that the facility attempted to obtain any personal or professional references. The surveyor reviewed the above concerns regarding Employees 3, 4, 5, and 6 during an interview with Employee 10 (human resources director) on April 25, 2024, at 8:30 AM. Interview with Employee 10 on April 25, 2024, at 4:06 PM confirmed that she had no additional information regarding the above concerns. 483.12(b)(1)-(3) Develop/implement Abuse/neglect Policies Previously cited deficiency 5/5/23 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(1)(3)(e)(1) Management (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa Code 201.19(6)(7)(8) Personnel policies and procedures

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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. 20725 Based on clinical record review and resident and staff interview, it was determined that the facility failed to ensure resident and/or responsible party participation in comprehensive care plans for two of two residents reviewed for care planning concerns (Residents 8 and 69). Findings include: Interview with Resident 8 on April 23, 2024, at 3:32 PM revealed that she denied any invitation to participate in her care plan meetings. Resident 8 stated, I haven't had no meetings like that at all. Clinical record review for Resident 8 revealed an undated printed invitation, addressed to Resident 8, that indicated there would be a meeting to discuss a care plan. The letter instructed that she should RSVP to the social service office as soon as possible or the facility would continue with the care conference, .as scheduled above; however, there was no date or time included on this page of the invitation. There was no email, phone number, or facility staff member name provided on the invitation to inform Resident 8 who or how to contact someone regarding the letter. A Care Plan Meeting Note dated December 26, 2023, at 3:53 PM documented, Family/resident invited, family/resident did not attend. The note stipulated, Care Plan Meeting notes uploaded under misc.; however, there were no notes uploaded under miscellaneous information in Resident 8's electronic medical record. Information provided by the facility on April 26, 2024, at 9:02 AM (following the surveyor's questioning) revealed handwritten documentation (reportedly held in another staff's office and not uploaded into Resident 8's electronic medical record) that revealed neither Resident 8 or her responsible party attended a care plan conference on December 26, 2023. There was no explanation included in Resident 8's medical record if their participation was determined not practicable for the development of her care plan. Nursing documentation dated March 22, 2024, at 1:13 PM revealed that a care plan meeting was scheduled for March 27, 2024, at 1:45 PM with the resident. No progress note documentation in Resident 8's electronic medical record indicated that there was a care plan meeting held on March 27, 2024. Information provided by the facility on April 26, 2024, at 9:02 AM (following the surveyor's questioning) revealed handwritten documentation (reportedly held in another staff's office and not uploaded into Resident 8's electronic medical record) that revealed a care plan conference on March 27, 2024, included no information regarding Resident 8's problems or needs or evaluation of goals for the nursing, social services, therapy, and resident/family sections of the document. There was no documentation in Resident 8's record to indicate that the facility took steps to identify and eliminate barriers that limit Resident 8's ability to participate in her care planning. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident 69 on April 24, 2024, at 11:58 AM indicated that he was not familiar with care plan meetings. Care plan conference documentation dated November 2, 2023, indicated that neither Resident 69 nor his responsible party attended. Clinical record review for Resident 69 revealed an undated printed invitation, addressed to Resident 69 and his daughter, that indicated there would be a meeting to discuss a care plan. The letter instructed that he should RSVP to the social service office as soon as possible or the facility would continue with the care conference, .as scheduled above; however, there was no date or time included on this page of the invitation. There was no email, phone number, or staff member name provided on the invitation to inform Resident 69 who or how to contact someone regarding the letter. A second page entitled, CARE PLAN MEETING, instructed to, Please click below to read your Care Plan Invitation for December 19th, 2023. Times are not included in Care Plan Invitation. To receive your meeting time, please contact Social Services. There was no phone number or email address included in the notice to facilitate contacting the social services department. Care plan conference documentation dated December 19, 2023, indicated that neither Resident 69 nor his responsible party attended. There was no documentation in Resident 69's record to indicate that his or his responsible party's participation was determined not practicable for the development of his care plan. There was no indication that the facility took steps to identify and eliminate barriers that limit Resident 69's ability to participate in his care planning. The surveyor reviewed the above concerns regarding resident/responsible party participation for the development of residents' care plans during interviews with Employee 1 (regional director of clinical services) and the Director of Nursing on April 24, 2024, at 2:00 PM, April 25, 2024, at 2:00 PM, and April 26, 2024, at 8:50 AM. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36798 Based on select policy review, clinical record review, and resident and staff interview, it was determined that the facility failed to provide the highest practicable care regarding a fluid restriction for one of one resident reviewed (Resident 62), and physician ordered treatments for one of one resident reviewed (Resident 2). Findings include: The facility policy entitled, Fluid restriction or Encouragement last reviewed without changes on March 29, 2024, revealed that residents are encouraged and assisted as needed to consume the amount of fluids appropriate for their diagnoses and medical status. Fluid restrictions will have a dietician or physician's order specifying the total amount of fluid per day. The total amount may be broken down into recommendations for the fluids at meals, between meals, and with medication passes. Fluids consumed should be recorded as accurately as possible. Appropriate documentation should be completed regarding the resident's compliance or refusal regarding fluid recommendations. Clinical record review for Resident 62 revealed that she was readmitted to the facility on [DATE], after a hospital admission for congestive heart failure (CHF, a condition in which the heart cannot pump blood well enough to meet the body's needs causing the body to retain fluid). Resident 62's clinical record revealed that she was ordered a fluid restriction on February 14, 2024. The orders indicated that she was to only have 1500 milliliters (ml) of fluid every 24 hours. She was to only have 270 ml with her medications on dayshift, 270 ml with her medications on evening shift, and 120 ml with her medications on night shift. There were no other orders that designated how the remaining 1500 ml of fluid were to be provided to her. Further clinical record review revealed that on February 29, 2024, Resident 62's fluid restriction orders were changed and designated amounts with medication administration were as follows: 370 ml with medications on dayshift, 370 ml with medications on evening shift, and 220 ml with medications on night shift. There were no other orders that designated how the remaining 1500 ml of fluid were to be provided to her. On March 19, 2024, Resident 62's fluid restriction orders were changed to 1800 ml every 24 hour period as follows for medications and meals: medications: dayshift 360 ml; evening shift 240 ml and night shift 120 ml meals: 480 ml Breakfast; 360 ml Lunch; 240 ml Dinner Review of Resident 62's clinical record revealed that the only fluid intakes documented were located on her Medication Administration Record (MAR, a form used to document medications administered) for the months of February 14-29, and March 1-19, 2024, and only included the fluids given to her with her medications. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 62's clinical record revealed no fluid intake documentation for the dates of March 19 to April 24, 2024. Interview with the Director of Nursing on April 25, 2024, at 2:40 PM revealed that the Dietician did not correctly code Resident 62's new fluid restriction order on March 19, 2024, so it did not show up on her MAR for the nurses to document her fluid intake. She also confirmed that there was no documentation recording what Resident 62's fluid intake was with meals or in between meals, and there was no evidence that the fluid restriction was being reviewed to ensure compliance. Further clinical record review for Resident 62 revealed a dietary progress note dated April 2, 2024, at 1:01 PM that indicated Resident 62 continues to adhere to 1800 ml/day fluid restriction. A dietary progress note dated April 11, 2024, at 2:03 PM revealed that Resident 62 has variable adherence to her current daily fluid restriction order. A dietary progress note dated April 18, 2024, at 4:10 PM revealed that Resident 62's adherence to her daily fluid restriction remains variable. Interview with Employee13 (RD, registered dietician), on April 25, 2024, at 3:55 PM revealed that she was basing her progress notes of April 2, 2024, April 11, 2024, and April 18, 2024, off observations of the resident and her room and the fact that Resident 62 continues to order out of the facility for food and drinks keeping her out of compliance with her fluid restriction. Employee 13 confirmed that there was no clinical documentation related to Resident 62's total fluid restriction that she based the above progress notes on. The Director of Nursing was made aware of the concerns with Resident 62's fluid restriction in a meeting on April 26, 2024, at 9:22 AM. The facility failed to provide the highest practicable care related to Resident 62's physician ordered fluid restriction. Clinical record review for Resident 2 revealed the resident has a diabetic foot ulcer to the right second toe. Observation of Resident 2's right second toe with Employee 1, Regional Director of Clinical Services, on April 26, 2024, at 10:00 AM revealed a scabbed area to the top of the right second toe that appeared to be 0.5 cm x 0.5 cm, no drainage, and some surrounding erythema (redness). Nursing documentation for Resident 2 dated January 29, 2024, at 8:22 PM revealed that staff first noted an open area to the top of the resident's right second toe. The toe was described as bent with a wound base that has slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy, and mucinous in texture) and tenderness when touched. Nursing documentation for Resident 2 dated February 17, 2024, at 2:44 AM revealed the resident's right second toe diabetic foot ulcer was scabbed over. A physician's order for Resident 2 dated February 17, 2024, instructed staff to cleanse the right second toe with normal saline solution, apply skin prep to the wound base, and leave open to air every shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Treatment Administration Record for Resident 2 for February 2024 revealed the treatment was not documented as being completed on the following shifts: evening shift on February 23, 2024; day shift and night shift on February 24, 2024. There was no documented evidence in the clinical record as to why the treatment was not completed per the medical provider's order or any documentation that the resident refused the treatment. Clinical record review for Resident 2 revealed skin and wound documentation from the wound care provider dated February 27, 2024, at 8:39 AM that indicated the right second toe diabetic foot ulcer was documented as Worsening. An order for Resident 2 dated February 28, 2024, instructed staff to cleanse the right second toe with normal saline solution, apply medical grade honey to the wound base, and secure with bordered gauze every day shift. Review of the Treatment Administration Record for Resident 2 for March 2024 revealed the treatment was not documented as being completed on the following dates: March 9 and March 12, 2024. There was no documented evidence in the clinical record as to why the treatment was not completed per the medical provider's order or any documentation that the resident refused the treatment. Clinical record review for Resident 2 revealed skin and wound documentation from the wound care provider dated April 23, 2024, at 2:49 AM that indicated the resident had a diabetic foot ulcer that was improving with delayed wound closure to the right second toe. The documentation further noted, The patient needs offloading to the area of foot ulcer, glycemic control, and routine wound dressing management. Continue routine foot care. The above information regarding Resident 2's wound was reviewed with the Director of Nursing (DON) on April 26, 2024, at 12:30 PM. The DON could provide no further information regarding the missed treatments other than the DON believed the staff were not waking the resident for the ordered night shift treatment. 483.25 Quality of Care Previously cited deficiency 5/5/2023 28 Pa. Code 211.10(a)(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20725 Based on clinical record review and resident and staff interview, it was determined that the facility failed to obtain necessary audiology services for one of one resident reviewed for hearing concerns (Resident 8). Findings include: Interview with Resident 8 on April 23, 2024, at 3:12 PM revealed she was extremely hard of hearing and that she required the use of a dry erase board to communicate every question to her during the interview. Resident 8 stated that, .they've been promising me that a hearing doctor would come in and clean my ears and give me hearing aids, but no one has come, haven't seen anyone. Clinical record review for Resident 8 revealed an admission MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) assessment dated [DATE], that assessed Resident 8 as having highly impaired hearing (with the use of a hearing aid if used); but that no hearing aid was used. The care assessment area (CAA, section of the assessment that documents the facility's decision to proceed to a care plan) of the assessment noted that hearing was one of the triggered conditions; and that the facility would develop a plan of care. Review of a plan of care initiated December 28, 2023, to address Resident 8's care preferences revealed that Resident 8 had interventions that included she used a dry-erase board to assist with communication; and confirmed that staff identified that Resident 8 had highly impaired hearing on January 8, 2024. A plan of care initiated December 14, 2023, and was last revised January 11, 2024, identified that Resident 8 had the potential for impaired communication related to hearing loss. Interventions listed in the plan of care instructed staff to assist with hearing aid placement and maintenance, if available, use non-verbal communication as needed, and that Resident 8 utilized a dry erase board for communication. A consent for services from the facility's contracted provider for vision, podiatry, dental, and audiology included Resident 8's signature dated February 13, 2024, indicating her consent for those services. Documentation by the facility's contracted provider for audiology services dated February 23, 2024, indicated that Resident 8 was evaluated for a hearing aid check, that Resident 8 was an experienced hearing aid user with one hearing aid on the left side, that hearing aids were purchased through this provider and were fit on November 20, 2023. The left hearing aid, . is missing. Submitted a loss and damage claim under warranty. The plan was to fit replacement left hearing aid once received and follow-up with hearing aid fitting in one month. Although the document repeated hearing aids (plural), and assessed Resident 8 as having bilateral sensorineural (type of hearing loss in which the root cause lies in the inner ear) hearing loss, the document referred only to the left hearing aid and did not assess or plan treatment for a right hearing aid. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing on April 25, 2024, at 12:26 PM confirmed that any information provided by the facility still did not indicate that Resident 8 received professional audiology services after the February 23, 2024, progress note. Interview with the Director of Nursing and Employee 1 (regional director of clinical services) on April 25, 2024, at 2:04 PM revealed that facility staff believed Resident 8 was to have one hearing aid (does not have), was to have it repaired/replaced in one month (has been two months), that there has been no follow-up visit, and that nothing in Resident 8's medical record indicated that staff incorporated her one hearing aid into her plan of care. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18229 Based on clinical record review and family and staff interview, it was determined that the facility failed to implement treatment and services to promote the healing of a pressure ulcer for one of four residents reviewed for pressure ulcer concerns (Resident 40). Findings include: Clinical record review revealed the facility admitted Resident 40 on [DATE]. Review of Resident 40's admission assessment noted nursing staff assessed Resident 40 with an unstageable pressure sore on his coccyx measuring 1.5 centimeters (cm) by 0.5 cm with an unknown depth. Review of Resident 40's care plan initiated on [DATE], revealed the facility implemented a wound treatment, and instructed nursing to observe the wound dressing daily to ensure that the dressing remains intact and there are no signs and symptoms of infection or increased drainage. Review of Resident 40's Treatment Administration Record (TAR, a form the facility utilizes to document treatments) dated [DATE] revealed the facility did not initiate a treatment to Resident 40's wound until [DATE]. Interview with the Director of Nursing on [DATE], at 12:13 PM confirmed these findings and stated that the nurse aides were applying a barrier cream with incontinent episodes. Review of a Skin and Wound note dated [DATE], noted the unstageable pressure ulcer on Resident 40's coccyx was worsening and now measured 2.4 cm by 1.6 cm by 0.2 cm. The treatment recommendations were to clean Resident 40's wound with normal saline, apply medical-grade honey to the base of the wound, secure it with bordered foam, and change it every day and as needed. Review of a Skin and Wound note dated [DATE], noted the unstageable pressure ulcer on Resident 40's coccyx was worsening and now measured 4 cm by 2.5 cm by 1.5 cm. Surgical debridement was completed, and the treatment was changed to cleanse the wound with Dakin's solution, apply Dakin's moistened fluffed gauze to the base of the wound, secure with bordered foam, and change twice a day and as needed. Review of Resident 40's TAR revealed that nursing staff did not apply the Dakin's treatment as ordered from [DATE] to 22, 2023, due to not arriving from the pharmacy. Documentation from the nurse practitioner dated [DATE], revealed that she spoke to Resident 40's family, and they voiced concerns that Resident 40's sacral wound had progressively worsened since admission. Resident 40's representative stated that she can see bone. The documentation further revealed that Resident 40's representative requested an air mattress before Resident 40 arrived at the facility, but no one ever completed this request even though Resident 40 was admitted with a pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing documentation dated [DATE], revealed that Resident 40 was sent to the hospital and admitted with severe sepsis and osteomyelitis (bone infection) of the coccyx. Documentation noted Resident 40 returned to the facility on [DATE]. Resident 40's representative requested to speak to the surveyor on [DATE], at 12:38 PM. Resident 40's representative confirmed that she asked the facility to place an air mattress on his bed on admission due to his pressure ulcer. She stated that no one would listen to her. Resident 40's daughter stated that the air mattress never worked right. She stated that on [DATE], when a family member sat on Resident 40's bed, the mattress deflated. Resident 40's representative stated that he expired on [DATE]. Interview with Employee 22 (maintenance) confirmed the air mattress was not placed on Resident 40's bed on admission liked requested. He stated that it was placed on Resident 40's bed on [DATE]. Employee 22 stated that he replaced the faulty air mattress when made aware by the family. Nursing documentation dated [DATE], at 5:48 PM revealed that Dakin's solution was not available. Nursing documentation dated [DATE], revealed there was no Dakin's solution and Resident 40's responsible party was at the facility and stated she wanted the dressing ordered from the hospital to be applied. Review of the [DATE] TAR revealed there were no documented dressings to Resident 40's wound on [DATE] and 31, 2023. Review of the Skin and Wound note dated [DATE], noted Resident 40's coccyx was a Stage 4 (extends below the subcutaneous fat into deep tissues, including muscle, tendons, and ligaments} measuring 4.5 cm by 5.5 cm by 2 cm. Resident 40's last Skin and Wound note dated [DATE], revealed Resident 40's coccyx pressure ulcer measured 4 cm by 6 cm by 1.5 cm. The facility failed to implement treatment and services to promote the healing of Resident 40's pressure ulcer. 483.25(b)(1)(i)(ii) Treatment/svcs to Prevent/heal Pressure Ulcer Previously cited deficiency [DATE] 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.5(f)(ii)(iv)(ix) Medical records 28 Pa. Code 211.10(a)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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	395868	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Hearthside	450 Waupelani Drive State College, PA 16801

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44738 Based on clinical record review and staff interview, it was determined that the facility failed to provide the appropriate recommended services for a resident's range of motion for four of nine residents reviewed (Residents 6, 11, 14, and 51). Findings included: Clinical record review for Resident 11 revealed a quarterly MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated March 6, 2024, that indicated the resident had a BIMS (Brief Interview for Mental Status) score of 3 that indicated a severe cognitive impairment level. The current care plan for Resident 1 revealed the resident requires assistance with activities of daily living (ADL) care related to dementia, weakness, and impaired balance. The care plan indicated the resident was dependent on staff for transfers and required extensive assistance of two from staff for bed mobility. A review of the most current physical therapy discharge summary for Resident 11 dated March 6, 2024, at 11:42 AM revealed recommendations from therapy for a restorative nursing program that included passive range of motion (PROM) supine exercises to the bilateral lower extremities daily as tolerated. A review of the most current occupational therapy discharge summary for Resident 11 dated March 14, 2024, at 4:26 PM revealed recommendations from therapy included a restorative nursing program that noted the following: To facilitate patient maintaining current level of performance and in order to prevent decline, development of and instruction in the following RNPs (restorative nursing program) has been completed with the IDT (interdisciplinary team): ROM (range of motion, movement of the body to maintain a resident's ability). A review of facility documentation for Resident 11 titled, Therapy Discharge Recommendation Sheet, marked as informational and dated March 14, 2024, indicated the following recommendations: Supine passive range of motion exercises to bilateral lower extremities; two to three sets with 10 to 15 repetitions daily. Supine passive range of motion exercises with some active movement to the bilateral upper extremities; two to three sets with 10 repetitions daily. A review of the current tasks for Resident 11 included the following program that was dated June 13, 2023: Active ROM: Upper and lower extremities with ADLs with 15 repetitions and a participation goal of 15 minutes as tolerated to be completed daily. Further review revealed that staff were documenting this program as being completed as ordered. An interview with Employee 17, Director of Rehabilitation, on April 26, 2024, at 10:36 AM regarding Resident 11 revealed that the programs on the Therapy Discharge Recommendation Sheet were different than the program on the tasks list in the clinical record. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Employee 1, Regional Director of Clinical Services, on April 26, 2024, at 11:00 AM revealed that it appears the program under the tasks list in the clinical record was never updated to reflect the recommendations from therapy dated March 14, 2024. Clinical record review for Resident 14 revealed his most recent MDS dated [DATE], noting lower extremity impairment on both sides. Further review of Resident 14's clinical record revealed a physical therapy discharge summary dated February 22, 2024, recommending passive range of motion to bilateral knees to maintain joint range of motion, and gentle passive range of motion to bilateral lower extremities every day as able. Further review of Resident 14's clinical record revealed no documentation that nursing staff completed Resident 14's passive range of motion recommended by physical therapy. Clinical record review for Resident 51 revealed his most recent MDS dated [DATE], nursing staff assessed Resident 51 as having lower extremity impairment on both sides. Further review of Resident 51's clinical record revealed a physical therapy discharge summary dated March 15, 2024, recommending gentle passive/active range of motion to her bilateral lower extremities every day, twice for 10 reps to maintain her lower extremity strength and joint range of motion as tolerated. Further review of Resident 51's clinical record revealed no documentation that nursing staff completed Resident 51's passive/active range of motion as recommended by therapy. Interview with Employee 21 (physical therapist aide) on April 26, 2024, at 10:26 AM confirmed these findings for Resident's 14 and 51. Employee 21 revealed that the facility has not had a restorative nursing program since she was hired over a year ago. The above information for Residents 14 and 51 were reviewed in an interview with the Director of Nursing on April 26, 2024, at 11:51 AM. Clinical record review for Resident 6 revealed an MDS dated [DATE], that indicated he had an impairment to both upper extremities. Review of Resident 6's current care plan revealed he was at risk for a decline in his range of motion related to left side hemiplegia (paralysis). The goal indicated that he would not show a decline in range of motion with passive range of motion. The interventions indicated to encourage resident to participate in passive range of motion, move joints slowly and smoothly, and for restorative to assess resident quarterly and as needed. Review of Resident 6's task documentation (computerized documentation of the care completed for a resident) revealed that he was to have PROM to his upper and lower extremities for 15 minutes providing 15 repetitions to each extremity. This was to be completed every shift. Further review of Resident 6's task documentation for the PROM revealed that from February 1-8, 2024, not applicable was documented for his PROM program 10 times. He was then admitted to the hospital from February 8-16, 2024. The PROM program resumed on February 17, 2024. Task documentation revealed that not applicable was documented 9 times from February 17-29, 2024. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of task documentation for March 1-31, 2024, revealed that staff documented not applicable without explanation, 38 times when the program was scheduled for Resident 6's PROM program. Review of task documentation for Resident 6's PROM program from April 1-24, 2024, revealed that staff documented not applicable 33 times when the program was scheduled without explanation. Interview of the Director of Nursing on April 26, 2024, at 9:15 AM revealed that the staff told her that they document not applicable when the resident does not get their full 15 minutes of PROM. Review of PROM task documentation for February, March, and April 2024, for Resident 6 revealed that staff were documenting the number of minutes even when it was less than 15 minutes and this was confirmed with the Director of Nursing on April 26, 2024, at 9:30 AM. The facility failed to provide the appropriate recommended services to maintain or prevent decline in range of motion for Residents 6, 11, 14, and 51. 483.25(c) Mobility Previously cited 5/5/2023 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 20725 Based on clinical record review, observation, and family and staff interview, it was determined that the facility failed to implement interventions to deter resident falls and prevent potential injury for two of 12 residents reviewed for fall concerns (Residents 20 and 48). Findings include: Clinical record review for Resident 20 revealed a plan of care developed by the facility to address her risk for falls. Interventions listed in the plan of care included bilateral fall mats at all times when she is in bed since October 17, 2023. Observation of Resident 20 on April 23, 2024, at 3:00 PM revealed she was in bed. There was a fall mat on the left side of her bed. There was no fall mat on the right side of her bed. Observation of Resident 20 on April 26, 2024, at 10:51 AM revealed she was in bed with a fall mat on only the left side of her bed. Interview with Employee 2 (licensed practical nurse) on April 26, 2024, at 10:56 AM at Resident 20's bedside, confirmed that there was only one fall mat in her room. The right side of her bed was not equipped with a fall mat. The surveyor reviewed the above concern regarding Resident 20's fall mat during an interview with Employee 1 (regional director of clinical services) on April 26, 2024, at 11:00 AM. Interview with Resident 48's wife on April 23, 2024, at 1:35 PM revealed that Resident 48 fell approximately six weeks ago when he tried to get up by himself and hit his head on the door frame. Resident 48 had to go to the hospital and receive treatment to a laceration on his head. Nursing documentation dated December 16, 2023, at 8:11 PM revealed that the nurse aide brought the licensed practical nurse to Resident 48's room to find him sitting on the floor in his room. Resident 48 stated that he was trying to get to the toilet. Review of the facility's Incident/Accident Investigation dated December 16, 2023, revealed that the plan to prevent future fall recurrence included to obtain laboratory testing including a urinalysis (testing of the urine for any infection). Resident 48's clinical record did not contain evidence that the facility obtained laboratory or urine testing as planned for Resident 48 in response to this fall. Interview with the Director of Nursing on April 26, 2024, at 8:50 AM confirmed that the facility could not provide evidence of laboratory or urine testing in response to Resident 48's fall on December 16, 2023. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing documentation dated December 17, 2023, at 6:45 PM revealed that Resident 48 was sitting on the floor in the television lounge after an attempt to transfer without assistance. Review of the facility's Incident/Accident Investigation dated December 17, 2023, revealed that Resident 48 is redirected and reminded numerous times to not attempt to stand without staff assistance. The document did not indicate that the facility implemented any new intervention to prevent fall recurrence for Resident 48 at that time. Interdisciplinary documentation dated December 28, 2023, at 10:02 AM revealed that the team reviewed Resident 48's fall that occurred on December 17, 2023 (11 days earlier). The documentation indicated that the new intervention implemented to prevent fall recurrence was to place a sign on the table in the lounge to ring for assistance. The documentation repeated Resident 48's known behavior of non-compliance with his transfer and ambulation status; however, the team did not identify that Resident 48 may not benefit from a sign to ring for assistance. Review of a plan of care developed by the facility to address Resident 48's risk for falls related to his history of falls, cognitive impairment, potential medication side effects, left-sided paralysis (loss of extremity function), non-compliance with transfer and ambulation status, and impulsivity, revealed interventions that included to place a sign on the table in the television lounge to remind Resident 48 to, Call for staff assistance, do not attempt to stand on your own. The plan of care stipulated that Resident 48 was non-compliant in following all the interventions in place; however, there was no intervention to alert staff timely when he is non-compliant with his plan of care (e.g., alarms, increased supervision, or alterations in his seating and bed surfaces to deter his attempts to transfer or ambulate unassisted). Observation of Resident 48 in the television lounge on April 26, 2024, at 11:00 AM with Employee 1, confirmed that there was no sign on the table to, Call for staff assistance, do not attempt to stand on your own. Nursing documentation dated December 23, 2023, at 9:40 AM revealed that the facility transferred Resident 48 to the hospital emergency room . Nursing documentation dated December 23, 2023, at 10:17 AM revealed that staff called the registered nurse to the nursing unit. Resident 48 was on the floor, on his back, in front of his room. Resident 48 reported to staff that he needed to use the bathroom; however, would not wait for staff to assist him. Staff heard a bang and found him on the floor with his head bleeding. Staff called the certified registered nurse practitioner who provided an order to send Resident 48 to the emergency room for his wound evaluation. Interdisciplinary documentation dated December 27, 2023, at 9:51 AM revealed that the team reviewed Resident 48's fall on December 23, 2023. The documentation confirmed that Resident 48 was sent to the emergency room for evaluation and received staples to his head laceration. The team decided that Resident 48 was focused on toileting and that the new intervention to prevent fall recurrence would be to complete a post void residual (use a medical device over the skin to assess the amount of urine left in the bladder after urination) and refer him for psychiatric services. Review of the facility's Incident/Accident investigation dated December 23, 2023, assessed Resident 48's wound as a laceration to the back of his head that measured 2 cm (centimeters) by 0.25 cm. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing on April 26, 2024, at 8:50 AM revealed that the facility had no evidence staff obtained a post void residual assessment or a psychiatric evaluation in response to Resident 48's fall. Clinical record review of consultant provider documentation revealed that Resident 48 did not have a psychology evaluation until February 1, 2024. Nursing documentation dated February 7, 2024, at 12:25 AM revealed that staff at the nurse's station heard a loud bang and observed Resident 48, supine (on his back) in the doorway of his room. His wheelchair was unlocked and positioned to the right of him. The nurse aide reported that Resident 48 unlocked his wheelchair, stood up with his urinal, lost his balance, and fell . Interdisciplinary team documentation dated February 7, 2024, at 9:46 AM revealed that the intervention implemented to prevent fall recurrence was to instruct maintenance staff to install anti-rollback brakes (equipment on a wheelchair that prevents the wheels from rolling backward unintentionally) on Resident 48's wheelchair. Review of Resident 48's plan of care developed by the facility to address his fall risk indicated that the facility discontinued the anti-rollback system to Resident 48's wheelchair on September 14, 2023. The plan of care revealed no evidence that the facility included anti-rollback equipment in the list of interventions after his fall on February 7, 2024. Nursing documentation dated March 8, 2024, at 8:47 PM revealed that staff observed Resident 48 in front of his toilet, on the floor. Resident 48 stated, I was trying to sit on the w/c (wheelchair) and the w/c kicked out. Staff, .reminded (Resident 48) to use the call bell that is located near the toilet for assistance. Staff did not recognize Resident 48's risk for falls when left alone in the bathroom despite his known behavior of non-compliance with his transfer status. Interdisciplinary team documentation dated March 11, 2024, at 9:53 AM revealed that the team reviewed Resident 48's fall on March 8, 2024, at 7:30 PM. The team reiterated that Resident 48 was getting off the toilet to sit on his wheelchair when the chair, kicked out, and he sat on the floor. The documentation indicated that a new intervention was for therapy to assess Resident 48 for an appropriate chair with an anti-rollback device. The interdisciplinary team failed to identify that the anti-rollback device was an intervention planned after Resident 48's fall on February 7, 2024, at 12:25 AM. Interview with the Director of Nursing on April 26, 2024, at 8:50 AM confirmed that the facility could not provide any nursing, maintenance, or therapy staff documentation that the facility implemented an anti-rollback device to Resident 48's wheelchair after his fall on February 7, 2024. The interview also confirmed that, although the facility identified Resident 48 was impulsive and non-compliant with requesting staff assistance with transfers, Resident 48 was left alone in the bathroom on March 8, 2024, when he fell transferring from the toilet to his wheelchair. 483.25(d)(1)(2) Free of Accident Hazards/supervision/devices (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Previously cited deficiency 5/5/23 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 20725 Based on clinical record review, observation, and staff interview, it was determined that the facility failed to administer supplemental oxygen as prescribed by the physician for two of five residents reviewed for oxygen concerns (Residents 8 and 62). Findings include: Clinical record review for Resident 8 revealed an active physician's order dated December 14, 2023, that instructed staff to administer supplemental oxygen via a nasal cannula (NC, flexible tubing with small prongs at one end inserted into the nostrils for the application of supplemental oxygen) at 3 liters per minute (l/m) continuously. Observation of Resident 8 on April 23, 2024, at 3:52 PM revealed the application of supplemental oxygen via a NC and a room concentrator (medical device used to concentrate the oxygen available in room air to administer oxygen-enriched supply back to the resident). The administration setting on the room concentrator was 2.5 l/m. Observation of Resident 8 on April 26, 2024, at 11:13 AM again revealed the application of supplemental oxygen via a NC and room concentrator at a rate of 2.5 l/m. Interview with Employee 1 (regional director of clinical services) on April 26, 2024, at 11:15 AM confirmed that staff applied Resident 8's supplemental oxygen at 2.5 l/m when her active physician's order instructed staff to apply the supplemental oxygen at a rate of 3 l/m. Clinical record review for Resident 62 revealed an active physician's order dated February 12, 2024, that instructed staff to administer supplemental oxygen via a NC at 2 l/m continuously. Observation of Resident 62 on April 24, 2024, at 12:11 PM revealed the application of supplemental oxygen via a NC and a room concentrator. The administration setting on the room concentrator was 3.5 l/m. Observation of Resident 62 on April 25, 2024, at 12:40 PM revealed the application of supplemental oxygen via NC and a room concentrator. The administration setting on the room concentrator was 3.5 l/m. Concurrent observation and interview with Employee 14, Licensed Practical Nurse, confirmed that the concentrator was set at 3.5 l/m and should have only been at 2 l/m per Resident 62's current physician order. The Director of Nursing was made aware of concerns with Resident 62's oxygen on April 25, 2024, at 2:40 PM. The facility failed to administer supplemental oxygen as prescribed by the physician for Residents 8 and 62. 483.25(i) Respiratory/tracheostomy Care and Suctioning Previously cited deficiency 5/5/23 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18229 Based on clinical record review and staff interview, it was determined that the facility failed to identify triggers related to a resident's diagnosis of Post-Traumatic Stress Disorder, to provide culturally, competent, trauma-informed care, and to eliminate or mitigate re-traumatization for two of four residents reviewed for mood/behavior (Residents 14 and 28). Findings include: Clinical record review for Resident 14 revealed a diagnosis of Post Traumatic Stress Disorder (PTSD, a mental and behavioral disorder that develops related to a terrifying event) since admission on March 24, 2021. Resident 14 was unable to be interviewed related to his diagnosis of PTSD due to his current cognitive status. A review of Resident 14's admission minimum data set (MDS, an assessment completed by the facility at intervals to determine care needs) assessment dated [DATE], indicated a diagnosis of PTSD for Resident 14. A review of Resident 14's most recent quarterly MDS assessment dated [DATE], indicated PTSD continued to be an active diagnosis for Resident 14. Further review of Resident 14's care plan identified he had a diagnosis of PTSD. There were no identified triggers (everyday situations that cause a person to re-experience the traumatic event as if it was reoccurring). Clinical record review for Resident 28 revealed a diagnosis of PTSD since admission on September 7, 2023. Resident 28 was unable to be interviewed related to his diagnosis of PTSD due to his current cognitive status. A review of Resident 28's admission MDS assessment dated [DATE], indicated a diagnosis of PTSD for Resident 28. A review of Resident 28's most recent quarterly MDS assessment, dated February 13, 2024, indicated PTSD continued to be an active diagnosis for Resident 28. An interview with the Director of Nursing on April 25, 2024, at 9:50 AM confirmed these findings. The facility failed to identify and care plan triggers that may retraumatize Residents 14 and 28 related to their diagnosis of PTSD. 28 Pa Code 211.12 (d)(3)(5) Nursing services

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 20725 Based on review of select facility policies and procedures, clinical record review, observation, and staff interview, it was determined that the facility failed to assess the entrapment risk of assist bar use for two of six residents reviewed for accident concerns (Residents 8 and 20) Findings include: The facility policy entitled, Proper Use of Bed Rails, last reviewed without changes on March 29, 2024, revealed that it is the policy of the facility to utilize a person-centered approach when determining the use of bed rails. Entrapment, is an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail. Resident assessment must also assess the resident's risk from using bed rails. Examples of the potential risks with the use of bed rails include accident hazards (e.g., falls, entrapment, and other injuries sustained from attempts to climb over, around, between, or through the rails, or over the footboard). The resident assessment should assess the resident's risk of entrapment between the mattress and bed rail or in the bed rail itself. The medical record should include evidence of the assessment of the resident, the bed, the mattress, and rail for entrapment risk (which would include ensuring bed dimensions are appropriate for resident size/weight). Installation and Maintenance of Bed Rails includes inspecting and regularly checking the mattress and bed rails for areas of possible entrapment; and ensuring the bed frame, bed rail, and mattress do not leave a gap wide enough to entrap a resident's head or body, regardless of mattress width, length, and/or depth. Ongoing Monitoring and Supervision includes ongoing evaluation of risks as follows: a nurse assigned to the resident will complete reassessments in accordance with the facility's assessment schedule, but not less than quarterly, upon a significant change in status, or a change in the type of bed/mattress/rail. The maintenance director, or designee, is responsible for adhering to a routine maintenance and inspection schedule for all bed frames, mattresses, and bed rails. The Bed Entrapment Grid portion of the policy describe the entrapment zones as follows: Zone 1, within the rail Zone 2, between the top of a compressed mattress to the bottom of the rail, between rail and supports Zone 3, horizontal space between rail and mattress Zone 4, between top of compressed mattress and bottom of rail at the end of the rail Zone 5, between split rails Zone 6, between rail and edge of head/foot board Zone 7, between head or foot board and mattress (continued on next page)

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Embassy of Hearthside	450 Waupelani Drive State College, PA 16801

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clinical record review for Resident 8 revealed an active physician's order dated December 18, 2023, for the use of bilateral enabler bars to aide with turning and repositioning. A Maintenance Bed Rail Evaluation dated April 16, 2024, indicated that maintenance staff only evaluated Zone 1 and Zone 3 for entrapment risks. Observation of Resident 8 on April 23, 2024, at 3:52 PM revealed she was in bed; bilateral assist bars were mounted to the head of the bed. Resident 8's bed was equipped with a footboard. Resident 8's bed and equipment would make Zone 1, Zone 2, Zone3, Zone 4, Zone 6, and Zone 7 potential areas of entrapment risk. The surveyor reviewed the above concerns regarding Resident 8's entrapment risk assessment with Employee 1 (regional director of clinical services) on April 25, 2024, at 12:00 PM. Clinical record review for Resident 20 revealed an active physician's order dated March 31, 2023, for the use of bilateral enabler bars to aide with turning and repositioning; and an active physician's order dated November 13, 2019, for the use of bilateral assist rails for bed mobility. Observation of Resident 20 on April 23, 2024, at 3:01 PM revealed she was in bed; bilateral assist rails were mounted to the head of the bed. Resident 20's bed was equipped with a headboard and a footboard. Resident 20's bed and equipment would make Zone 1, Zone 2, Zone3, Zone 4, Zone 6, and Zone 7 potential areas of entrapment risk. A Maintenance Bed Rail Evaluation dated April 16, 2024, indicated that maintenance staff only evaluated Zone 1 and Zone 3 for Resident 20's entrapment risks. An interview with Employee 1 and the Director of Nursing on April 25, 2024, at 2:00 PM confirmed the above findings. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20725 Based on clinical record review, observation, and family, resident, and staff interview, it was determined that the facility failed to arrange for behavioral health care and services to maintain the highest practicable well-being for one of four residents reviewed for behavioral concerns (Resident 78; University nursing unit, Resident 69). Findings include: Review of the Facility Assessment (document developed by the facility to determine what resources are necessary to care for its residents competently) revealed that the facility identified the number of specialty unit beds specifically for those with dementia and the diseases/conditions and physical/cognitive disabilities cared for included psychiatric/mood disorders. Resident acuity affecting licensed nurses included behavioral health, dementia, mood disorders (like bipolar disorder) and schizophrenia. Specific Care or Practices for the Mental Health and Behavior category included a current contract with a new service. Clinical record review for Resident 78 revealed a diagnoses list that included [NAME]'s encephalopathy ([NAME]-Korsakoff syndrome is a type of memory disorder due to a lack of thiamin (vitamin B1); most often happens in people with alcohol use disorder and malnutrition) and alcohol abuse. Interview with Resident 78's daughter on April 23, 2024, at 4:20 PM revealed that her opinion of her father was that he was very difficult due to his history of alcohol abuse; .he's just like a toddler. She stated that there were conversations with facility staff about sending Resident 78 to an inpatient facility; however, she could not afford to pay for his bed-hold privately while he went there for treatment. She stated that she had to wait until his Medicaid application was approved for his long-term care stay; however, at this point, Resident 78 is required to, spend down, any assets before Medicaid will assume the costs for his care. Resident 78's daughter stated that no one had mentioned to her if the bed-hold cost could be used towards his spending down before his Medicaid approval. Resident 78's daughter stated that she did not believe that any psychological service professionals treated her father after an initial assessment upon his admission to the facility (November 9, 2023). Clinical record review of a Psychiatric Evaluation and Consultation by the facility's contracted provider dated November 30, 2023, as an initial evaluation, revealed that Resident 78 would benefit from continued behavioral health; and that the plan was to follow-up in one month or sooner if indicated. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clinical record review for Resident 78 revealed social service documentation dated February 20, 2024, at 4:00 PM that the writer spoke with Resident 78's daughter about the behaviors that he exhibits (sitting sideways on a chair, crawling on the floor, and attempting to stand at handrails, and combativeness with care). The writer educated Resident 78's daughter about Resident 78 benefitting from going to an inpatient psychiatric location for assessment and treatment to assist with his behaviors. The documentation confirmed that Resident 78's daughter verbalized understanding, would like for Resident 78 to be sent to an inpatient facility, but stated that she wanted his Medicaid to be approved for the bed hold prior to sending him for inpatient psych services. Documentation by the certified registered nurse practitioner (CRNP) dated February 29, 2024, at 12:11 PM indicated that Resident 78 was seen that date for a psychotropic visit and reviewed the psychotropic medications used in his plan of care: Depakote (mood stabilizer) 250 mg (milligrams) every eight hours Haldol (antipsychotic used to treat mood disorders) 1 mg twice daily Ativan (antianxiety medication) 0.5 mg every six hours The assessment listed Resident 78's diagnoses/problems that included: Alcohol dependence with alcohol induced psychotic disorder with hallucinations (characterized by hallucinations (false perceptions of reality that can affect any of the five senses), paranoia (intense, irrational, persistent instinct or thought process of fearful feelings and thoughts), and fear Unspecified mood disorder (a diagnosis for people who have symptoms of a mood disorder like depression, but do not meet the criteria for any specific type) Restlessness and agitation Nursing documentation dated March 8, 2024, at 11:52 AM revealed that staff observed Resident 78 attempting to enter other residents' rooms and became combative when staff attempted to redirect him. A nurse aide witnessed Resident 78 in a female resident's room where he picked up the bed remote and was swinging it; almost hitting the female resident and the resident's family member that was present. Staff were able to get Resident 78 out of the room, but he attempted to hit them multiple times. Nursing documentation dated March 8, 2024, at 1:07 PM revealed that Resident 78 was having increased behaviors. Resident 78 overturned the refrigerator in the registered nursing office and was walking into all rooms and arguing with the residents who resided in those rooms. Documentation by the CRNP dated April 5, 2024, at 10:20 AM revealed that new orders on that date included the use of Aricept (drug used to treat brain disorders like dementia by reducing the destruction of necessary chemicals in the brain) 5 mg every day at hour of sleep. The documentation indicated that Resident 78 was physically aggressive with staff and all care. He has had multiple medication changes and will not improve with medications. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing documentation dated April 7, 2024, at 2:04 PM revealed that Resident 78 was alert, pleasant, and cooperative until 1:00 PM when he began threatening to throw things and hit people. Resident 78 stated, I'll throw this chair at you, and he attempted to pick up a broda chair (larger, customizable, semi-tilt reclining wheelchair) but was unable to lift it. Nursing documentation dated April 11, 2024, at 12:31 PM revealed that Resident 78 was exit-seeking at the main entrance and had put himself on the floor in the lobby. Nursing documentation dated April 12, 2024, at 5:37 AM revealed that Resident 78 had been awake the entire shift, eating constantly throughout the night, wandering up and down the halls, getting up and down from the floor. He wandered into another female's room causing her to yell at him. He was not easily redirected due to agitation. Nursing documentation dated April 18, 2024, at 8:25 PM revealed that Resident 78 urinated on the floor at the nurses' station. Nursing documentation dated April 18, 2024, at 5:22 PM revealed that Resident 78 was violent toward staff and threatening to other residents. Resident 78 had a bowel movement and threw it in the direction of another resident. Resident 78 tried to trip a nurse aide for no apparent reason. Review of the plan of care developed by the facility to address Resident 78's mood and potential to express depressive behaviors revealed interventions that included a psychological consult as needed. Interview with Employee 1 and the Director of Nursing on April 25, 2024, at 2:25 PM revealed that the facility recently signed a new contract with a behavioral management company, that the psychologist comes to the facility, but it was unknown if Resident 78 received services from the psychologist. The facility was unable to provide any evidence that a behavioral health or psychiatric professional treated Resident 78 after his initial assessment in November 2023. Interview with Resident 69 on April 24, 2024, at 11:48 AM revealed that he reported a male resident had gotten in his bed and was slow to respond when he told him to leave. During the interview with Resident 69 on April 24, 2024, at 12:14 PM Resident 78 attempted to wander in Resident 69's room. Resident 69 yelled at Resident 78 to leave, which caused staff to respond and redirect Resident 78 from the room. Resident 69 confirmed that Resident 78 is the male resident he referred to; and stated that there are times when Resident 78 is wandering while naked. Observation of Resident 78 on April 26, 2024, at 11:28 AM revealed he was in the hallway of the nursing unit, sitting on the floor, with a cup of juice. Interview with Employee 11 (nurse aide) on the date and time of the observation revealed that Resident 78 was no worse than usual at the time; .plenty of days he repeatedly puts himself on the floor. The facility failed to provide Resident 78 the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with his plan of care. 28 Pa. Code 211.2(d)(3)(7) Medical director (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 18229 Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement individualized person-centered care plans to address dementia and cognitive loss displayed by one of two residents reviewed (Residents 56). Findings include: Clinical record review for Resident 56 revealed that the facility admitted him on June 20, 2023, with diagnoses including dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life) with other behavioral disturbances. A review of Resident 56's admission Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated June 28, 2023, indicated that the facility assessed Resident 56 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed. A review of Resident 56's care plan revealed that there was no indication that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss. The findings were reviewed with the Director of Nursing on April 25, 2024, at 11:33 AM. She confirmed the facility had no further documentation that the facility developed and implemented an individualized person-centered care plan to address Residents 56's dementia and cognitive loss. 483.40(b)(3) Dementia Treatment and Services Previously cited 5/5/23 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 20725 Based on clinical record review and staff interview it was determined that the facility failed to ensure that the consultant pharmacist reported irregularities to the attending physician and that the physician appropriately responded to reported irregularities for two of five residents reviewed for potentially unnecessary medications (Residents 20 and 52). Findings include: Clinical record review for Resident 20 revealed a consultant pharmacist recommendation to the physician on July 28, 2023, to evaluate Resident 20's use of the Oxcarbazepine medication (anti-seizure medication used to treat Resident 20's dementia with psychotic disturbance, condition where individuals with cognitive decline experience symptoms such as hallucinations and delusional thinking) from 150 mg twice daily. The certified registered nurse practitioner (CRNP) responded to the recommendation on August 25, 2023, that the recommendation was declined because the reduction would likely exacerbate Resident 20's underlying psychiatric disorder. Resident 20's active physician order for the Oxcarbazepine medication indicated that it had been at the same dose since March 9, 2019. There was no evidence that Resident 20 failed a previous attempt at a dose reduction of that medication. Review of Resident 20's physician orders for the use of the antipsychotic, Risperdal, revealed that she had a dose reduction from 0.5 mg twice daily to 0.5 mg daily on March 21, 2022, then another dose reduction to 0. 25 mg daily on April 18, 2023, without any documented adverse effects. Resident 20's clinical record did not provide evidence that her target behavior symptoms would likely exacerbate after a reduction in a psychotropic medication. Pharmacy documentation on August 25, 2023, December 18, 2023, January 15, 2024, February 16, 2024, and April 22, 2024, indicated that the consultant pharmacist had a new recommendation; however, the documentation did not indicate if the pharmacist forwarded a report to the physician, the Director of Nursing, or both. Interview with the Director of Nursing on April 26, 2024, at 8:50 AM, and April 26, 2024, at 12:30 PM, confirmed that the facility could not provide a separate, written report that was sent from the consultant pharmacist to the attending physician/facility's medical director and/or the Director of Nursing on August 25, 2023, December 18, 2023, January 15, 2024, February 16, 2024, and April 22, 2024. Clinical record review for Resident 52 revealed a pharmacy medication regimen review assessments dated December 14, 2023, and March 19, 2024, that indicated a review by the pharmacist was completed and a new recommendation was made. The assessment note did not indicate if the recommendations were forwarded to the Director of Nursing, the Physician, or both. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further clinical record review for Resident 52 revealed that there was no evidence in the clinical record indicating what the recommendations were and if they had been addressed by the appropriate medical professional. Interview with the Director of Nursing on April 26, 2024, at 12:44 PM confirmed that pharmacy recommendations for the dates of December 14, 2023, and March 19, 2024, for Resident 52, were not available in his clinical record, and that she could not locate the recommendations provided by the pharmacist. The facility failed to ensure that the consultant pharmacist reported irregularities to the attending physician and that the physician appropriately responded to reported irregularities for potentially unnecessary medications for Residents 20 and 52. 28 Pa. Code 211.2(d)(3) Medical director 28 Pa. Code 211.9(k) Pharmacy services 28 Pa. Code 211.12(d)(1)(3)(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. 18229 Based on clinical record review and staff interview, it was determined that the facility failed to ensure a resident's medication regime was free from potentially unnecessary medications for two of six residents reviewed for medication regime review (Residents 56 and 20). Findings include: Clinical record review revealed the facility admitted Resident 56 on June 20, 2023. Resident 56's clinical record revealed a physician's order dated June 26, 2023, noting the facility added Trazodone (an antidepressant-sedative medication) 100 milligrams (mg), one tablet on June 26, 2023, for insomnia. There was no diagnosis of insomnia at this time. Review of the consultant pharmacist recommendation dated September 25, 2023, revealed hypnotic/sedative medications should be reviewed for gradual dose reductions (GDR) to determine if symptoms can be controlled at a lower dose, or without the medication. The consultant pharmacist recommended a gradual dose reduction. Resident 56's physician indicated he is stable on his current regimen and his mood instability is too great. Review of the consultant pharmacist recommendations dated December 13, 2023, and March 19, 2024, revealed the same recommendation for Resident 56's Trazodone listed above. Resident 56's physician responded, no GDR, benefit outweighs the risk. Review of Resident 56's behavior tracking documentation revealed there was no evidence the facility was monitoring Resident 56's insomnia to ensure his Trazadone was medically necessary. There was no evidence that the facility attempted a gradual dose reduction of Resident 56's Trazodone. Interview with the Director of Nursing on April 26, 2024, at 10:47 AM confirmed Resident 56 was not admitted to the facility on Trazodone, and that the facility had no evidence of a failed GDR that was evidenced by a return or worsening of target behaviors. The facility was unable to provide documentation of the clinically significant symptoms that required the continued use of Resident 56's Trazodone. Clinical record review for Resident 20 revealed a consultant pharmacist recommendation to the physician on July 28, 2023, to evaluate Resident 20's use of the Oxcarbazepine medication (anti-seizure medication used to treat Resident 20's dementia with psychotic disturbance, condition where individuals with cognitive decline experience symptoms such as hallucinations and delusional thinking) from 150 mg twice daily. The certified registered nurse practitioner (CRNP) responded to the recommendation on August 25, 2023, that the recommendation was declined because the reduction would likely exacerbate Resident 20's underlying psychiatric disorder. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 20's active physician order for the Oxcarbazepine medication indicated that it had been at the same dose since March 9, 2019. There was no evidence that Resident 20 failed a previous attempt at a dose reduction of that medication. Review of Resident 20's physician orders for the use of the antipsychotic, Risperdal, revealed that she had a dose reduction from 0.5 mg twice daily to 0.5 mg daily on March 21, 2022, then another dose reduction to 0. 25 mg daily on April 18, 2023, without any documented adverse effects. Resident 20's clinical record did not provide evidence that her target behavior symptoms would likely exacerbate after a reduction in a psychotropic medication. Documentation by the CRNP dated February 5, 2024, at 12:59 PM noted that her assessment of Resident 20 during the routine visit was that she reported a good appetite, was sleeping well, and that there were no concerns reported by nursing staff. Nursing documentation dated February 6, 2024, at 10:09 PM revealed that antibiotic therapy continued for Resident 20 due to a labia boil (a painful, pus-filled bump that develops when a hair follicle becomes infected outside of the vagina). Nursing documentation dated February 8, 2024, at 12:33 PM revealed that the facility moved a new roommate into Resident 20's room, which resulted in her yelling at the roommate, screaming that she did not want anyone in her room. There was no indication that Resident 20's comments were delusional or independent of the stimulus of the change from a private room to a semi-private room. Nursing documentation dated February 8, 2024, at 6:52 PM revealed that Resident 20 was in her room, yelling at her new roommate to get out of the room. Resident 20 would not halt the behavior and administration staff instructed nursing staff to move the roommate out of Resident 20's room. A physician's order dated February 10, 2024, increased Resident 20's Risperdal from 0.25 mg daily to 0.5 mg daily. There was no evidence that Resident 20 continued to exhibit inappropriate behaviors after the roommate was moved out of her room and before the physician doubled her Risperdal dose. A plan of care developed by the facility to address Resident 20's impaired cognitive function related to her vascular dementia (general term for problems with reasoning, planning, memory, and other thought processes caused by brain damage from impair blood flow to the brain) initiated March 11, 2019, listed interventions that included, Keep (Resident 20's) routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Discuss with MD and family the ongoing need for use of medication. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. Monitor/record occurrence of target behavior symptoms and document per facility protocol. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing and Employee 20 (activities director) on April 26, 2024, at 12:38 PM reviewed available target behavior tracking for Resident 20. The interview indicated that the documentation completed by nurse aide staff deleted in the electronic system after 30 days. The resulting information available indicated a few times each target behavior had occurred in one week; however, did not indicate if the behaviors extended over many days or occurred all in one shift (or brief time). The interview confirmed that the facility's justification for increasing Resident 20's antipsychotic medication, Risperdal, was the episode of target behaviors for the hours Resident 20 had a roommate; during a time when she received antibiotic treatment for a medical condition. Behavior Summary Reports available from December 10, 2023, to January 6, 2024, revealed Resident 20 had one episode of yelling. Behavior Summary Reports available from January 7, 2024, to February 3, 2024, revealed Resident 20 had zero target behaviors. The facility failed to allow the modification of other causes (an acute medical condition and a change in routine of a new roommate) for Resident 20's symptoms to work before determining that the symptoms were persistent or clinically significant enough to warrant the increase in medication therapy. 28 Pa. Code 211.12(d)(1)(3)(5) 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. 18229 Based on observation, clinical record review, review of select facility policies and procedures, and staff interview, it was determined that the facility failed to ensure a medication error rate below five percent (Residents 56 and 61). Findings include: The facility's medication error rate was 7.89 percent based on 38 medication opportunities with three medication errors. The policy entitled Medication Administration, last reviewed on March 29, 2024, indicates that medications will be administered by legally authorized and trained persons in accordance with applicable State, Local, and Federal laws and consistent with accepted standards of practice. The nurse is responsible to read the label comparing it to the medication administration record before preparing the medication. Observation of a medication administration pass on April 23, 2024, at 9:35 AM revealed Employee 15 (licensed practical nurse, LPN), prepared and administered Resident 56's medications. Employee 15 administered Resident 56's medications with water. Review of Resident 56's pharmacy medication label revealed that his Metoprolol (blood pressure medication) 25 milligrams, one tablet was instructed to be given with food due to side effects labeled dizzy and drowsy. Resident 56's Metoprolol was not given with food. Resident 56 was unable to be interviewed due to his current cognitive status. Observation of a medication administration pass on April 23, 2024, at 9:50 AM revealed Employee 15 prepared and administered Resident 61's medications. Employee 15 administered Resident 61's medications with water. Review of Resident 61's pharmacy label revealed that his Aspirin (anti-inflammatory medication) and Multivitamin with minerals tablets were instructed to be given with food. Resident 61's aspirin and multivitamin with minerals was not given with food. Resident 61 was unable to be interviewed due to his current cognitive status. There was no evidence of breakfast trays on the Heirloom nursing unit at the time the surveyor entered on April 23, 2024, at 9:23 AM. Review of the facility's mealtimes revealed that the Heirloom nursing unit breakfast trays are delivered at 6:45 AM. The surveyor reviewed the above findings during an interview with the Nursing Home Administrator on April 25, 2024, at 2:07 PM. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services

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Embassy of Hearthside	450 Waupelani Drive State College, PA 16801

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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** 36798 Based on observation and resident and staff interview, it was determined that the facility failed to properly secure medications on one of three nursing units ([NAME] unit, Resident 23). Findings include: Observation of Resident 23's room on the [NAME] Hall on April 24, 2024, at 11:55 AM revealed her in her bed with her overbed table beside the bed on her left-hand side. Noted on the overbed table was a small medicine cup with four pills in it. Resident 23 reached over to her bedside stand to get the remote to turn down her television and she knocked over the medication cup spilling the four pills to the floor. She indicated to the surveyor that they were her morning pills that she did not finish taking because she forgot. The surveyor immediately alerted Resident 23's medication nurse about the event. Concurrent interview with Employee 16, Licensed Practical Nurse, revealed that he thought Resident 23 took the medications and was unaware they were still in a cup on her bedside table. The medications that were in the cup were identified as calcium acetate (a medication used to treat high phosphorus in the blood) 667 mg (milligrams), Simethicone tab (used to treat gas and bloating) 80 mg, Fish oil (a supplement used to help lower cholesterol 1000 mg, and hydralazine hcl (a medication used to treat blood pressure) 25 mg. The Director of Nursing and Employee 1, director of clinical services, were made aware of the concerns related to medication security on the [NAME] unit related to Resident 23's unsecure medications on April 25, 2024, at 2:33 PM. The facility failed to secure Resident 23's medications as noted above. 28 Pa. Code 211.9 (k) Pharmacy services 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20725 Based on clinical record review, observation, and staff and resident interview, it was determined that the facility failed to provide dental care services for two of five residents reviewed for dental concerns (Residents 8 and 20). Findings include: Interview with Resident 8 on April 23, 2024, at 3:12 PM revealed that she had not received dental services since being admitted to the facility on [DATE]. Resident 8 stated, My teeth are breaking and falling out. Observation of Resident 8 on the date and time of the interview revealed that she had missing, likely broken, and discolored natural teeth. Clinical record review for Resident 8 revealed an admission MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) assessment dated [DATE], that assessed Resident 8 as having obvious or likely cavity or broken natural teeth with mouth or facial pain, discomfort, or difficulty with chewing. The dental care area triggered for staff to develop a plan of care to address the concern. A plan of care initiated by the facility on December 30, 2023, identified that Resident 8 was at risk for dental or chewing problems related to missing or broken teeth. The plan of care did not include an intervention regarding arranging for appointments or Resident 8's preference for professional dental services. A consent for services from the facility's contracted provider for vision, podiatry, dental, and audiology services included Resident 8's signature dated February 13, 2024, indicating her consent for those services. The surveyor requested any evidence of any professional dental services for Resident 8 since her admission to the facility during an interview with Employee 1 (regional director of clinical services) and the Director of Nursing on April 24, 2024, at 2:00 PM. The facility provided a letter by the contracted dental provider addressed to, Dear Resident/Family/Friend, to inform the recipient that there was an upcoming dental visit on March 1, 2024. There was no evidence in Resident 8's medical record that she received professional dental services on March 1, 2024. Interview with the Director of Nursing on April 25, 2024, at 12:26 PM revealed that the facility could not provide any evidence that Resident 8 received professional dental services since her admission to the facility. Clinical record review for Resident 20 revealed a plan of care initiated by the facility on September 15, 2020, (last revised by the facility on January 28, 2024) that identified Resident 20 had oral/dental health problems with multiple missing and broken teeth. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing documentation dated April 6, 2024, at 12:28 AM indicated that Resident 20 recently had services provided/performed by a licensed public health dental hygiene practitioner and were preventative in nature. The services did not constitute comprehensive dental diagnosis and/or care. Documentation by the facility's contracted dental provider on March 29, 2024, indicated services by a dental hygienist for prophylactic cleaning. The documentation stipulated that a dentist was not present during the visit. Documentation by the certified registered nurse practitioner dated April 9, 2024, at 2:27 PM revealed that Resident 20 complained of a headache and toothache. The documentation indicated that Resident 20 was on the schedule for the in-house dentist on April 12, 2024. Nursing documentation dated April 10, 2024, at 12:26 PM revealed that Resident 20 was having some mouth pain with a bad tooth. The documentation indicated that she would see the dentist that Friday (April 12, 2024). Resident 20's clinical record did not contain evidence that she received dental services on April 12, 2024. Documentation by the facility's contracted dental services provider dated March 22, 2023, revealed that Resident 20 received an, annual exam. Documentation by the facility's contracted dental services provider dated March 22, 2024, revealed that Resident 20 received a, periodic exam. Interview with the Director of Nursing on April 26, 2024, at 8:50 AM confirmed the facility had no further evidence of professional dental services for Resident 20. The facility failed to assist Resident 20 to receive professional dental services every six months as an incurred medical expense under the State plan. 483.55(b)(1)-(5) Routine/emergency Dental Services in NFs Previously cited deficiency 5/5/23 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 211.15 Dental 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** 44738 Based on review of select facility policies, observation, and staff interview, it was determined that the facility failed to store food items in a safe and sanitary manner, maintain equipment in a sanitary condition, and prepare food items in accordance with professional standards in the main kitchen. Findings include: Initial tour of the facility's main kitchen with Employee 19, Dietary Manager, on [DATE], between 9:18 AM and 10:30 AM revealed the following: A white dry erase board was falling off the wall. There was a six pack of hoagie rolls located in a walk-in cooler with no date or label on them. There was a roll of thawed beef with a prepared date of ,d+[DATE] and an expired use by date of ,d+[DATE] on it. There was a significant amount of dust and debris on a window air conditioning unit in the dry goods storage area. There was a build-up of a black substance on the corners of the air vents and a significant build-up of the same substance on the interior vents. There was a significant number of cobwebs located on the ceiling border with the wall located in the dry goods storage area. An air conditioning unit located in a corner of the main kitchen had a significant build-up of dust on it including the air filter on the front of the unit. Two circular air outlets located at the front top of the unit were expelling air into the ambient environment of the kitchen. One of the outlets had several layers of duct tape around it with noted dust stuck to the tape. The other outlet had a build-up of a black, sticky substance on the interior of the outlet. A previously repaired section of the ceiling located above the area from the main kitchen to the walk-in cooler had a plastic-like sheet over what appeared to be a hole. A corner was starting to curl and expose the previously repaired hole. The plastic-like sheet had several screws in it that were only partially screwed into the repair. A large, opened bag of sprinkles was found in a stainless-steel cabinet near the middle of the kitchen that had no expiration and had a date of ,d+[DATE] with no year. A metal wire storage rack holding various pans, large bowls, and empty food storage buckets had a build-up of dust on it and the bottom shelf protective covering (to protect from mop splash) had a white dust-like substance coating the top of the entire covering. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A rack of food trays that Employee 19 identified as clean located in the dishwashing area had several trays on the bottom shelf. There was no protective covering to protect these clean food trays on the bottom shelf from mop splash during floor cleaning or splashes from the wet floor. The ground directly behind the facility's main dumpsters had a discarded stainless steel butter knife, a hairnet, and a used glove. The above information was reviewed in a meeting with Employee 1, Regional Director of Clinical Services, and the Director of Nursing on [DATE], at 2:36 PM. A review of the facility policy titled, Record of Food Temperatures, last reviewed per the document on [DATE], revealed that it is the policy of the facility to record food temperatures daily to ensure food is at the proper serving temperature(s) before trays are assembled. Some items in the policy included: Food temperature will be checked on all items prepared in the dietary department; measure and record the temperatures for each food product and milk at all meals and record the temperature on the temperature log. A review of the food temperature logs for [DATE] and [DATE] with Employee 19 on [DATE], at 11:40 AM revealed the following dates with no recorded temperatures: [DATE] (lunch) [DATE] (breakfast and lunch) [DATE] (breakfast and lunch) [DATE] (dinner) Employee 19 confirmed the above missing temperatures at the time of the findings and could provide no further evidence that the food temperatures were taken on the above dates. The above information regarding the missing food temperatures was reviewed with the Director of Nursing on [DATE], at 2:07 PM. 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide a neutral and fair arbitration process and agree to arbitrator and venue. 36798 Based on review of the facility's arbitration agreement and staff interview, it was determined that the facility's arbitration agreement failed to ensure a neutral and fair arbitration process by ensuring both the resident or his or her representative, have the opportunity for the selection of a venue convenient to both parties, and the selection of a neutral arbitrator, for one of one resident reviewed with a signed arbitration agreement (Resident 8). Findings include: Review of an Arbitration Agreement (an agreement that the resident and the facility will resolve legal disputes through binding arbitration, waiving their right to a trial) signed by Resident 8 on December 13, 2023, revealed that the arbitration agreement failed to allow for a choice of venue convenient to both parties. Further review of the facility's arbitration agreement revealed that the facility failed to provide for the selection of a neutral arbitrator (an impartial, or unbiased third-party decision maker, contracted with, and agreed to by both parties to resolve their dispute) as one is designated in the facility arbitration agreement. Interview with Employee 1, Director of Clinical Services, on April 26, 2024, at 9:03 AM confirmed that the Arbitration Agreement did not allow for a choice of venue convenient to both parties and that the agreement designated an entity that would conduct the Arbitration. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(2) Management. 28 Pa. Code 201.29(a)(j) Resident rights

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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. 44738 Based on observation, clinical record review, and resident and staff interview, it was determined that the facility failed to implement appropriate enhanced barrier transmission-based precautions for five of 18 residents reviewed (Residents 6, 33, 40, 68, and 69). Findings include: Review of the memo entitled Enhanced Barrier Precautions (EBP, gown and glove use) in Nursing Homes to Prevent the Spread of Multi-drug Resistant Organisms released by the Center for Medicaid and Medicare Services (CMS) on March 20, 2024, with an implementation date of April 1, 2024, revealed that nursing care facilities are to use EBP for residents with chronic wounds or indwelling medical devices (i.e., indwelling urinary catheters) during high-contact resident care activities regardless of their multidrug-resistant organism status. High-contact activity would include things like dressing, transferring, changing linens, providing hygiene, changing briefs, wound care, or device care. Clinical record review for Resident 33 revealed current physician orders that included the following: change the 16 French indwelling catheter every 30 days as needed due to obstructive and reflex uropathy (a problem with urinary flow due to various structural and functional problems); change the indwelling catheter drainage bag once each month and as needed; and indwelling catheter care every shift and as needed. The care plan for Resident 33 revealed a current care plan related to the use of a foley catheter (a catheter inserted into the bladder to drain urine). Further clinical record review for Resident 33 revealed no evidence that the resident was on EBP. An interview with Employee 12, licensed practical nurse, on April 23, 2024, at 11:57 AM revealed that Resident 33 was not on any EBP or transmission-based precautions. Employee 12 further noted the resident had a urinalysis (a urine test) that was just sent out due to infection concerns; however, the results were still pending. Observation of Resident 33 on April 23, 2024, at 11:59 AM and April 24, 2024, at 10:30 AM revealed the resident had an indwelling foley catheter with a urine collection bag partially filled with urine. There were no EBP in place or any indications to staff or visitors that the resident was on EBP. An interview with Employee 1, Regional Director of Clinical Services, on April 24, 2024, at 2:15 PM confirmed that Resident 33 was not on EBP; however, should be on EBP due to the indwelling foley catheter. Employee 1 further advised that the facility is still in the process of implementing EBP for residents that require EBP such as Resident 33. Observation of Resident 6 on April 23, 2024, at 1:20 PM and April 24, 2024, at 9:42 AM revealed the resident had an indwelling foley catheter with a urine collection bag partially filled with urine. There were no EBP in place or any indications to staff or visitors that the resident was on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Resident 6 on April 26, 2024, at 10:30 AM during a dressing change to a Stage 4 pressure ulcer (a sore on the body caused by prolonged pressure to the area, that has bone, tendon or muscle exposed) to his sacrum (the bone located at the base of the spine) revealed that there were no EBP in place or any indications to staff or visitors that the resident required EBP. Observation of Resident 68 on April 23, 2024, at 12:12 PM and April 24, 2024, at 10:15 AM revealed that he received nutrition through a PEG tube (Percutaneous endoscopic gastrostomy, a tube inserted through the wall of the abdomen directly into the stomach used to provide nourishment, hydration, and medications). There were no EBP in place or any indications to staff or visitors that the resident was on EBP An interview with Employee 1, Regional Director of Clinical Services, on April 24, 2024, at 2:39 PM confirmed that Residents 6 and 68 were not on EBP. Employee 1 further advised that the facility is still in the process of implementing EBP for residents that require EBP Observation of Resident 69's room on April 23, 2024, at 4:11 PM revealed no indication that he required EBP. Interview with Employee 8 (licensed practical nurse who identified herself as the nurse assigned to Resident 69's care on this date and time) confirmed the finding. Employee 8 stated that Employee 9 (nurse aide) was assigned as the nurse aide providing care to Resident 69 on this date. Interview with Employee 9 on April 23, 2024, at 4:11 PM revealed that he wears gloves when providing care to Resident 69; however, there were no additional infection control precautions used. Interview with Resident 69 on April 24, 2024, at 12:21 PM revealed that he believed that he was currently taking an antibiotic for a urinary tract infection. Observation of Resident 69 on the date and time of the interview revealed that he had an indwelling urinary catheter collection bag on the left side of his bed with tubing visible entering the leg of his pants. Resident 69 confirmed that he has been using an indwelling urinary catheter due to insufficient emptying of his bladder. Observation of Resident 69's room at the time of the observation and interview revealed no evidence of EBP. Clinical record review for Resident 69 revealed a physician's order dated April 18, 2024, that indicated that Resident 69 had an indwelling urinary catheter due to obstructive urinary disease (blockages prevent the complete emptying of urine from the bladder naturally). Nursing documentation dated April 8, 2024, at 1:33 PM revealed that the nurse educated Resident 69 regarding the risks associated with placing his indwelling urinary catheter collection bag on the floor. Resident 69 verbalized understanding, but replied, I'll probably keep doing it. Clinical record review of a laboratory report dated April 12, 2024, revealed that Resident 69 had a urinary tract infection with two bacterial organisms (Proteus mirabilis and Enterococcus faecalis). The completed urine culture printed on April 15, 2024, noted that Resident 69's result had, Complicated UTI (urinary tract infection) Interpretations. A physician's order starting April 15, 2024, instructed staff to administer the antibiotic, Cefuroxime Axetil, 500 milligrams (mg), two times a day related to a personal history of urinary tract infections. Resident 69 finished the antibiotic on April 21, 2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order starting April 16, 2024, instructed staff to administer the antibiotic, Macrobid, 100 mg, two times a day for a urinary tract infection for seven days. Resident 69 finished the antibiotic on April 22, 2024. Interview with Employee 1 and the Director of Nursing on April 25, 2024, at 2:00 PM confirmed that the facility did not implement enhanced barrier precautions for Resident 69 who had an indwelling urinary catheter, recent history of a urinary tract infection, and exhibited non-compliance with good infection control behaviors pertaining to his catheter use. Clinical record review for Resident 40 revealed a physician's order dated April 4, 2024, for staff to cleanse Resident 40's Stage 4 pressure ulcer twice a day and as needed for soilage and dislodgement. Observation of Resident 40's room on April 23, 2024, at 10:19 AM, and April 24, 2024, at 11:03 AM revealed there were no EBP in place or any indications to staff or visitors that the resident was on EBP. An interview with Employee 18 (licensed practical nurse) revealed that Resident 40 is not on any precautions. Interview with the Director of Nursing and Employee 1 on April 24, 2024, at 2:05 PM confirmed that Resident 40 was not on EBP but should be due to his Stage 4 pressure ulcer. Employee 1 further advised that the facility is still in the process of implementing EBP for residents who require EBP, such as Resident 40. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(d) Resident care policies