

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395893	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2025
NAME OF PROVIDER OR SUPPLIER Care Pavilion Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6212 Walnut Street Philadelphia, PA 19139	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609</p> <p>Based on staff interviews and review of resident's records and facility policy, it was determined that the facility did not ensure that a resident had reasonable access to their personal funds for one of 36 resident records reviewed (Resident 91).</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Resident Trust Policy revised July 2023 indicated the facility ensures that the residents has the right to have access to their personal funds.</p> <p>Resident R91 was admitted to the facility on [DATE] diagnosed with epilepsy (brain condition that causes recurring seizures), Parkinson's Disease (progressive disease of the central nervous system), cataract (clouding of the lens of the eye), severe stage of primary open-angle glaucoma (increase eye pressure resulting in the inability of fluid to drain [NAME] the inner eye), bilateral and had severe cognitive impairment and required a responsible party (RP) to take care of his affairs.</p> <p>Interview with the RP on February 11, 2025, at 12:00 p.m. indicated no one from the facility escorts the resident to the business office to receive his monthly allowance. The RP further stated they helped the resident only one time late last year but never helped again.</p> <p>Review of Resident R91's statement revealed only one withdrawal occurred in November 2024.</p> <p>The Director of Nursing confirmed on February 13, 2025, the facility should accommodate Resident R91 to the business office.</p> <p>28 Pa. Code 201.29(a) Resident rights</p> <p>28 Pa. Code 201.18(a)(b)(3) Management</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609</p> <p>Based on review of clinical records and interviews with staff and facility policy, it was determined the facility did not ensure a resident's code status was updated to reflect the residents wishes for one of 36 resident records reviewed (Resident R101).</p> <p>Findings include:</p> <p>Review of facility policy titled, Advanced Care Planning states, it is the policy of the facility to support the rights of residents in making decisions regarding their care and treatment.</p> <p>Resident R101 was admitted to the facility on [DATE] with the diagnosed with epilepsy (brain condition that causes recurring seizures), anxiety disorder, hemiplegia (weakness of one side of the body) following cerebral infarction and major depressive disorder and was placed on hospice October 31, 2024.</p> <p>Review of Resident R101 hospice communication book and resident care plan revealed the resident's Physician Orders for Life-Sustaining Treatment and Medical Orders for Life-Sustaining Treatment (POLST- are medical orders that specify a person's wishes for end-of-life care) stated Resident R101 wishes were for, No resuscitation; Comfort Care Measures Only.</p> <p>Further review of Resident R101 clinical record revealed the facility failed to honor the resident's wishes and it remained Full Code, indicating the resident's preference for all possible life-saving measures to be taken in the event of a cardiac or respiratory arrest. This was confirmed with Licensed Practical nurse LPN Employee E18 on February 18, 2025, at 10:30a.m.</p> <p>28 Pa. Code 211.12(d)(5) Nursing services</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277</p> <p>Based on observations and resident interviews, it was determined that the facility failed to maintain the facility in clean and homelike environment for two of six nursing units toured (3 west and 3 east).</p> <p>Findings Include:</p> <p>Interview on February 11, 2025, at 1:15 p.m. with Resident R502 revealed about two weeks ago there was allegedly a leak from the unit above and water was pouring from the ceiling.</p> <p>Observations on February 11, 2025, at 1:15 p.m. in room [ROOM NUMBER] confirmed the ceiling tiles above the sink in the room and in bathroom had water damage and had a brown/yellow discoloration.</p> <p>Observations on February 12, 2025, at 11:55 a.m. on the 3 east nursing unit revealed in the soiled linen closet there was multiple bags of soiled linen and trash on the floor of the closet.</p> <p>Observations on February 12, 2025, at 12:00 p.m. in room [ROOM NUMBER] revealed there was leftover food wrapped in foil on the night stand next to the B-Bed.</p> <p>Observations on February 12, 2025, at 12:23 p.m. in room [ROOM NUMBER] revealed the panel on the wall was peeling off.</p> <p>28 Pa Code 201.14 (a) Responsibility of licensee.</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277</p> <p>Based on review of facility policy, facility documentation, clinical records, and staff interviews, it was determined the facility failed to protect Resident R271 with severe cognitive impairment from unwanted/non-consensual sexual contact by Resident R137 who had a history of sexually inappropriate behavior, including an unsolicited sexual contact with Resident 208 on January 31, 2025. This failure resulted in an Immediate Jeopardy situation when Resident R137 was found pinning down and performing oral sex on Resident R271. (Resident R137 and Resident R271)</p> <p>Findings Include:</p> <p>Review of facility policy titled Abuse reviewed December 13, 2024, revealed sexual abuse is defined as non-consensual sexual contact of any type with a resident. It is the policy of the facility that residents will be protected from abuse while they are residing at the facility.</p> <p>Review of the Facility Assessment Tool (determines what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies) dated January 16, 2025, revealed more than half (55%) of the resident demographic was made up of psychiatric/mood disorders. Continued review of the facility assessment revealed that approximately 50% of the residents living in the Memory Care unit (4th floor nursing unit) have behaviors toward others, wandering or exit seeking behaviors.</p> <p>Review of Resident R137's admission Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated January 20, 2025, revealed resident was admitted to the facility on [DATE], and had moderate cognitive impairment. Further review of the MDS assessment revealed Resident R137 was independent for mobility (walking 10 and 50 feet) and noted diagnoses of Depression (major loss of interest in pleasurable activities) and alcohol dependence with alcohol-induced persisting Dementia (progressive degenerative disease of the brain).</p> <p>Review of Resident R137's comprehensive care plan dated January 16, 2025, revealed the resident displayed inappropriate sexual behaviors (verbal or physical) related to making inappropriate remarks. Resident R137 touches other residents and/or staff inappropriately.</p> <p>Review of Resident R137's clinical record revealed a nursing note dated January 31, 2025, at 3:24 p.m. that revealed [Resident R137] is engaged in inappropriate sexual behavior with staff and other residents. He attempted to touch the private parts of one staff and another resident.</p> <p>Additional review of Resident R137's comprehensive care plan revealed the care plan was revised on January 31, 2025, to include new interventions for every 15 minute checks.</p> <p>Review of Resident R208's quarterly MDS dated [DATE], revealed the resident was rarely/never understood and had short-term and long-term memory problem. Further review of the MDS assessment revealed Resident R208 had diagnoses of Manic Depression, Bipolar Disease (condition in which a person has period of depression and periods of extreme happiness), and Adjustment Disorder with mixed anxiety and depressed mood.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident R208's comprehensive care plan dated February 23, 2024, revealed the resident had an alteration in neurological status related to traumatic brain injury (TBI). Intervention dated February 23, 2024, included to cue and redirect Resident R208 as needed.</p> <p>Interview on February 13, 2025, at 11:15 a.m. with Licensed Nurse 4th floor Unit Manager, Employee E14, revealed this employee was unaware of who's private parts Resident R137 attempted to touch, and did not have an incident report (formal document that records unexpected events, accidents, or issues within a company. The document provides a detailed account of the incident, including where and when it happened, who was involved, and any contributing factors) for the incident of January 31, 2025.</p> <p>Interview on February 13, 2025, at 11:26 a.m. with Licensed Nurse, Employee E23, revealed on January 31, 2025, staff overheard screaming from Resident R208's room. When the nurse aide responded to the screaming, Resident R137 was observed attempting to touch Resident R208's penis. Continued interview with Licensed Nurse, Employee E23, revealed this incident was the first of witnessing Resident R137 act sexually inappropriate.</p> <p>Interview on February 13, 2025, at 11:40 a.m. with Nurse Aide, Employee E24, revealed on January 31, 2025, the employee responded to yelling in Resident R208's room and Resident R137 was observed pulling at Resident R208's pants saying [Resident R137] wanted to suck Resident R208's penis. Continued interview with Nurse Aide, Employee E24, revealed this incident was reported to the charge nurse.</p> <p>Review of Resident R271's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated November 8, 2024, revealed the resident was rarely/never understood. Resident R271 assessed with BIMS (Brief Interview of Mental Status) of 3, which indicated the resident had severe cognitive impairment.</p> <p>Further review of Resident R271's MDS assessment revealed Resident R271 had behaviors of wandering daily and diagnoses of Dementia and Psychotic Disorder (loss of contact with reality).</p> <p>Review of Resident R271's clinical record revealed a nursing progress note dated January 25, 2025, indicating the resident was observed by the nursing staff wandering into other residents' rooms. The nursing staff indicated the resident was redirected to his/her room several times.</p> <p>Further review of Resident R271's clinical record revealed a nursing progress note dated January 30, 2025, that indicated this resident was wandering around the nursing unit.</p> <p>Review of Resident R271's comprehensive care plan initiated at the time of admission to the facility on [DATE], revealed the resident had behavior problem related to Psychosis, wandering in other resident's rooms, and difficult in redirect. Interventions developed included to check in on the resident every 30 minutes and informed resident that behavior is not acceptable and suggest appropriate ways to express self</p> <p>Review of Resident R271's clinical record revealed a nurse practitioner assessment dated [DATE], that indicated this resident had diagnoses of Psychosis (loss of contact with reality resulting in disorganized thinking) and Dementia. The nurse practitioner indicated being unable to obtain information from Resident R271 because of cognitive deficits.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Continued review of Resident R271 clinical record revealed a nursing note dated February 12, 2025, that indicated this resident was wandering about the nursing unit and required redirection at all times.</p> <p>Interview on February 13, 2025, at 11:00 a.m. with Licensed Nurse, Employee E13, who was familiar with the care of Resident R271 confirmed this resident was significantly confused and wandered about the nursing unit ad lib (as desired).</p> <p>Interview on February 13, 2025, at 11:15 a.m. with Licensed Nurse 4th floor Unit Manager, Employee E14, confirmed, Resident R271 had been wandering into other residents' rooms since admission to the facility in August 2024. The nurse reported the other residents do not want Resident R271 wandering inside their bedrooms. This nurse also confirmed that besides every 30 minute checks, the care plan for Resident R271 had not been revised to include recreational needs for resident's with Dementia.</p> <p>Review of Resident R271's clinical record revealed a nursing progress note dated February 13, 2025, that indicated Resident R271 was sent to the emergency room of the hospital as a sexual assault victim. The nursing staff documented Resident R271 had a change in mental status as a result of the sexual assault.</p> <p>Review of Resident R271's hospital record revealed Resident R271 was sent to the hospital on February 13, 2025, because the resident was found on the floor receiving oral sex from another resident (Resident R137).</p> <p>Review of facility documentation revealed a statement by Nurse Aide, Employee E22, dated February 12, 2025, that indicated as Nurse Aide, Employee E22, was coming out of another resident's room; the employee witnessed the Resident R271 being pinned down by Resident R137. As Nurse Aide, Employee E22, entered the room Resident R137 was observed to have both of Resident R271's arms pinned to his/her side performing oral sex on Resident R271. Resident R271 was observed squirming and holding onto his/her brief. Nurse aide, Employee E22, promptly notified the charge nurse of the incident who subsequently responded to the incident and was able to get Resident R137 off Resident R271. Resident R271 was then escorted back to his/her room until the local police arrived.</p> <p>Interview on February 13, 2025, at 12:53 p.m. with Nurse Aide, Employee E20, revealed on February 12, 2025, at approximately 9:30 p.m. Nurse Aide, Employee E22, called for assistance and when Nurse Aide, Employee E20, responded she observed Resident R137 holding down Resident R271 and performing oral sex. Nurse Aide, Employee E20, revealed Resident R137 was completely unaware that staff were in the doorway observing the incident. Further interview revealed Nurse Aide, Employee E20, and Nurse Aide, Employee E22, went to get the charge nurse to assist and then went back to the resident's room before intervening.</p> <p>Interview on February 13, 2025, at 3:20 p.m. with Licensed Nurse, Employee E16, revealed approximately two weeks prior during an initial encounter with Resident R137, the resident asked Licensed Nurse, Employee E16, if Employee E16 had a big penis and if Resident R137 could suck his penis.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Continued interview with Licensed Nurse, Employee E16, revealed that on February 12, 2025, at approximately 9:30 p.m., the employee was notified by Nurse Aides, Employee E20 and E22, that Resident R137 was performing oral sex on Resident R271. Licensed Nurse, Employee E16, promptly responded to the incident between Resident R137 and R271. Licensed Nurse, Employee E16, observed Resident R137 performing oral sex on and subsequently had to physically remove Resident R137 from Resident R271.</p> <p>Interview on February 13, 2025, at approximately 9:45 a.m. with the Director of Nursing, Employee E2, confirmed that revealed on February 12, 2025, around 9:30 p.m. Resident R137 was found/observed performing oral sex on Resident R271.</p> <p>An Immediate Jeopardy situation was identified to the Nursing Home Administrator, Employee E1, and Director of Nursing, Employee E2, on February 13, 2025, at 12:02 p.m. for the facility's failure to protect a resident from sexual abuse (non-consensual sexual contact) by a resident who had a history of sexually inappropriate behaviors. This resulted in Resident R137 pinning down and performing oral sex on Resident R271 while Resident R271 was observed squirming and holding onto his/her brief.</p> <p>An Immediate Jeopardy template (document which included information necessary to establish each of the key components of immediate jeopardy) was provided to the Nursing Home Administrator, Employee E1, and Director of Nursing, Employee E2, on February 13, 2025, at 12:11 p.m.</p> <p>The facility submitted a written plan of action on February 13, 2025, at approximately 2:51 p.m. and implemented the plan of action which included:</p> <ol style="list-style-type: none"> 1. Resident R271 and Resident R137 were immediately separated and monitored by staff on February 12, 2025. 2. Police were called and arrived at the facility shortly after the incident on February 12, 2025. 3. Both residents (Resident R271 and R137) were sent to the local hospital emergency room for evaluation on February 12, 2025 and remained at the facility as of February 13, 2025. 4. Both residents (Resident R271 and R137) responsible parties were made aware of transfer and incident on February 12, 2025. 5. Skin checks were completed on 4-west with no adverse findings on February 12, 2025. 6. Current residents with known sexual behaviors were audited for recent behaviors and appropriate care planned interventions to ensure the safety of other residents. 7. Social worker completed random resident interviews to ensure no unwanted sexual behaviors have occurred or were occurring. 8. Abuse policy education was initiated house wide for identifying and reporting sexual abuse and sexually promiscuous behaviors including examples of such behaviors. <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>9. Change in Condition policy education was initiated with the nursing staff. Resident's exhibiting behaviors will have a change in condition assessment completed and will be discussed in clinical meeting for further care plan review and intervention implementation. When a behavior is observed, the resident(s) will be put on 1:1 observation until they are able to be assessed by IDT (interdisciplinary team) and the supervisor/DON or designee will be made aware.</p> <p>10. The Change in Condition policy was reviewed and revised.</p> <p>11. The Abuse policy was reviewed and updated to include examples of sexual abuse, warning signs and soft signs (excessive clingyness, low self esteem, recurrent nightmares, or overly friendliness towards strangers) of sexual abuse.</p> <p>12. Residents with documented behaviors will be audited weekly x 4 weeks to ensure interventions and care plans are in place. Results of auditing will be reviewed during QAPI meeting to determine further need for ongoing auditing.</p> <p>Review of clinical records confirmed Resident R271 and R137 were transferred to the hospital and responsible parties were notified of the transfer and incident. Both residents remained at the hospital as of February 14, 2025.</p> <p>Review of facility documentation confirmed the facility completed skin checks for all residents on 4-west with no adverse findings.</p> <p>Review of facility plan of action confirmed the facility completed the audits to ensure other residents with known sexual behaviors had appropriate care planned interventions to ensure the safety of other residents.</p> <p>Interview with the Director of Nursing, Employee E2, on February 14, 2025, at 11:47 a.m. revealed each nursing unit census was printed out and reviewed with the unit manager to identify residents with sexually inappropriate behaviors. Any identified residents had care plans reviewed and ensured proper interventions were in place to keep residents safe. Further interview with the Director of Nursing, Employee E2, revealed staff also identified residents with wandering behaviors as these residents are at an increased risk for abuse.</p> <p>Further review of facility documentation confirmed residents were interviewed to ensure no unwanted sexual behaviors occurred.</p> <p>Interviews conducted with 37 staff members from all departments were conducted on February 14, 2025. All staff members reported that they received education regarding the abuse policy for identify identifying and reporting sexual abuse and sexually promiscuous behaviors including examples of such behaviors. Licensed nursing staff, nursing assistants as well as ancillary staff from all departments, including maintenance, therapy, dietary, activities, and housekeeping were interviewed.</p> <p>Interviews with licensed nursing staff confirmed staff were educated on the change in condition policy and interventions to implement for a resident exhibiting behaviors.</p> <p>The Abuse and Change in Condition policies were reviewed for revisions.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Immediately Jeopardy was lifted on February 14, 2025, at 12:32 p.m.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.10 (d) Resident care policies</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609</p> <p>Based on review of clinical records, and interviews with staff and facility policy, it was determined that the facility failed to provide vision and audiology services in a timely manner for one out of 36 residents reviewed (Resident R91).</p> <p>Findings include:</p> <p>Resident R91 was admitted to the facility on [DATE] diagnosed with epilepsy (brain condition that causes recurring seizures), Parkinson's Disease (progressive disease of the central nervous system), cataract (clouding of the lens of the eye), severe stage of primary open-angle glaucoma (increase eye pressure resulting in the inability of fluid to drain [NAME] the inner eye), bilateral and had severe cognitive impairment.</p> <p>Interview with Resident R91's family member on February 11, 2025 at 12:00 p.m. indicated they have been asking to see a doctor about his glaucoma and cataracts . The family stated the resident told them he only sees shadows. Also during the interview, the family indicated the resident was hard of hearing and asked the facility to see the audiologist and has not seen one.</p> <p>Review of Resident R91's audiology appointment dated January 16, 2024, revealed Resident R91 had a scheduled audiology appointment but was unable to be assessed due to impacted ears and was told the ears needed to be cleaned. Records reveal no evidence second audiologist appointment was not made.</p> <p>Continue review of Resident R91's clinical records revealed the resident was seen by Optometry in July 21, 2023 and noted to Refer to ophthalmology for end-stage glaucoma. Records reveal no evidence the appointment was made.</p> <p>On January 18, 2025 the Director of Nursing confirmed no ophthalmology appointment was found or scheduled for Resident R91</p> <p>28 Pa. Code 201.14(a)(b) Responsibility of licensee.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277</p> <p>Based on review of facility policy, review of clinical records, observations and staff interviews, it was determined that the facility failed to implement pressure ulcer prevention interventions for three of six residents reviewed for pressure ulcers (Resident R122, Resident R231 and R153).</p> <p>Findings Include:</p> <p>Review of the facility's policy titled, Prevention of Pressure Ulcers states to identify residents at risk for pressure ulcers, common sites of pressure ulcers include back of head, around ears, and heels of feet. Reduce or remove underlying risk factors and monitor the impact of the interventions and to modify the interventions as appropriate.</p> <p>Review of Resident R122's clinical record revealed a physician order dated September 17, 2022, to put on heel protectors to bilateral heels while Resident R122 was in bed for the prevention of skin breakdown.</p> <p>Review of Resident R122's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated January 15, 2025, revealed the resident was dependent on staff for putting on and taking off footwear. Continued review of the MDS revealed Resident R122 had severe cognitive impairment and was at risk of developing pressure ulcers/injuries.</p> <p>Observations on February 12, 2025, at 12:31 p.m. revealed Resident R122 was in bed. Observations with Registered Nurse, Employee E19, revealed Resident R122 did not have heel protectors on while in bed. No heel protectors were present in room at time of observation.</p> <p>Review of Resident R231's clinical record revealed a physician order dated November 10, 2022, to put on heel protectors to bilateral heels while Resident R231 was in bed for the prevention of skin breakdown.</p> <p>Review of Resident R231's quarterly MDS dated [DATE], revealed the resident was dependent on staff for putting on and taking off footwear. Continued review of the MDS revealed Resident R231 had severe cognitive impairment and was at risk of developing pressure ulcers/injuries.</p> <p>Observations on February 18, 2025, at 9:44 a.m. revealed Resident R231 was in bed. Observations with Registered Nurse, Employee E19, revealed Resident R231 did not have heel protectors on while in bed. No heel protectors were present in room at time of observation.</p> <p>Resident R153 was admitted to the facility diagnosed with chronic obstructive pulmonary disease (COPD is a lung disease that makes it difficult to breathe) and was ordered 3 liters of continuous supplemental oxygen with instruction to use ear mates to oxygen tubing at all times to help relieve pressure dated April 25, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview the resident stated a few weeks ago she had a sore behind her left ear from the tubing and it was very painful. Interview with the resident's nurse, Licensed Practical nurse LPN Employee E18 confirmed on February 11, 2025, at 11:30 a.m. the facility failed to provide ear mates to Resident R153 to prevent pressure injury.</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(3) Nursing services</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>43277</p> <p>]</p> <p>Based on observations, review of clinical records, and staff interview, it was determined that the facility failed to ensure residents with limited range of motion received treatment and services to maintain or improve range of motion/mobility for one of one resident reviewed with limited range of motion (Resident R231).</p> <p>Findings Include:</p> <p>Review of Resident R231's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated November 23, 2024, revealed the resident had severe cognitive impairment and had diagnoses of hemiplegia (one sided paralysis or weakness of the face, arm, or leg) affecting left nondominant side, muscle wasting, and other muscle spasm.</p> <p>Review of Resident R231's comprehensive care plan dated June 1, 2022, revealed the resident had an activities of daily living self-care performance deficit related to non-verbal, non-oriented, weakness to right upper arm, and lower legs.</p> <p>Continued review of Resident R231's comprehensive care plan dated April 4, 2023, revealed the resident had limited physical mobility related to contractures (when muscles, tendons, joints, or other tissues tighten or shorten causing a deformity), neurological deficits, and weakness.</p> <p>Observations on February 12, 2025, at 12:48 p.m. revealed Resident R231 was resting in bed and had a right-hand contracture. Resident R231 did not have a splint (devices that support, protect, or assist in the movement of various body parts) or other orthotic device on at the time of observations.</p> <p>Observations on February 18, 2025, at 9:45 a.m. with the Registered Nurse, Employee E19, confirmed Resident R231 had a right-hand contracture and was not wearing a splint or other orthotic device.</p> <p>Interview on February 18, 2025, at 9:45 a.m. with the Registered Nurse, Employee E19, revealed this employee was unsure if Resident R231 was supposed to be wearing a splint for the right-hand contracture.</p> <p>Interview on February 18, 2025, at 11:56 a.m. with the Director of Rehab, Employee 26, revealed when Resident R231 was discharged from occupational therapy treatment on March 8, 2024, a right resting hand splint was recommended.</p> <p>Review of Resident R231's Occupational Therapy Evaluation and Plan of treatment dated January 28, 2025, by Occupation Therapist, Employee E27, revealed Resident R231 was referred for occupational therapy due to a change in upper body contracture status, range of motion and mobility resulting in impairments with participating in functional activities and activities of daily living.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on February 18, 2025, at 12:13 p.m. with Occupational Therapist, Employee E27, revealed when Resident R231 was evaluated for occupational therapy on January 28, 2025, there was no evidence that Resident R231 had prior use of a splint. Occupational therapist, Employee E27, reported there was no splint in the resident's room and that when the employee attempted to apply the splint Resident R231 was too contracted, and the splint did not fit the way it should.</p> <p>Interview on February 18, 2025, at 12:27 p.m. with Registered Nurse, Employee E19, confirmed Resident R231 did not have a physician order for a splint.</p> <p>Review of Resident R231's entire clinical record revealed no documented evidence the resident had a splint.</p> <p>28 Pa. Code 211.12 (d)(3) Nursing services.</p> <p>28 Pa. Code 211.12 (d)(5) Nursing services.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609</p> <p>Based on review of clinical records, interviews with staff and review of facility documentation and policy, it was determined the facility failed to ensure residents received adequate supervision to maintain residents' safety for 3 of 36 resident records reviewed (Residents R93, 253, and 224)</p> <p>Findings include:</p> <p>Review of the facility's policy titled Accidents stated its purpose is provide an environment that is free from controllable accident hazards and provision of supervision needed to prevent avoidable accidents.</p> <p>Review of Resident R93's clinical record revealed that the resident was admitted to the facility on [DATE] with the diagnoses of dementia (progressive degenerative disease of the brain) unspecified severity with agitation, alcohol dependence with alcohol-induced persisting dementia, and anxiety disorder.</p> <p>Review of Resident R93 initially cared planned in May 2020 revealed that a care plan was developed for aggression and verbal abuse related to the resident's diagnosis of dementia, poor impulse control, behaviors of pushing others, and the physical altercations with other residents. The goal was that Resident R93 would not harm self or others through the review date. Interventions included monitor/document/report signs of Resident R93 posing a danger to self or others, for staff to redirect the resident from agitating other residents and to distract him with an activity, initiated January 2023 and checking on the resident every 15 minutes-initiated February 2023.</p> <p>Review of Resident R93 nurses note dated June 25, 2024, indicated the resident's room was changed to a different resident's room and also stated, resident-to resident altercation resident (R93) went into another resident's room (R253) and urinated in the sink the other resident (R253) followed him and they got in to a fight. R93 was punched in the mouth and gums bleeding. Resident R253 is care planned for being physically aggressive with poor impulse control.</p> <p>Interview with the unit manager on February 18, 2025 at 12:30 p.m. indicated she saw the urine in the sink and R93 was in the room and knew what happened. Resident R252 is a big guy and they started fighting pointing to the area in the hallway near Resident R253's room. That's what they do they walk around and around all day.</p> <p>On August 27, 2024 nurses note indicated Resident R93 was observed with a hematoma on the resident's forehead, and a cut by the left eyebrow and was told by the nursing assistant the resident was found on the peer's bed in a bloody sheet. The peer was his roommate Resident R224 also known to be aggressive, and care planned for cognitive deficits, dependent on staff for meeting his emotional, intellectual, physical and social needs . Care planned for being physically aggressive with poor impulse control. Continuing the same nurses note stated when the staff asked Resident R224 why he did it Resident R224 stated. He should not have sat on his bed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Nurse Practioner progress note dated August 28, 2024. assessed Resident R93 after the physical altercation with his roommate with scattered bruising to the bilateral cheeks, forehead, inner canthus of the right eye and forehead and bump on the left forehead with scratch marks above the left eyebrow.</p> <p>Continuing Resident R93's clinical record revealed on October 4, 2024, Resident R93 is noted alert/confused wandered around the unit, continues to go in other residents' rooms, not easy to redirect, always resisted to redirection.</p> <p>October 9, 2024, revealed that Resident R93 was sitting in Resident R281's wheelchair. Resident R281 was noticed with bloody nose and a scratch to the lower jaw. Resident R282 identified Resident R93 as the person who punched him because he demanded Resdient R93 to leave his room. Facility incident report indicated Resident R282 received a nosebleed and a 2cm left lower jaw scratch.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee</p> <p>28 Pa. Code 201.18 (e)(1)(3) Management</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>39343</p> <p>Based on review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to implement treatment and services for incontinence management for two of five residents reviewed with incontinence (Resident R80, and R256).</p> <p>Findings include:</p> <p>Review of physician order for Resident R80, dated April 4, 2024, indicated an order for Supra Pubic Urinary Catheter with size 16FR/30 cc balloon.</p> <p>On February 18, 2025, at 11:49 a.m., it was observed that Resident R80 had a Supra Pubic Urinary Catheter of 16FR/10ML, instead of 16FR/30 cc balloon. At the time of the finding, confirmed the same with the Unit Manager, a Licensed Nurse, Employee E28.</p> <p>Review of physician order for Resident R256, dated October 14, 2024, indicated an order for Supra Pubic urinary Catheter with size 14FR/10 cc balloon.</p> <p>On February 18, 2025, at 10:55 a.m., it was observed that Resident R256 had a Supra Pubic Urinary Catheter of 14FR/30 cc, instead of 14FR/10 cc Balloon. At the time of the finding, confirmed the same with a Licensed Nurse, Employee E29.</p> <p>28 Pa Code 211.12(d)(1) Nursing services</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277</p> <p>Based on review of facility policy, observations, review of clinical record, and resident interview, it was determined that the facility failed to monitor and modify interventions consistent with the resident's assessed needs to maintain acceptable parameters of nutritional status for two of four residents reviewed for nutrition (Resident R251 and R214).</p> <p>Findings Include:</p> <p>Review of facility policy Weight Assessment and Intervention dated February 15, 2022, revealed the nursing staff and Registered Dietitian will work to prevent, monitor, and intervene for undesirable weight loss of the residents. Any weight change of greater than or less than 5 pounds within 30 days will be retaken for confirmation.</p> <p>Significant Weight Changes are defined as:</p> <p>a. more or less than 5% within 30 days; and</p> <p>b. more or less than 10% within 6 months.</p> <p>Review of Resident R251's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated January 24, 2025, revealed the resident had severe cognitive impairment and had a diagnosis of dysphagia (difficulty swallowing), and cognitive communication deficit.</p> <p>Continued review of Resident R251's quarterly MDS revealed no weight was documented/recorded under Section K - Swallowing/Nutritional Status.</p> <p>Review of Resident R251's comprehensive care plan dated March 10, 2024, revealed the resident was at risk for malnutrition related to dysphagia, dementia (which can subsequently impact food intake/weights), protein calorie malnutrition (health condition that develops when someone doesn't have enough nutrients to meet their body's needs), actual body weight less than ideal body weight, and history of refusing weights.</p> <p>Observations on February 12, 2025, at 12:47 p.m. revealed Resident R251 had a thin/frail appearance and had not eaten much of the lunch meal.</p> <p>Interview on February 12, 2025, at 12:51 p.m. with Registered Nurse, Employee E19, revealed Resident R251 was a slow eater.</p> <p>Review of Resident R251's weight history revealed a documented weight on December 9, 2024, of 138.6 pounds and a documented weight on January 10, 2025, of 131.4 pounds, which reflected a 7.2 pound / 5.2% significant weight loss in one month.</p> <p>Review of Resident R251's clinical record revealed a nursing progress note dated January 21, 2025, that the resident refused to be reweighed.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Continued review of Resident R251's clinical record revealed the weight obtained on January 10, 2025, was struck out by Registered Dietitian, Employee E30, on January 28, 2025, with no re-weight obtained.</p> <p>Review of Resident R251's nutrition assessment dated [DATE], indicated that Resident R251's weight was stable and assessed the resident based on a weight of 138.6 pounds. The nutrition assessment failed to address the potential/questionable weight loss that was deemed inaccurate with no supporting documentation.</p> <p>Continued review of Resident R251's weight history revealed a documented weight on February 6, 2025, of 128.8 pounds which further confirmed a weight loss trend. This reflected a 10.4 pound / 7.5% weight loss from December 9, 2024.</p> <p>Review of Resident R251's entire clinical record revealed no documented evidence the weight loss on February 6, 2025, had yet been addressed by the Registered Dietitian as of February 14, 2025.</p> <p>Review of Resident R214's significant change MDS dated [DATE], revealed the resident had moderate cognitive impairment and had significant weight loss in the last month or last six months. Continued review of the MDS revealed Resident R214 had a diagnosis of malnutrition.</p> <p>Review of Resident R214's comprehensive care plan dated May 28, 2024, revealed the resident had a nutrition problem (or potential for) related to malnutrition, history of variable meal intakes, and history of significant weight changes.</p> <p>Review of Resident R214's weight history revealed a documented weight on October 7, 2024, of 96.6 pounds and a documented weight on November 7, 2024, of 84 pounds which reflected a 12.6 pound / 13% significant weight loss in one month.</p> <p>Review of Resident R214's clinical record revealed the significant weight loss was not addressed until December 6, 2024, in a nutrition assessment completed by the Registered Dietitian which confirmed the significant weight loss and additional interventions were added to the plan of care.</p> <p>Continued review of Resident R214's weight history revealed the weight loss was sustained and continued to trend down to 78 pounds on December 9, 2024, which reflected another significant weight loss of 6 pounds / 7% in one month.</p> <p>28 Pa. Code 211.10 (d) Resident care policies.</p> <p>28 Pa. Code 211.12 (d)(5) Nursing Services.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39343</p> <p>Based on review of clinical record and interviews with staff, it was determined that the facility failed to follow physician orders regarding tube feeding for one resident out of six residents' with tube feedings reviewed. (Resident R96).</p> <p>Findings include:</p> <p>Review of Resident R96's clinical record revealed the resident was admitted to the facility on [DATE]. Resident R96 had diagnoses of Adult Failure to Thrive, (Adult failure to thrive is a decline seen in older adults - typically those with multiple chronic medical conditions - resulting in poor nutrition, weight loss, inactivity, depression and decreasing functional ability), and Gastrostomy (a surgical procedure that creates an opening (stoma) in the stomach through the abdominal wall. This opening allows a tube (gastrostomy tube) to be inserted directly into the stomach for feeding, medication administration, or gastric decompression).</p> <p>Review of Resident R96's physician orders revealed an order dated January 22, 2025, to administer Jevity 1.2 Cal Enteral Liquid via Feeding Pump @ 60 Milliliters/hr x 18 hours per day or until total volume infused, every shift for tube feeding protocol.</p> <p>Observation on February 18, 2025, at 11:39 a.m., revealed that the tube feeding was set up for Resident R96, and that the feeding rate was set 60 milliliters per hour for Jevity 1.5 and not for Jevity 1.2 as ordered by the physician.</p> <p>The same was confirmed with the Unit Manager, a Licensed Nurse, Employee E28.</p> <p>28 Pa Code 211.10(c) Resident care policies</p> <p>28 Pa Code 211.12(d)(1)(3) Nursing services</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>36609</p> <p>Based on observation, interview review of clinical records it was determined that the facility failed to provide oxygen therapy consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for one of 36 resident records reviewed (Resident R153)</p> <p>Findings include:</p> <p>Resident R153 was admitted to the facility diagnosed with chronic obstructive pulmonary disease (a lung disease that makes it difficult to breathe) and was ordered 3 liters of continuous supplemental oxygen with instruction to change the tubing every Wednesday and initial and date the new tubing.</p> <p>Observation and interview with the resident's nurse, Licensed nurse, Employee E18 confirmed on February 11, 2025, at 11:30a.m. that the tubing was not dated to indicate when it was last changed, and the oxygen was set at 4.5 liters not 3 liters per the physician's orders.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>39343</p> <p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>Based on staff interviews and the review of clinical records, it was determined that the facility failed to maintain complete and accurate records related to dialysis communication for one of four dialysis residents reviewed (Resident R64).</p> <p>Findings include:</p> <p>Review of Resident 648's physician order, dated November 15, 2024, revealed Resident R64 receives Hemo dialysis treatment on Mondays, Wednesdays, and Fridays.</p> <p>Review of Resident R64 's Hemodialysis Communication Record revealed that on November 22, 2024; November 27, 2024; December 2, 2024; December 6, 2024; December 13, 2024; December 20, 2024; December 25, 2024; January 13, 2025; January 15, 2025; January 17, 2025; January 20, 2025; January 22, 2025; January 25, 2025; January 27, 2025; January 29, 2025; January 31, 2025; February 5, 2025; February 7, 2025; February 10, 2025; and February 12, 2025, it was lacking information on bruit (A dialysis bruit is a whooshing sound heard over a dialysis fistula or graft that indicates how well the access is working), thrill (A dialysis thrill is a vibration felt over a fistula or graft that indicates blood flow. It's a sign that the access is working properly), Signs and Symptoms of infection if any, and the Signature of the Nursing Home Nurse.</p> <p>Interview with the Charge , a Licensed Nurse, Employee E3, on February 18, 2024, at 10:10 a.m., confirmed lack of information in the Hemodialysis Communication Record of Resident R64.</p> <p>28 Pa. Code 211.5(f)(vii) Clinical records</p> <p>28 Pa. Code 211.12(d)(3) Nursing services</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277</p> <p>Based on review of facility policy, review of clinical records, and resident and staff interviews, it was determined that the facility failed to provide pharmaceutical services to meet the needs of each resident for one 36 residents reviewed (Resident R502).</p> <p>Findings Include:</p> <p>Review of facility policy Administering Medications revised April 17, 2024, revealed medications should be administered in a safe and timely manner, and as prescribed. Continued review of facility policy revealed that if a medication is not available the nurse will identify reason for the unavailable medication and subsequently reach out to the pharmacy as applicable, to determine when medication will be available. If the medication is not available in the emergency supply the nurse should contact the physician for further instructions.</p> <p>Review of Resident R502's clinical record revealed the resident was newly admitted to the facility on [DATE], and was identified as alert and oriented (AAOX3- aware of who they are, where they are, and what time it is) and was able to communicate needs without problems.</p> <p>Interview on February 11, 2025, at 1:15 p.m. with Resident R502 revealed the resident had not received testosterone medication yet since admitted to the facility.</p> <p>Review of Resident R502's clinical record revealed a physician order dated February 3, 2025, to apply testosterone transdermal gel 10mg at bedtime daily.</p> <p>Review of Resident R502's medication administration record confirmed Resident R502 has not received Testosterone from February 3, 2025, through February 14, 2025.</p> <p>Review of Resident R502's clinical record revealed the doctor was notified twice on February 5, 2025, and once on February 8, 2025, that the resident required a new order for Testosterone per the pharmacy request. Further review of Resident R502's clinical record revealed no documented evidence the physician responded to/addressed notifications from nursing to obtain the resident's medication.</p> <p>Review of Resident R502's entire clinical record revealed no documented evidence nursing implemented the proper procedures to obtain the resident's medication for February 3-4, February 6-7, and February 9-13.</p> <p>Interview on February 14, 2025, at 10:30 a.m. with Registered Nurse, Employee E19, confirmed Resident R502's missed medication doses, and that the unavailable medication was not communicated from the 3:00 p.m. to the 11:00 p.m. nursing shift. Registered Nurse, Employee E19, confirmed nursing staff did not implement/follow the proper procedures to ensure the acquiring and administering of Resident R502's medication.</p> <p>28 Pa. Code 211.9 (a)(1) Pharmacy services</p> <p>(continued on next page)</p>		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>06525</p> <p>Based on observations of the food service, reviews of policies and procedures and interviews with residents and staff, it was determined that the facility did not ensure food was palatable, attractive and prepared and served in portion sizes to meet each residents' needs. (Residents: R 278, R 267, R50, R 241, R10, R175, R 299, R 279, R5, R16, and R11).</p> <p>Findings include:</p> <p>A review of the policy titled test tray evaluation dated January 17, 2019, revealed that test tray evaluations and monitoring were the responsibility of the food and nutrition services department. The policy indicated that the food and nutrition services department was to use the meal tray evaluation system to objectively evaluate the quality of the foods being served to the residents.</p> <p>A review of the policy titled altered portions dated January 17, 2019, revealed that it was the responsibility of the registered dietitian to ensure that all residents food preferences were being honored to promote meal satisfaction. The policy indicated that double portion sizes of foods at meals would be ordered by the physician.</p> <p>Observations of the noon meal service on the one east nursing unit at noon on January 12, 2025, revealed that the menu was planned for hamburger steak with onions, steamed rice, pearled carrots and cinnamon apples.</p> <p>Observations were made on February 12, 2025, during the preparation, delivery and service of foods and fluids planned for the residents' meals on the one east nursing. Food service on the one east nursing unit revealed that the preparation of the hamburger steak with onions was unappetizing and inedible for those residents ordered regular no added salt large portions, regular consistent carbohydrate and renal diets. The hamburger steak was over cooked, unable to be cut with a knife, hard and rubbery.</p> <p>The Residents: R 278, R 267, R50, R 241, R10, R175, R 299, R 279, R5 and R16 were observed asking the nursing staff for a replacement meal tray; because they could not eat or swallow the food.</p> <p>Alert and oriented residents that were interviewed (Residents: R 299, R 279, R5, R16, R 278, R 267 and R50) reported that often have to ask for substitute foods and drinks because the dietary staff were preparing foods and fluids that they requested not to have on the menus. The residents collectively reported that their food preferences were not being honored at the facility. Further interview with these residents identified and confirmed problems with food preparation and service, of the preplanned menu items.</p> <p>Interviews with the nursing staff (Employees E10, E11, E12) on the one east nursing unit confirmed the lack of food preparation skills by the dietary employees. The nursing staff reported that the hamburger steak with onions was inedible on February 12, 2025 and that there were other items sent on the meal trays that were not appetizing and in a form that were satisfactory for the residents.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on February 12, 2025, at 12:01 p.m. with alert and oriented Resident R11 revealed the food was not palatable.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>06525</p> <p>Based on observations of the food and nutrition services department, reviews of the pest control operator's reports, interviews with staff, reviews of policies and procedures and reviews of the city department of health inspection report, it was determined that the dietary services was not maintained in accordance with standards for food service safety .</p> <p>Findings include:</p> <p>A review of the policy titled Sanitation of Dining and food service areas dated January 17, 2019 revealed that it was the responsibility of the food service staff to maintain the sanitation of the main kitchen through cleaning. It was the responsibility of the food service director to over see the cleaning and sanitation throughout the dietary department. The cleaning schedule indicated that the dietary and housekeeping staff were responsible for the routine cleaning of the ceiling area of the main kitchen.</p> <p>Observations of the entire ceiling area throughout the main kitchen revealed porous, bulging tiles that were water damaged.</p> <p>Interview with the Director of Dietary Services, Employee E7 and the Maintenance Director, Employee E8 at 10:00 a.m., on February 11, 2025 confirmed that water piping burst above the main kitchen during the month of Janaury, 2025. At that time the operations of the main kitchen for dinner and breakfast the following morning had to be delayed; because the meal preparation and tray line set up had to be done in the hallway outside the main kitchen; until the piping was shut off and the water stopped dripping and flowing into the kitchen above the food service equipment.</p> <p>Observations revealed ceiling tiles that were missing leaving exposed electrical wiring, vents and coils.</p> <p>Observations revealed ceiling tiles that were soiled with food debris, grease, rust and dirt. The rusting was predominantly along the metal supports situated on tracks of the drop down ceiling design.</p> <p>Reviews of the City department of health inspection report for the main kitchen dated December 10, 2024, revealed that the facility was issued a citation for damaged ceiling tiles in the ware wash area of the kitchen. The inspection report also cited the acoustic stained drop ceiling tiles throughout the main kitchen particular concern for those directly over hot stoves and storage areas.</p> <p>Pest control reports for December, 2024, January and February, 2025 for the main kitchen were reviewed and revealed that the kitchen was being treated for cockroaches. The pest control operator pointed out areas of food debris near hot food service equipment that needed to be cleaned and removed.</p> <p>A review of the food inspection report from the City Department of health December 10, 2024 damaged ceiling tiles in the ware wash area. Acoustic stained ceiling tiles in the main kitchen and ware wash area.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interviews with the Director of Maintenance and the Director of Dietary Services at 10:30 a.m., on February 11, 2025 revealed that a purchase order was placed on January 30, 2025 for white washable ceiling tiles for the main kitchen. The Maintenance Director, Employee E8, reported that a total of 100 ceiling tiles will be necessary for the main kitchen to ensure that the food and nutrition services department was operating within the standards for food service safety.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code: 201.18(b)(3)(2.1) Management</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277</p> <p>Based on review of facility documentation, review of clinical records, and interviews with staff, it was determined that the Nursing Home Administrator and the Director of Nursing failed to effectively manage the facility resulting in an Immediate Jeopardy situation with a resident who had a history of sexually inappropriate behaviors engaging in unwanted/non-consensual sexual contact with a resident who had severe cognitive impairment.</p> <p>Findings Include:</p> <p>Review of the job description of the Nursing Home Administrator (NHA) revealed that, the employee assumes full-time administrative authority, responsibility and accountability for the operations of the nursing facility. The employee manages facility employees in the provision of care and services rendered in accordance with professional standards, and in compliance with state and federal laws and regulations. The employee implements operational and financial objectives of management and allocates resources in an efficient and economical manner to attain or maintain the highest practicable physical, mental and psycho-social well-being of each resident.</p> <p>Review of the job description of the Director of Nursing (DON) revealed that, the employee assumes full time administrative and clinical authority, responsibility, and accountability for the delivery of nursing services in the facility. The employee manages employees in the provision of care and services according to professional standards of nursing practice, consistent with facility philosophy of care and state and federal laws and regulations. In collaboration with the Nursing Home Administrator, allocates department resources in an efficient manner to enable each resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The employee communicates and interprets policies and procedures to nursing staff and subsequently monitors practice for effective implementation.</p> <p>Review of Resident R137's admission Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated January 20, 2025, revealed resident was admitted to the facility on [DATE], and had moderate cognitive impairment.</p> <p>Further review of the MDS assessment revealed Resident R137 was independent for mobility (walking 10 and 50 feet) and noted diagnoses of Depression (major loss of interest in pleasurable activities) and alcohol dependence with alcohol-induced persisting Dementia (progressive degenerative disease of the brain).</p> <p>Review of Resident R137's comprehensive care plan dated January 16, 2025, revealed the resident displayed inappropriate sexual behaviors (verbal or physical) related to making inappropriate remarks. Resident R137 touches other residents and/or staff inappropriately.</p> <p>Review of Resident R137's clinical record revealed a nursing note dated January 31, 2025, at 3:24 p.m. that revealed [Resident R137] is engaged in inappropriate sexual behavior with staff and other residents. He attempted to touch the private parts of one staff and another resident.</p> <p>(continued on next page)</p>

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R208's quarterly MDS dated [DATE], revealed the resident was rarely/never understood and had short-term and long-term memory problem. Further review of the MDS assessment revealed Resident R208 had diagnoses of Manic Depression, Bipolar Disease (condition in which a person has period of depression and periods of extreme happiness), and adjustment disorder with mixed anxiety and depressed mood.</p> <p>Interview on February 13, 2025, at 11:40 a.m. with Nurse Aide, Employee E24, revealed on January 31, 2025, the employee responded to yelling in Resident R208's room and Resident R137 was observed pulling at Resident R208's pants saying [Resident R137] wanted to suck Resident R208's penis. Continued interview with Nurse Aide, Employee E24, revealed this incident was reported to the charge nurse.</p> <p>Review of Resident R271's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated November 8, 2024, revealed the resident was rarely/never understood. Resident R271 assessed with BIMS (Brief Interview of Mental Status) of 3, which indicated the resident had severe cognitive impairment. Further review of Resident R271's MDS assessment revealed Resident R271 had diagnoses of Dementia and Psychotic Disorder (loss of contact with reality).</p> <p>Review of Resident R271's comprehensive care plan dated August 8, 2024, revealed the resident had a behavior problem related to psychosis, wandering in other resident's rooms and difficult to redirect.</p> <p>Review of Resident R271's clinical record revealed a nursing progress note dated February 13, 2025, that indicated Resident R271 was sent to the emergency room of the hospital as a sexual assault victim. The nursing staff documented Resident R271 had a change in mental status as a result of the sexual assault.</p> <p>Review of facility documentation revealed a statement by Nurse Aide, Employee E22, dated February 12, 2025, that indicated as Nurse Aide, Employee E22, was coming out of another resident's room; the employee witnessed the Resident R271 being pinned down by Resident R137. As Nurse Aide, Employee E22, entered the room Resident R137 was observed to have both of Resident R271's arms pinned to his/her side performing oral sex on Resident R271. Resident R271 was observed squirting and holding onto his/her brief. Nurse aide, Employee E22, promptly notified the charge nurse of the incident who subsequently responded to the incident and was able to get Resident R137 off Resident R271. Resident R271 was then escorted back to his/her room until the local police arrived.</p> <p>Interview on February 13, 2025, at 12:53 p.m. with Nurse Aide, Employee E20, revealed on February 12, 2025, at approximately 9:30 p.m. Nurse Aide, Employee E22, called for assistance and when Nurse Aide, Employee E20, responded she observed Resident R137 holding down Resident R271 and performing oral sex. Nurse Aide, Employee E20, revealed Resident R137 was completely unaware that staff were in the doorway observing the incident. Further interview revealed Nurse Aide, Employee E20, and Nurse Aide, Employee E22, went to get the charge nurse to assist and then went back to the resident's room before intervening.</p> <p>Interview on February 13, 2025, at 3:20 p.m. with Licensed Nurse, Employee E16, revealed approximately two weeks prior during an initial encounter with Resident R137, the resident asked Licensed Nurse, Employee E16, if Employee E16 had a big penis and if Resident R137 could suck his penis.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Continued interview with Licensed Nurse, Employee E16, revealed that on February 12, 2025, at approximately 9:30 p.m., the employee was notified by Nurse Aides, Employee E20 and E22, that Resident R137 was performing oral sex on Resident R271. Licensed Nurse, Employee E16, promptly responded to the incident between Resident R137 and R271. Licensed Nurse, Employee E16, observed Resident R137 performing oral sex on and subsequently had to physically remove Resident R137 from Resident R271.</p> <p>Interview on February 13, 2025, at approximately 9:45 a.m. with the Director of Nursing, Employee E2, confirmed that revealed on February 12, 2025, around 9:30 p.m. Resident R137 was found/observed performing oral sex on Resident R271.</p> <p>Based on the deficiencies identified in this report, the Nursing Home Administrator and Director of Nursing failed to fulfill essential duties and responsibilities of their position to ensure that the Federal and State guidelines and Regulations were followed, contributing to the Immediate Jeopardy situation.</p> <p>Refer to F600.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee.</p> <p>28 Pa. Code 211.12 (c) Nursing services.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>39343</p> <p>Provide and implement an infection prevention and control program.</p> <p>Based on observations, review of facility policies, review of facility documentation, clinical record review and interviews with staff, it was determined that the facility failed to maintain an effective infection control program related with Enhanced Barrier Precautions for one of two residents reviewed (Residentb R96).</p> <p>Findings include:</p> <p>Review of literature revealed that Enhanced Barrier Precautions are infection control Intervention designed to reduce the transmission of novel or Multi-Drug-Resistant Organisms. Enhanced Barrier Precautions require to employ the use of targeted personal protective equipment (PPE) during high contact patient/resident activities.</p> <p>On February 18, 2025, at 11:28 a.m. review of physician order for Resident R96 revealed an order dated February 12, 2025, for Enhanced Barrier Precautions: Gown and Gloves during high contact care/activities with resident, every shift for prophylaxis secondary to peg tube, and chronic wound.</p> <p>Observation on February 18, 2025, at 11:39 a.m. revealed that a Licensed nurse, Employee E28, was cleaning the peg tube site of Resident R 96; but Licensed nurse, Employee E28 did not wear the PPE, even though Resident R96 was on Enhanced Barrier Precautions. At the time of the finding, confirmed the same with Licnesed nurse, Employee E28.</p> <p>28 Pa. Code 211.10(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p>		