STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395918	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitions Healthcare Shook Home	55 South Second Street Chambersburg, PA 17201

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37116 Based on clinical record review and resident and staff interviews, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for three of 15 residents reviewed (Residents 7, 27, and 41). Findings Include: Review of Resident 7's clinical record revealed diagnoses that included muscle weakness and other abnormalities of gait and mobility (difficulty walking caused by various conditions). Review of facility incident reports dated March 11 and 12, 2024, revealed that Resident 7 experienced a fall on each of those dates when she was lowered to the floor by staff. Review of Resident 7's April 24, 2024, comprehensive MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) revealed it was coded to indicate that Resident 7 had not experienced any falls since her last assessment dated [DATE]. In email correspondence received from the Nursing Home Administrator (NHA) on May 30, 2024, at 12:26 PM, he confirmed that Resident 7's March 11 and 12, 2024, falls were not properly captured on her April 24, 2024, MDS assessment. Review of Resident 27's clinical record revealed diagnoses that included chronic venous insufficiency (a condition in which blood pools in the veins, straining the walls of the veins), congestive heart failure (CHF - a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply), and hypertension (high blood pressure). During an interview with Resident 27 on May 28, 2024, at 10:23 AM, he revealed he had concerns about a wound he acquired in the hospital that hasn't healed. Review of select facility wound tracking documentation on May 28, 2024, at 1:45 PM, revealed Resident 27 was noted as having an active hospital acquired pressure injury (damage to the skin or other tissues caused by prolonged periods of pressure) since his admission on February 27, 2024. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 27's Admission MDS with ARD (assessment reference date- last day of the assessment period) of March 4, 2024, revealed Resident 27 was marked no to indicate he does not have a pressure injury. During an interview with Employee 2 (Registered Nurse Assessment Coordinator) on May 30, 2024, at 10:40 AM, she revealed she missed his pressure injury on the assessment because the wound doctor didn't see him until later in the day when he got admitted from the hospital. Interview with the NHA on May 30, 2024, at 11:11 AM, revealed he would expect Resident 27's MDS assessment to be completed accurately. Review of Resident 41's clinical record revealed diagnoses that included Protein calorie malnutrition (PCM - an imbalance between the nutrients your body needs to function and the nutrients it gets), bullous pemphigoid (a skin condition that causes large, fluid-filled blisters), and anxiety disorder (a persistent feeling of worry, nervousness, or unease). Review of Resident 41's clinical record on May 30, 2024, at 10:07 AM, revealed she was admitted to hospice (end of life) services on April 8, 2024, with an admitting diagnosis of PCM. Review of Resident 41's Significant Change MDS with ARD of April 14, 2024, revealed under Section I, subsection I5600. Malnutrition (protein or calorie) or at risk for malnutrition, Resident 27 was marked no to indicate she does not have an active diagnosis of PCM. During an interview with Employee 2 on May 30, 2024, at 10:39 AM, she revealed she missed Resident 41's diagnosis of PCM because she was admitted to hospice at the hospital on April 8, 2024, and that diagnosis was not on her discharge summary when she returned from the hospital later that day. Interview with the NHA on May 30, 2024, at 11:12 AM, revealed he would expect Resident 41's MDS assessment to be completed accurately. 28 Pa. Code 211.5(f) Medical Records 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 - Some	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** 33305 Based on facility policy reviews, observations, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure the resident care plan was reviewed and revised to reflect the resident's current status for four of 15 residents reviewed (Residents 18, 27, 41, and 45). Findings include: Review of facility policy, titled Care Plan-Comprehensive, last revised September 28, 2022, stated, Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. The care planning/interdisciplinary team is responsible for the review and updating of care plans: a. When there has been a significant change in the resident's condition, d. At least quarterly. Review of facility policy, titled Bed System Safety, revised July 2, 2019, revealed that the interdisciplinary team will review bed system evaluations and develop the appropriate care plan for the use of positioning devices and side rails. Review of Resident 18's clinical record revealed diagnoses that included Parkinson's Disease (long-term movement disorder where the brain cells that control movement start to die and cause changes in how one moves, feels, and acts) and osteoarthritis (joint degeneration resulting in pain). Observation on May 28, 2024, at 10:22 AM, revealed bilateral upper side rails on Resident 18's bed. Review of Resident 18's active physician orders revealed an order for bilateral enablers, or 1/4 upper side rails if bed does not accomodate enablers, effective April 30, 2024. Review of Resident 18's current care plan failed to reveal any information related to the presence or use of side rails. During an interview with the Nursing Home Administrator (NHA) on May 30, 2024, at 11:32 AM, he confirmed that Resident 18's use of side rails should have been included in his care plan. Review of Resident 27's clinical record revealed diagnoses that included chronic venous insufficiency (a condition in which blood pools in the veins, straining the walls of the veins), congestive heart failure (CHF - a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply), and hypertension (high blood pressure). Review of select facility wound tracking documentation on May 29, 2024, at 9:55 AM, revealed Resident 27 was noted as having an active pressure injury (damage to the skin or other tissues caused by prolonged periods of pressure) since he was admitted on [DATE]. During an interview with Resident 27 on May 28, 2024, at 10:23 AM, he revealed he had concerns about a wound he acquired in the hospital that hasn't healed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 27's care plan on May 30, 2024, at 10:52 AM, failed to reveal a comprehensive care plan for a pressure injury. During an interview with the NHA on May 30, 2023, at 11:55 AM, he revealed that Resident 27's care plan has an intervention for a wound treatment order that was initiated on May 27, 2024, but he would expect Resident 27 to have a comprehensive care plan for his pressure injury he has had since admission. Review of Resident 41's clinical record revealed diagnoses that included Protein calorie malnutrition (PCM - an imbalance between the nutrients your body needs to function and the nutrients it gets), bullous pemphigoid (a skin condition that causes large, fluid-filled blisters), and anxiety disorder (a persistent feeling of worry, nervousness, or unease). Review of Resident 41's physician orders revealed orders related to as needed oxygen use, including changing the oxygen tubing and humidifier bottle. Observation in Resident 41's room on May 28, 2024, at 12:02 PM, revealed oxygen equipment dated May 15, 2024. Review of Resident 41's clinical record on May 30, 2024, at 10:05 AM, revealed she was administered oxygen on May 15, 2024, due to shortness of breath. Review of Resident 41's clinical record on May 30, 2024, at 10:07 AM, revealed she was admitted to hospice (end of life) services on April 8, 2024. Review of Resident 41's care plan on May 28, 2024, at 1:02 PM, failed to reveal a care plan for hospice services or oxygen use. During an interview with the NHA on May 30, 2023, at 11:12 AM, he revealed he would expect Resident 41 to have a care plan for hospice services and oxygen use. A review of Resident 45's clinical record on May 29, 2024, at 9:00 AM, revealed clinical diagnoses that included hospice (end of life status) and a stage 3 pressure ulcer (ulcer involving full thickness of skin loss, exposing tissue) of the sacral (large, triangular bone at the base of the spine and at the upper and back part of the pelvic cavity). A review of Resident 45's physician orders on May 28, 2024, revealed an order for daily wound care for the stage 3 pressure ulcer. A review of the clinical record revealed that Resident 45 developed a stage 2 pressure ulcer (ulcer involving loss of the top layers of the skin) September 18, 2023, that progressed to a stage 3 pressure ulcer on November 20, 2023. A review of Resident 45's care plan on May 29, 2024, revealed the facility never revised the care plan until January 29, 2024, to reveal the stage 2 or the stage 3 pressure ulcers and interventions. During an interview with the Employee 1 (Regional Nurse) and the NHA on May 30, 2024, at 11:15 AM, both confirmed that Resident 45's pressure ulcers should have been included in her care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.12(d)(1)(2)(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. 33879 Based on clinical record review and staff interviews, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards of practice to meet each resident's physical, mental, and psychosocial needs for three of 15 residents reviewed (Residents 7, 41, and 154). Findings Include: Review of Resident 7's clinical record revealed diagnoses that included anxiety disorder (mental disorder characterized by feelings of worry about future events and/or fear in reaction to current events) and major depressive disorder (mental disorder characterized by at least two weeks of low mood that is present across most situations). Review of Resident 7's May 2024 MAR (Medication Administration Records - forms used to document physician orders as well as when and how medications are administered to a resident) revealed an order for Aripiprazole (antipsychotic medication) one time a day for mood related to major depressive disorder and generalized anxiety disorder, effective April 18, 2023. Further review of the MAR revealed that it was not documented that Aripiprazole was administered to Resident 7 on May 1-3, 2024. Review of corresponding nursing progress notes revealed the following: on May 1, 2024 - Not available in the cart, will reorder; on May 2, 2024 - Not available in the cart, will reorder; and on May 3, 2024 - Not available at this time. Pharmacy aware. Medication ordered. Further review of available clinical documentation failed to reveal that the physician was notified of the aforementioned missed doses of medication. During an interview with the Regional Nurse and Nursing Home Administrator (NHA) on May 30, 2024, at 11:31 AM, they revealed that they could not locate any evidence that the physician was notified of Resident 7's missed doses of Aripiprazole. The NHA revealed the expectation that the physician should have been notified. Review of Resident 41's clinical record revealed diagnoses that included bullous pemphigoid (a skin condition that causes large, fluid-filled blisters), protein calorie malnutrition (PCM - an imbalance between the nutrients your body needs to function and the nutrients it gets), and anxiety disorder (a persistent feeling of worry, nervousness, or unease). Review of Resident 41's physician orders revealed an order for: Treatment to Right hip: Cleanse area with Normal Saline/wound cleanser, Pat dry. Apply Medi honey to the open areas, cover with an island dressing. Pain medicine 1/2 hour before dressing changes, every day shift, with a start date of April 23, 2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 41's physician orders revealed an order for: Morphine Sulfate, Give 2.5 ml (ml - metric unit of measure) by mouth every 2 hours as needed for pain or respiratory distress, with a start date of April 8, 2024. Review of Resident 41's clinical record revealed a nursing progress note on April 23, 2024, that read, in part, Hospice Recommendations: pain medicine 1/2 hour before dressing changes. Review of Resident 41's April 2024 and May 2024 MAR failed to reveal that pain medication was documented as administered prior to the daily wound treatments. Further Review of Resident 41's May 2024 TAR (Treatment Administration Record- record of treatment orders), revealed her wound treatments to her right hip were not documented as administered on May 11 and 28, 2024. During an interview with Employee 5 (Licensed Practical Nurse) on May 30, 2024, at 1:08 PM, she revealed she didn't administer Resident 41's wound treatment on May 28, 2024, day shift, as the Resident was sitting in the sun room throughout the shift. She further stated she passed the wound treatment on to second shift, but that there was no documentation in Resident 41's clinical record to indicate the treatment was done on the next shift. Further she revealed she was not aware of the order to administer pain medication prior to the wound treatment. Interview with Employee 7 (Licensed Practical Nurse) on May 30, 2024, at 1:10 PM, revealed she did Resident 41's wound treatment that morning, but did not administer pain medication a half hour beforehand, and she could not locate any documentation to indicate Resident 41's wound treatments were completed on May 11 and 28, 2024. She further revealed she did not know she had the order to administer the pain medication prior to the wound treatments. During an interview with the Director of Nursing on May 30, 2024, at 1:17 PM, the surveyor revealed the concern with Resident 41's missing wound treatment documentation and lack of pain medication administration per physician order. No further information was provided. Review of Resident 154's clinical record revealed diagnoses that included major depressive disorder and anxiety disorder. Review of Resident 154's clinical record revealed that, upon admission on May 23, 2024, Resident 154 was ordered buspirone (anti-anxiety medication) 30 milligrams (mg - metric unit of measure) one tablet by mouth twice a day for depression; bupropion (antidepression medication) extended release 150 mg one table twice a day; and Vesicare (medication used to treat overactive bladder) 10 mg once a day. Review of Resident 154's MAR revealed that the facility did not have Resident 154's buspirone and bupropion medication for administration from the evening shift of May 23, 2024, through to the day shift administration time on May 28, 2024; a total of 10 administrations. Review of the MAR also revealed that the facility did not administer Resident 154's Vesicare medication from May 24 to 28, 2024, for a total of five administrations. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 154's interdisciplinary progress notes revealed no documented notification to the attending physician that Resident 154 was not receiving the ordered buspirone, bupropion, nor Vesicare. During a staff interview on May 30, 2024, at approximately 12:45 PM, NHA revealed it was the facility's expectation that the attending physician is notified when a resident does not receive a medication. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 33879 Based on clinical record review, observations, and staff interviews, it was determined that the facility failed to provide care and services to prevent and treat pressure injuries in accordance with professional standards for one of three residents reviewed for pressure injuries (Resident 9). Findings include: Review of Resident 9's clinical records revealed diagnoses that included dementia (progressive, irreversible degenerative brain disease that results in decreased contact with reality and decreased ability to perform activities of daily living) and end stage renal disease (severely compromised ability of the kidneys to filter toxins from the blood). Review of Resident 9's physician orders revealed an active order which stated, Monitor dry blisters on toes - if drainage noted, apply Mepilex transfer and [dressing] and schedule to change [Monday, Wednesday, Saturday and as-needed], dated July 6, 2022. During a treatment observation on May 29, 2024, at approximately 11:41 AM, Resident 9 was observed to have an open blister to the outer aspect of her right fifth toe. The area appeared to be approximately 0.5 centimeters (cm - metric unit of measure) in width and 0.5 cm in length, with no depth. There was a small amount of loose skin and the characteristics of the area were consistent with a stage II pressure injury (shallow open area of the skin that does not present with slough/eschar [dead cells/skin] caused by pressure over a bony prominence). After the observation, Employee 3 revealed that Resident 9 had a fluid filled blister and confirmed that the blister had become an open area. Review of Resident 9's clinical record revealed no documentation of the open area, to include progress note from nursing staff regarding the formation of a pressure injury, notification of the physician of the open area on the right fifth toe, wound assessment(s) including dimensions and characteristics of the wound, nor a care plan for the pressure injury. It was also revealed that there was no evaluation of the area by the wound team or physician. Review of Resident 9's weekly skin checks revealed no skin check identified the area observed on Resident 9's right fifth toe. During a staff interview on May 29, 2024, at approximately 1:30 PM, Director of Nursing (DON) revealed that the order for a treatment and dressing, reviewed above, was from an unrelated skin condition that was not pressure injuries. Review of a wound assessment conducted on May 29, 2024 at 7:54 PM, confirmed the observations as the facility assessed the wound as a 0.6 cm by 0.5 cm pressure injury. During a staff interview on May 30, 2024, at approximately 12:30 PM, DON revealed that, due to the lack of documentation and/or assessments, the facility was unable to determine the exact date that the pressure injury first presented. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a staff interview on May 30, 2024, at approximately 12:45 PM, Nursing Home Administrator (NHA) revealed it was the facility's expectation that new wounds are reported to the attending physician and the facility wound team for care, services, and treatment. During the interview, NHA revealed the facility was unable to locate a policy regarding notification of the attending physician regarding a change in condition of a resident. 28 Pa code 201.18(b)(1)(3) Management 28 Pa code 211.12(d)(1)(3)(5) Nursing services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 33879 Based on clinical record review and resident and staff interviews, it was determined that the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs to meet the needs of each resident for two of 18 residents reviewed (Residents 7 and 154). Findings Include: Review of Resident 7's clinical record revealed diagnoses that included anxiety disorder (mental disorder characterized by feelings of worry about future events and/or fear in reaction to current events) and major depressive disorder (mental disorder characterized by at least two weeks of low mood that is present across most situations). Review of Resident 7's May 2024 MAR (Medication Administration Records - forms used to document physician orders as well as when and how medications are administered to a resident) revealed an order for Aripiprazole (antipsychotic medication) one time a day for mood related to major depressive disorder and generalized anxiety disorder, effective April 18, 2023. Further review of the MAR revealed that it was not documented that Aripiprazole was administered to Resident 7 on May 1-3, 2024. Review of corresponding nursing progress notes revealed the following: on May 1, 2024 - Not available in the cart, will reorder; on May 2, 2024 - Not available in the cart, will reorder; and on May 3, 2024 - Not available at this time. Pharmacy aware. Medication ordered. During an interview with the Nursing Home Administrator (NHA) on May 30, 2024, at 11:31 AM, he revealed that he had no additional information regarding why Resident 7's Aripiprazole was not available. Review of Resident 154's clinical record revealed diagnoses that included major depressive disorder (mental health disorder characterized by low mood, loss of enjoyable activities, changes in appetite and/or sleep patterns) and anxiety disorder (feelings of worry and/or fear that interfere with daily activities). During an interview with Resident 154 on May 28, 2024, at approximately 12:30 PM, Resident 154 expressed concerns regarding receiving all her medications. Review of Resident 154's clinical record revealed that, upon admission on May 23, 2024, Resident 154 was ordered buspirone (anti-anxiety medication) 30 milligrams (mg - metric unit of measure) one tablet by mouth twice a day for depression; bupropion (antidepressant medication) extended release 150 mg one table twice a day; and Vesicare (medication used to treat overactive bladder) 10 mg once a day. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 154's MAR revealed that the facility did not have Resident 154's buspirone and bupropion medication for administration from the evening shift of May 23, 2024, through to the day shift administration time on May 28, 2024; a total of 10 administrations. Review of the MAR also revealed that the facility did administer Resident 154's Vesicare medication from May 24 to 28, 2024, for a total of five administrations. Review of Resident 154's progress notes revealed staff documented that the medications were not received by the pharmacy. During a staff interview on May 30, 2024, at approximately 12:30 PM, Director of Nursing (DON) revealed that when staff initially entered Resident 154's medication orders into the electronic health record, an error was made causing the pharmacy to not send the medication. During the interview, DON stated that facility staff contacted pharmacy regarding the lack of medication, but that the pharmacy computer system showed that delivery was not needed for the medications. During the interview, DON revealed it was expected that orders are entered correctly. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 37116 Based on clinical record review, policy review, and staff interviews, it was determined that the facility failed to ensure that the drug regimen of each resident was reviewed at least monthly by a licensed pharmacist, that irregularities were reported to the appropriate parties, and that these reports were acted upon for two of 5 residents reviewed for unnecessary medications (Residents 7 and 41). Findings include: Review of facility policy, titled Medication Regimen Review - Pharmacy, revised August 10, 2017, revealed that the medication regimen of each resident is reviewed by a licensed pharmacist according to federal, state, and local regulations. The pharmacist must report any irregularities to the attending physician, the facility's medical director, and the Director of Nursing (DON), and that these reports must be acted upon in a manner that meets the needs of the residents. Upon receipt of the written consultant pharmacist report for non-urgent recommendations, the DON or designee shall provide the report to the attending physician or their designee within 7 days, and the attending physician or designee should ideally respond within 7 days of the pharmacist's review date, but no later than the next regularly scheduled physician visit. Review of Resident 7's clinical record revealed diagnoses that included anxiety disorder (mental disorder characterized by feelings of worry about future events and/or fear in reaction to current events) and major depressive disorder (mental disorder characterized by at least two weeks of low mood that is present across most situations). Review of pharmacist note dated November 1, 2023, revealed the following recommendation: Medications reviewed. Please consider ordering a CBC [Complete Blood Count - blood test used to monitor or diagnose health conditions] to monitor this resident's SSRI [Selective Serotonin Reuptake Inhibitors - medications that treat depression by increasing levels of Serotonin in the brain] therapy. See recommendation form. Further review of Resident 7's clinical record failed to reveal any evidence that this recommendation was reviewed or acted upon. During an interview with the DON on May 30, 2024, at 1:32 PM, she revealed the facility received an email from the pharmacist on November 1, 2023, regarding pharmacy reviews for that month. Attached to the email was a blank recommendation form, so the facility assumed no recommendations were made. The DON also revealed that the facility was unaware that the pharmacist was entering notes into the Resident's electronic health record, so did not look there to see if any recommendations had been made. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395918	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitions Healthcare Shook Home	55 South Second Street Chambersburg, PA 17201

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Consultant Pharmacist Recommendation to Physician form dated February 27, 2024, revealed the pharmacist made the following recommendations after reviewing Resident 7's medication regimen: Please verify that the following PRN [as-needed] orders are still required and NOT considered for routine therapy .1. Baclofen [skeletal muscle relaxant] (not used in >60 days) 2. Chloraseptic [relieves sore throat and mouth pain] (not used in >60 days) 3. Hydrocortisone [used to reduce pain, swelling and allergic-type reactions] (not used in >60 days) 4. Lactulose [laxative] (not used in >60 days) 5. Miralax [laxative] (not used in >60 days) 6. Nystatin [antifungal] (not used in >60 days). Review of Consultant Pharmacist Recommendation to Physician Form dated March 24, 2024, revealed the same recommendation that was made on February 27, 2024, was again made on that date. Review of Resident 7's clinical record failed to reveal evidence that the recommendation made on February 27, 2024, was reviewed or acted upon between that date and the date of the pharmacist's next medication regimen review on March 24, 2024. During an interview with the DON on May 30, 2024, at 1:32 PM, she revealed the expectation that the February 2024 recommendation should have been reviewed and acted upon timely. Review of Resident 41's clinical record revealed diagnoses that included anxiety disorder, bullous pemphigoid (a skin condition that causes large, fluid-filled blisters), and protein calorie malnutrition (PCM - an imbalance between the nutrients your body needs to function and the nutrients it gets). Review of Resident 41's clinical record on May 29, 2024, at 9:50 AM, failed to reveal pharmacy medication regimen review notes for the months of January 2024 through March 2024. Review of select facility forms from the pharmacy, containing a list of residents who had no recommendations made for January 2024 through March 2024, failed to include Resident 41. During an interview with the Nursing Home Administrator on May 30, 2024, he revealed they are doing ongoing staff education on a new process since the building has switched pharmacy services as of December 2023. It was revealed that the recommendations get faxed over from the pharmacy and put in the physician folder for review, the physician should be signing off on any recommendations made, and then implemented and scanned into the resident's medical record accordingly. Interview with the DON on May 30, 2024, at 1:38 PM, revealed she is unable to locate Resident 41's pharmacy reviews with physician responses for the aforementioned months, and she would expect them to be available and reviewed by the physician. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services