STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395903	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Hills Healthcare and Rehabilitation Center	194 Swinderman Road Wexford, PA 15090

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on clinical record review, facility policy, and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for two of three residents with facility-initiated transfers (Residents R21 and R28). Findings include: Review of facility policy Documentation of Resident Discharge and Deaths dated 6/17/24, indicated to complete the resident transfer form and provide a photocopy of the following: resident face sheet, advance directive, medication administration record, current history and physical, current month's physician and verbal orders, pertinent diagnostic testing, and enter the name of each item sent as an attachment on the transfer form. Review of the clinical record indicated Resident R21 was admitted to the facility on [DATE]. Review of Resident R21's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/24/24, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and depression (a constant feeling of sadness and loss of interest). Review of Resident R21's clinical record revealed that the resident was transferred to the hospital on 7/16/24. Review of Resident R21's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R28 was admitted to the facility on [DATE]. Review of Resident R28's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia, and difficulty walking. (continued on next page)

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

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

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R28's clinical record revealed that the resident was transferred to the hospital on 9/17/24. Review of Resident R28's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. During an interview on 10/18/24, at 9:09 a.m. the Director of Nursing confirmed that there was no evidence that the necessary information was communicated to the receiving health care institution or provider upon transfer for two of three residents with facility-initiated transfers as required for two of three residents (Residents R21 and R28). 28 Pa. Code 201.29 (a)(c.3)(2) Resident rights.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on a review of Resident Assessment Instrument (RAI) User's Manual, clinical records, and staff interviews, it was determined that the facility failed to ensure that MDS assessments accurately reflected the resident's status for one of three residents (Resident R31). Findings include: Review of facility policy MDS/RAI/Care Plan dated 6/17/24, indicated during the first five days of a resident's admission or readmission to the facility the Registered Nurse Assessment Coordinator (RNAC) will establish an assessment date for the Initial Assessment and distribute a schedule to the Interdisciplinary Team. The assessment reference date (ARD) will be set to reflect an accurate reflection of the resident's care needs within a specific reference period. The RNAC will establish a schedule for each subsequent assessment and review changes in residents as they occur and determine if a Significant Change is clinically warranted. The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated the following instructions: - O0110K1, Hospice care: code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. Review of the clinical record indicated Resident R31 was admitted to the facility on [DATE]. Review of Resident R31's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/9/24, indicated diagnoses of high blood pressure, repeated falls, and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Review of a physician order dated 2/25/24, indicated to admit to hospice for diagnoses of dementia, effective 2/23/24. Review of Resident R31's Significant Change MDS dated [DATE], revealed that Section O0110K1 (Hospice care) was coded no, indicating that the resident did not receive any hospice care during the 14-day assessment period. Review of Resident R31's Quarterly MDS dated [DATE], revealed that Section O0110K1 (Hospice care) was coded no, indicating that the resident did not receive any hospice care during the 14-day assessment period. During an interview on 10/17/24, at 11:19 a.m. RNAC Employee E1 confirmed that the facility failed to make certain that resident assessments were accurate as required for one of three residents (Resident R31). 28 Pa. Code 211.5(f) Clinical records. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(5) Nursing services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to develop comprehensive care plans to meet resident care needs for six of 10 residents (Residents R5, R17, R28, R35, R44, and R47). Findings include: Review of facility policy MDS/RAI/Care Plan dated 6/17/24, indicated the Resident Assessment Instrument (RAI) and Care Planning Process provide a tool for an interdisciplinary approach to plan the care of the resident. The purpose of the RAI is to incorporate the identified medical, nursing, nutritional, rehabilitative, and psychosocial needs of each resident into interventions and goals to meet those needs. The RAI is a process that defines an interdisciplinary approach to resident assessment and plan of care to help resident attain the highest practicable functional level. The facility will develop a written plan of care individualized for each resident, which identifies through an assessment process his/her strengths, problems, and needs. Review of the facility policy Proper Use of Side Rails last reviewed 6/17/24, indicate the use of quarter or half-side rails as an assistive device will be addressed in the resident care plan. Review of Resident R5's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/5/24, indicates admission to facility on 8/29/24, with the diagnosis of atrial fibrillation (rapid and irregular heartbeat), hypertension (high blood pressure) and gastroesophageal disease (GERD-stomach acid flows back into the esophagus). During an observation on 10/15/24, at 09:47 a.m. bilateral quarter rails were observed on Resident R5's bed. Review of Resident R5's physician order dated 9/19/24, indicated bilateral quarter rails for positioning. Review of Resident R5's care plan on 10/17/24, failed to include goals and interventions related to the usage of bilateral quarter side rails for positioning. Review of Resident R17's MDS dated [DATE], indicated admission to facility on 01/30/19, with the diagnosis of coronary artery disease (buildup of plaque in the hearts arteries), heart failure (heart doesn't pump blood the way it should) and hypertension (high blood pressure). During an observation on 10/15/24, at 10:21 a.m. bilateral quarter rails were observed on Resident R17's bed. Review of Resident R 17's physician order dated 9/19/24 indicated bilateral quarter rails for positioning. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R17's care plan on 10/17/24, failed to include goals and interventions related to the usage of bilateral quarter side rails for positioning. Review of the clinical record indicated Resident R28 was admitted to the facility on [DATE]. Review of Resident R28's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and difficulty walking. During an observation on 10/15/24, at 10:55 a.m. bilateral quarter side rails were observed on Resident R28's bed. Review of a physician order dated 9/19/24, indicated to use bilateral (both sides) quarter side rails for positioning. Review of Resident R28's care plan on 10/16/24, failed to include goals and interventions related to the usage of quarter side rails for positioning. Review of Resident R35's MDS dated [DATE] indicated re-entry to facility on 12/1/22, with the diagnosis of anemia (low iron in the blood), hypertension (high blood pressure), and orthostatic blood pressure (blood pressure drops upon standing up) Review of physician order dated 1/4/24, indicated Blood glucose monitoring via Dexacom 6 monitor (sends real time glucometer readings to a compatible smart device). Review of Resident R35's care plan on 10/17/24, failed to include interventions for the Dexacom 6 monitor. During an interview on 10/17/24, Registered Nurse Assessment Coordinator (RNAC) Employee E1 confirmed the facility failed to include interventions for the Dexacom 6 monitor on Resident R35's care plan. Review of the clinical record indicated Resident R44 was admitted to the facility on [DATE]. Review of Resident R44's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes (too much sugar in the blood), and depression (a constant feeling of sadness, loss of interest). During an observation on 10/15/24, at 9:33 a.m. bilateral quarter side rails were observed on Resident R44's bed. Review of a physician order dated 9/19/24, indicated to use bilateral quarter side rails for positioning. Review of Resident R44's care plan on 10/16/24, failed to include goals and interventions related to the usage of quarter side rails for positioning. Review of Resident R47's MDS dated [DATE], indicated admission to facility on 8/11/23, with the diagnosis of GERD (stomach acid flows back into the esophagus), depression, and paraplegia (impairment in motor or sensory function of the lower extremities) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of physician order dated 9/19/24, indicate bilateral quarter rails for positioning. During an observation on 10/15/24, 10:37 a.m. bilateral quarter rails were observed on Resident R47's bed. Review of Resident R47's care plan on 10/17/24, failed to include goals and interventions related to the usage of quarter side rails for positioning. During an interview on 10/17/24, at 2:15 p.m. the Director of Nursing confirmed that the facility failed to develop comprehensive care plans to meet resident care needs as required for six of 10 residents (Residents R5, R17, R28, R35, R44, and R47). 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469 Based on review of facility policy, clinical records, and staff interview, it was determined the facility failed to update a care plan for one of three residents (Resident R23) to accurately reflect the current status of the resident and care needs. Findings include: Review of facility policy MDS/RAI/Care Plan dated 6/17/24, indicated the Resident Assessment Instrument (RAI) and Care Planning Process provide a tool for an interdisciplinary approach to plan the care of the resident. Residents will have a comprehensive care plan completed and reviewed within seven days of the completion date of the Minimum Data Set (MDS). The resident will be assessed at least quarterly and care plan reviewed by the interdisciplinary team. Review of Resident R23's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/31/24, indicated admission to the facility on [DATE] with the diagnosis of the diagnoses of heart failure (heart doesn't pump blood as well as it should), hypertension (high blood pressure), and left side hemiplegia (paralysis that affects one side of the body) Review of Resident R23's physician order dated 9/18/24, indicated bunny boot to right foot at all times while in bed. Review of Resident R23's physician order dated 9/18/24, indicated heel medix boot to left foot at all times while in bed. Review of Resident R23's care plan on 10/17/24, failed to identify the use of a bunny boot or heel medix boot. During an interview on 10/17/24, at 11:15 a.m. Registered Nurse Assessment Coordinator (RNAC) Employee E1 confirmed the facility failed to update a care plan for one of three residents (Resident R29) to accurately reflect the current status of the resident and care needs. 28 Pa. Code: 211.11(a)(b)(c)(d) Resident care plan. 28 Pa. Code: 211.12(d)(1)(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** 50075 Based on review of facility policy, clinical closed record review, and staff interviews, it was determined that the facility failed to ensure a resident had a physician discharge order to return home for one of three residents (Closed Record (CR) Resident R53) and failed to ensure a resident had a physician order for care and management of an over the bed trapeze bar for one of three residents (Resident R47). Findings include: Review of facility policy Documentation of Resident Discharge and Deaths dated 6/17/24, indicated documentation will be completed when a resident is discharged from this facility. Notification to attending physician, noting order for discharge. The following items are to be documented when a resident is discharged from the facility- Physicians Discharge order has been obtained. Review of the facility policy Transcribing Physician Orders dated 6/17/24, indicates physician orders will be transcribed when they are received. Review of CR Resident R53's Minimum Data Set (MDS-periodic assessment of care needs) dated 7/9/24, diagnoses of high blood pressure, depression, and atrial fibrillation (disease of the heart characterized by irregular and often faster heartbeat). A review of CR Resident R53's physician orders on 10/18/24, at 12:12 p.m. failed to contain a physician discharge order to discharge resident home on 7/23/24. During an interview on 10/18/24, at 12:15 p.m. the Director of Nursing (DON) confirmed the facility failed to ensure a resident had a physician discharge order to return home for one of three residents (Closed Record (CR) Resident R53). A review of Resident R47's MDS dated [DATE], indicated admission to facility on 8/11/23, with the diagnosis of GERD (stomach acid flows back into the esophagus), depression, and paraplegia (impairment in motor or sensory function of the lower extremities) During an observation on 10/15/24, at 10:37 a.m. an over the bed trapeze bar (helps bedridden people move) was observed over Resident R47's bed. A review of Resident R47's physician orders on 10/17/24, did not include orders for the over the bed trapeze bar. During an interview on 10/18/24 at 9:07 am the DON confirmed that the facility failed to ensure a resident had a physician order for care and management of an over the bed trapeze bar for one of three residents (Resident R47). 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.29(d) Resident Rights (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.10 (c)(d) Resident Care policies 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing service

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075 Based on review of facility policy, personnel records and staff interview it was determined that the facility failed to complete annual performance evaluations for two of five nurse aide personnel records (Nurse aide Employee E6 and Nurse aide Employee E7). Findings include: The facility Performance Evaluations policy reviewed 6/17/24, indicated that the job performance of each employee shall be reviewed and evaluated at least annually. Review of Nurse aide (NA) Employee E6's personnel record indicated she was hired to the facility on [DATE]. Review of NA Employee E6's personnel record for the evaluation period of 3/18/23 to 3/18/24, did not indicate a performance review with the employee was completed. Review of NA Employee E7's personnel record indicated she was hired to the facility on [DATE]. Review of NA Employee E7's personnel record for the evaluation period of 8/1/23 to 8/1/24, did not indicate a performance review with the employee was completed. During an interview on 10/16/24, at 11:15 a.m. the Director of Nursing confirmed that the facility failed to complete annual performance evaluations for NA Employee E6 and NA Employee E7, as required. 28 Pa Code: 201.20 (a)(b)(c)(d) Staff development.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469 Based on review of facility policies, observations, and staff interviews it was determined that the facility failed to properly store medical supplies and biologicals in one of three medication carts (first floor B hall medication cart), one of two medication rooms (first floor medication room) and properly secure stock medications in the central supply area. Findings include: A review of the facility Storage of Medications, last reviewed [DATE], indicates medications are stored in a safe, secure, and orderly manner. Compartments containing medications are locked when not in use. Medications are stored in an orderly manner in cabinets, drawers, or carts. A review of the facility Medication Administration, last reviewed [DATE], indicates medications are administered at the time they are prepared. A review of the State Operations Manual Rev., 225: issued [DATE], S483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. During an observation on [DATE], at 8:50 a.m. Licensed Practical Nurse (LPN) Employee E3 opened the top drawer to first floor B hall medication cart and removed a medication cup containing pills. LPN Employee E3 stated I just put them in here a few minutes ago, he was in the bathroom, LPN Employee E3 took the medication cup into Resident R45's room and administered the medications. During an interview on [DATE], at 8:51 a.m. LPN Employee E3 confirmed the medications for Resident R45 were prepared and not administered and placed in the top drawer of the mediation cart and that the facility failed to properly store medical supplies and biologicals in one of three medication carts (first floor B hall medication cart). During an observation on [DATE], at 9:24 a.m., of the first-floor medication room the following was observed under the sink: One bag containing blue toped blood drawl tubes. One bag containing yellow top blood drawl tubes. One bag containing needle hubs for blood drawls. In the unlocked cupboard over the sink a bottle of medication labeled Abilify belonging to Resident R31. LPN Employee E9 stated they were discontinued yesterday; I will destroy them right now. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview completed on [DATE] at 9:30 a.m. LPN Employee E9 confirmed the above observations and that the facility failed to properly store medical supplies and biologicals in one of two medication rooms (first floor medication room) During an observation and interview on [DATE], at 12:42 p.m. with the Nursing Home Administrator (NHA) of the central supply room revealed a shelf next to the entrance door containing over the counter medications that included but not inclusive to stool softeners, milk of magnesium bottles, miralax, allergy medications, pain revivers, vitamins. The NHA stated they are over the counter medication overflow. During an interview on [DATE], at 8:35 a.m. Registered Nurse (RN) Employee E10 stated If I need supplies, I usually go to the med room or downstairs in central, when queried of who can go into central? RN employee E10 stated just staff including the nurse aides. During an interview on [DATE], at 8:40 a.m. Nurse Aid (NA) Employee E6 stated If I need supplies, I go downstairs to central supply, when queried who can enter central supply? NA Employee E6 stated the staff goes in; I don't believe kitchen goes in. During an interview on [DATE], at 8:44 a.m. NA Employee E11 stated If I need supplies, I go down to central supply. We can get briefs, pullups, wipe, sanitizer wipes, cups for water pass, barrier cream, soap, antifungal powder, and other toiletries. During an interview on [DATE], at 8:48 a.m. NA Employee E12 stated if I run out of supplies usually, I will ask the nurse to find out where it is, they send me down to the stock room I think it's a code to get in. During an interview on [DATE] 08:51 a.m. NA Employee E13 stated If I run out of supplies, I would go into the supply room, it is secure with a code During an interview on [DATE], at 12:53 p.m. The Director of Nursing stated that the Central Supply area can be accessed by any clinical staff, I will pull the over-the-counter medications and put them in the medication room, there is plenty of room in there and confirmed the facility failed to properly secure stock medications. 28 Pa Code: 211.9 (a) Pharmacy services. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services. 28. Pa. Code: 211.10(a)(c)(d) Resident care policies.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Hills Healthcare and Rehabilitation Center	194 Swinderman Road Wexford, PA 15090

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49469 Based on a review of policy, observations, and staff interviews, it was determined that the facility failed to properly maintain kitchen equipment in a sanitary condition and failed to properly label, date, and store food products in the kitchen refrigerator and basement freezer creating the potential for unsafe conditions and the potential for cross contamination in the main kitchen, basement freezer storage area and in one of two kitchenettes (C and D level kitchenette). Findings include: A review of the facility Labeling and Dating Inservice, last reviewed 6/17/24, indicates policy statement: Healthcare Service Group, Inc., and its subsidiaries (HCSG) promotes the health and safety of all employees, as well as that of the clients and residents we serve. Proper labeling and dating ensure that all foods are stored, rotated, and utilized in a first in first out manner. All foods should be dated upon receipt before being stored. A review of the facility Food storage: cold foods last reviewed 6/17/24, indicates all foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. A review of the facility Equipment policy dated 6/17/24, indicates all foodservice equipment will be clean, sanitary, and in proper working order. During an observation of the main kitchen on 10/15/24, at 9:00 a.m. the following was observed: 2 frying pans under the prep sink shelf were stored not inverted. Hot plates and plate lids in cart were stored not inverted. During an interview on 10/15/24, at 9:05 a.m. the Dietary District Manager Employee E4 confirmed the above observations, and that the items should have been inverted. During an observation on 10/15/24, at 9:08 a.m. of the kitchen refrigerator Dietary Manager Employee E5 removed a bag of rolls with a knot tie on top and placed on counter in kitchen and stated to kitchen [NAME] Employee E8 here's todays rolls, upon further inspection the bag of frozen rolls were not labeled or dated. During an interview on 10/15/24, at 9:10 a.m. Dietary Manager Employee E5 confirmed the rolls failed to be labeled or dated. During an observation of the basement freezer on 10/15/24, at 9:13 a.m. the following was observed: A blue water bottle. An opened bottle of blue Gatorade (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A can of Starbucks double shot coffee A bottle of strawberry banana drink During an interview on 10/15/24, at 9:15 a.m. Dietary Manager Employee E5 confirmed the above observations and stated, it has to be housekeeping's. During an observation on 10/15/24, at 12:51 p.m. the kitchenette on the C and D level hallway contained the following: The upper right cabinet A black and white lunch bag. A 1/2 bottle of diet Pepsi. A tube of gorilla glue adhesive bonding. The upper left cabinet: An empty sharps container. During an interview on 10/15/24 at 12:52 p.m. the Director of Nursing (DON) removed the items and confirmed they should not be in the kitchen pantry area and that the facility failed to properly label, date, and store food products creating the potential for unsafe conditions and the potential for cross contamination. 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.6(c) Dietary services. 28 Pa. Code: 201.14(a) Responsibility of licensee.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075 Based on review of facility documents, resident clinical records and staff interviews it was determined that the facility failed to ensure a resident had the capacity to understand the terms of a binding arbitration agreement (a binding agreement by the parties to submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship, whether contractual or not. The decision is final, can be enforced by a court, and can only be appealed on very narrow grounds) for three of ten residents (Resident R17, Resident R25, and Resident R29). Findings include: Review of facility Binding Arbitration Agreement policy reviewed on 6/17/24, indicated residents or representatives are informed of the nature and implications of any proposed binding arbitration agreements so as to make informed decisions on whether to enter into such agreements. Residents or their representatives have the right to make informed decisions about important aspects of their health, welfare, and safety. After the terms and conditions of the agreement are explained, the resident or representative, must acknowledge that he or she understands the agreement before being asked to sign the document. Review of the admission record indicated Resident R17 was admitted to the facility on [DATE]. Review of Resident R17's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/18/20, indicated the diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and heart failure (a progressive heart disease that affects pumping action of the heart muscles). Resident R17's MDS assessment section C0200 Brief Interview for Mental Status (BIMS, a screening test that aides in detecting cognitive impairment). The BIMS total score suggests the following distributions: 13-15: cognitively intact, 8-12: moderately impaired, 0-7: severe impairment. Resident R17's BIMS score was a six, indicating severe impairment. Review of Resident R17's Binding Arbitration Agreement indicated that the resident signed the document on 12/30/22. Review of the admission record indicated Resident R25 was admitted to the facility on [DATE]. Review of Resident R25's MDS dated [DATE], indicated the diagnoses of high blood pressure, depression, and cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain). Resident R25's MDS assessment section C0200- BIMS score was a seven, indicating severe impairment. Review of Resident R25's Binding Arbitration Agreement indicated that the resident signed the document on 8/14/24. Review of the admission record indicated Resident R29 was admitted to the facility on [DATE]. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R29's MDS dated [DATE], indicated the diagnoses of high blood pressure, coronary artery disease (damage or disease in the heart's major blood vessels), and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Resident R29's MDS assessment section C0200- BIMS score was a seven, indicating severe impairment. Review of Resident R29's Binding Arbitration Agreement indicated that the resident signed the document on 12/30/22. During an interview on 10/16/24, at 1:28 p.m. the Director of Nursing confirmed the facility failed to ensure a resident had the capacity to understand the terms of a binding arbitration agreement for three of ten residents (Resident R17, Resident R25, and Resident R29). 28 Pa. Code: 201.14(a)(c)(d)(e) Responsibility of licensee. 28 Pa. Code: 201.18(e)(1) Management

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 50075 Based on facility policy review, review of Quality Assurance attendance records, and staff interview, it was determined that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all the required committee members for one of four quarterly meeting (December 2023 through February 2024). Findings Include: The facility Quality Assurance and Performance Improvement (QAPI) Program policy dated 6/17/24, indicated that the facility shall develop, implement, and maintain an ongoing, facility-wide, date-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents. Review of Quality assurance and performance improvement sign in sheets and attendance records indicated the facility failed to provide evidence that the facility conducted a March 2024 QAPI meeting. During an interview on 10/18/24, at 12:52 p.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to conduct QAA meetings at least quarterly with all the required committee members for one of four quarterly meeting (December 2023 through February 2024), as required. 28 Pa Code: 201.18(e)(1)(2)(3)(4) Management.