STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395929	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeview Healthcare & Rehab Center	200 Pennsylvania Avenue Shenandoah, PA 17976

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records, minutes from Residents' Council meetings, and grievances filed with the facility, and resident and staff interviews, it was determined that the facility failed to provide care in a manner and environment that promotes each resident's quality of life by failing to respond timely to residents' requests for assistance for six residents out of the 25 sampled (Residents 2, 20, 29, 33, 75, and 84) and experiences reported by three out of the five residents during a resident group interview (Residents 1, 26, and 83). Findings include: Clinical record review revealed that Resident 29 was admitted to the facility on [DATE]. A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 10, 2024, revealed that Resident 29 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). Clinical record review revealed that Resident 2 was admitted to the facility on [DATE]. An annual MDS assessment dated [DATE], revealed that Resident 2 is cognitively intact with a BIMS score of 15. Clinical record review revealed Resident 20 was admitted to the facility on [DATE]. A quarterly MDS assessment dated [DATE], revealed that Resident 20 is cognitively intact with a BIMS score of 15. A clinical record review revealed Resident 33 was admitted to the facility on [DATE]. A review of a quarterly MDS assessment dated [DATE], revealed that Resident 33 is cognitively intact with a BIMS score of 15. A clinical record review revealed Resident 75 was admitted to the facility on [DATE]. A review of an admission MDS assessment dated [DATE], revealed that Resident 75 is cognitively intact with a BIMS score of 15. A clinical record review revealed Resident 84 was admitted to the facility on [DATE]. A review of an admission MDS assessment dated [DATE], revealed that Resident 84 is cognitively intact with a BIMS score of 15. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A clinical record review revealed Resident 1 was admitted to the facility on [DATE]. A review of a quarterly MDS assessment dated [DATE], revealed that Resident 1 is cognitively intact with a BIMS score of 12. A clinical record review revealed Resident 26 was admitted to the facility on [DATE]. A review of a quarterly MDS assessment dated [DATE], revealed that Resident 26 is cognitively intact with a BIMS score of 15. A clinical record review revealed Resident 83 was admitted to the facility on [DATE]. A review of a quarterly MDS assessment dated [DATE], revealed that Resident 83 is cognitively intact with a BIMS score of 15. Resident council meeting minutes dated February 21, 2024, revealed that a concern was raised indicating that call bells were a problem related to nursing services. A resident in attendance indicated when you need staff, they are not there. A review of the minutes from the Resident Council meeting dated March 19, 2024, revealed that residents in attendance voiced concerns regarding staff's failure to answer their call bells in a timely manner and experiencing long wait times for nursing staff to respond to their requests for assistance via the nurse call bell system Resident council meeting minutes dated May 21, 2024, revealed that the residents expressed concerns regarding resident long wait times for nursing staff to provide requested care and needed assistance. The minutes indicated that Grievances were filed related to the residents' concerns raised at this meeting, which the facility noted as resolved. During an interview on July 23, 2024, at 11:15 AM, Resident 2 stated that she waits for hours for nursing staff to provide care when needed. She explained that this morning at 4:00 AM, she rang her call requesting staff assistance to be changed (urinary incontinence) and have a new bed pad. She stated that staff did not change her bed pad until 10:30 AM. During an interview on July 23, 2024, at 11:40 AM, Resident 33 stated that he rings his call bell when he needs help getting to the bathroom. He explained that he usually waits 15 to 20 minutes for staff assistance. He stated if staff do not respond in 15 minutes, then he transfers himself to the bathroom. Resident 33 stated that he knows it is unsafe for him to self-transfer, but he can't hold it {urine or bowels} longer than 15 minutes. During an interview on July 23, 2024, at 11:50 AM, Resident 84 stated that he doesn't ring his call bell often, but 2 nights in a row he rang for staff to bring him toilet paper. He explained that no one responded, and he ambulated to the nurses station to get a new roll of toilet paper. Resident 84 stated he couldn't recall how long he waited before he took himself to the nurse's station to get toilet paper. He stated that he was frustrated that no one stocked his bathroom with toilet paper two nights in a row. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on July 23, 2024, at 12:20 PM Resident 29 stated that recently she waited an hour and a half for staff to change her (incontinence) after she rang for help. She explained that she soiled her brief and staff informed her that they would be back in five minutes to change her, but staff did not come back for an hour and a half. Resident 29 stated that it is embarrassing, and it made her angry that she was sitting in feces. She explained that when staff call off, the wait times are long for care. Resident 29 stated that the nurses never help the nurse aides with changing residents or assisting residents to the bathroom. Resident 29 explained that if the nurses helped more, then the wait times would be shorter and care better for the residents. During an interview on July 23, 2024, at 12:45 PM, Resident 75 stated that the staff are good, but they need more help. She explained that on the night shift it usually takes an hour to be changed or to get staff assistance to use the bathroom. During a group meeting on July 24, 2024, at 10:00 AM, Residents 1, 26, and 23, stated that they have concerns with long wait times for staff assistance. Other residents present stated that they are independent and do not ring their call bells for help from staff, but are aware of the long waits other dependent waits experience. Resident 1 stated that she does not know exactly how long she waits, but stated that she waits and waits for staff to answer her call bell when she rings for assistance. Resident 26 stated that she waits up to two hours for staff assistance when she rings her call bell. Resident 26 explained that the wait times are the worst when nursing staff call off and during the night shift. She stated that there are some times, when there just is not enough staff available to assist the residents in a timely manner. Resident 23 stated that when there are not enough staff, she waits 45 minutes or longer for staff to answer her call bell for help. She stated that sometimes there are only two nursing staff working on her floor, and that causes long wait times for residents that rely on staff for assistance. During an interview on July 25, 2024, at 10:45 AM, Resident 20 stated that she experiences long wait times for staff to respond to her requests for assistance. She explained that when the agency nursing staff are working, the wait times are about 20 minutes or longer. Resident 20 stated that Friday nights and weekends are the worst for staffing and wait times for staff assistance. She explained that a few weeks ago she waited 2 hours for care from nursing staff. During an interview on July 26, 2024, at approximately 9:30 AM, the Nursing Home Administrator (NHA) verified that all residents at the facility should be treated with dignity and respect. The NHA was unable to explain why residents are reporting untimely staff responses to residents' requests for assistance, which is negatively affecting their quality of life in the facility. 28 Pa. Code 201.18 (e)(1)(3)(6) Management 28 Pa. Code 201.29 (a) Resident Rights 28 Pa. Code 211.12 (c)(d)(4)(5) Nursing services

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on observations and resident and staff interviews, it was determined that the facility failed to provide housekeeping and maintenance services to maintain a clean and orderly environment in two of the two nursing halls (Nursing Units 2 and 3). Findings include: An observation on July 23, 2024, at 10:46 AM, in resident room [ROOM NUMBER] revealed an unlabeled clear urine collection graduate hanging on an the grab assist bar adjacent to the toilet. A call bell cord was wrapped around the grab assist bar, was coated with black and brown discoloration stains. An observation on July 23, 2024, at 11:01 AM, revealed a foul urine smell outside of resident room [ROOM NUMBER]. An observation on July 23, 2024, at 11:18 AM, in resident room [ROOM NUMBER] revealed a foul urine smell. An observation on July 23, 2024, at 11:23 AM, in resident room [ROOM NUMBER] revealed that the window blinds that do not close and missing slats. An observation on July 23, 2024, at 12:29 PM, in resident room [ROOM NUMBER] revealed tan privacy curtains with brown stains at waist and head level on the window side of the room and white privacy curtains with a brown stain at head level on the door side of the room. An observation on July 24, 2024, at 11:30 AM, in the first-floor resident spiritual area revealed dead insects, stains, dirt, and debris on the window sill. [NAME] discoloration stains were observed on the floor. Dried liquid stains were extending down the wall from the ceiling. [NAME] discolorations and a buildup of dirt was observed along the bottom molding. A red cushion of chair was discolored with stains and white debris. An observation on July 24, 2024, at 11:35 AM, in the first-floor dining and activity area revealed buildup of dust and debris on the blades of the fans in the room. The room air conditioner filter was coated with a thick buildup of gray dust. The air conditioner's accordion window fins were covered with a buildup of dirt, debris, and dead insects. An observation July 24, 2024 at 12 P. M. of the third floor pantry floor revealed several of the floor tiles were lifting up from the floor creating an uneven surface. Multiple tiles were observed lifting up from the floor across the entire third floor resident hallway. A strong odor of urine and feces was present in the third floor shower. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The third floor resident dining/activity room floor was sticky and littered with dirt, food and paper debris. The floor baseboards around the perimeter of the room were dirty with liquid and food stains. The wall and floor under the wall mounted television was stained with dried liquid stains extending from the bottom of the television to the floor. The filters of the two air-conditioners were dirty and coated with lint. had The window sills in the room were covered with dirt and liquid stains. During an interview on July 24, 2024, at 9:05 AM, Employee 7, Director of Maintenance stated that the floors are cleaned regularly to eliminate the urine smell in resident rooms and hallways. Employee 7 explained that residents refuse care and urinate on the floor, leading to a continual smell of urine. Employee 7 stated that the urine seeped into some of the floor tiles and requires replacement or deep cleaning in order to eliminate the odor. An observation on July 26, 2024, at 10:30 AM, revealed a strong urine smell permeating the length of the 2nd floor resident hallway. The odor was foul-smelling and present outside of multiple resident rooms and near the nursing station. A clinical record review revealed Resident 20 was admitted to the facility on [DATE]. A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 22, 2024 revealed that Resident 20 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). During an interview on July 25, 2024, at 10:45 AM, Resident 20 stated that she has made numerous complaints to nursing staff and administration regarding the offensive odors and smells outside some resident rooms. She stated that it is a strong unpleasant urine smell and described it as horrible. Resident 20 stated that she feels it is against her rights to have to live in an environment with such awful odors. During an interview on July 26, 2024, at approximately 9:30 AM, the Nursing Home Administrator (NHA) confirmed that the facility is to be maintained in a manner that supports the resident's right to a clean and orderly environment. 28 Pa. Code 201.18 (e)(1)(2.1) Management 28 Pa. Code 201.29 (a) Resident Rights

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records, select facility policy and investigative reports, and staff and resident interviews, it was determined that the facility failed to ensure that one resident out of 25 sampled (Resident 29) was free from physical abuse, perpetrated by another resident, (Resident 2) which resulted in physical injury, a concussion, to the resident victim. Findings include: The facility's Abuse Prevention Policy and Procedure Manual dated as reviewed last by the facility on June 3, 2024, indicated it is the facility policy that abuse, neglect, and/or mistreatment of residents will not be tolerated in any manner. The purpose of the policy indicated all necessary steps shall be taken to ensure the provision of a safe and secure environment. The policy defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. Examples of physical abuse identified in the facility policy include complaints of physical mistreatment. Residents must not be subject to abuse by anyone, including but not limited to, facility staff, other residents, or other individuals. A clinical record review revealed that Resident 29 was admitted to the facility on [DATE], with diagnoses of severe morbid obesity (abnormal or excessive fat accumulation that presents a health risk) and major depressive disorder (a mental health disorder characterized by a persistently low or depressed mood, decreased interest in pleasurable activities, feelings of worthlessness, lack of energy, poor concentration, appetite changes, sleep disturbances, or suicidal thoughts). A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 10, 2024 revealed that Resident 29 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). A clinical record review revealed Resident 2 was admitted to the facility on [DATE], with diagnoses of chronic respiratory failure (a condition where the respiratory system is unable to remove carbon dioxide from or provide oxygen to the body) and hemiplegia (paralysis on one side of the body). A review of an annual MDS assessment dated [DATE], revealed that Resident 2 is cognitively intact with a BIMS score of 15. Resident 2's care plan revealed that the resident has alterations in her behavior manifested by physical abuse, verbal abuse, and socially inappropriate behavior related to mood affective disorder and adjustment disorder initiated on August 10, 2022. An incident report dated July 20, 2024, indicated Resident 29 reported to staff that Resident 2 pushed a bedside table, striking Resident 29 in the head. Resident 29 reported that she had her head down at the time near the table. The incident report indicated that Resident 29 was assessed with no visible redness, no edema, and no hematoma, but Resident 29 stated {her head} hurts. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A nursing progress note dated July 20, 2024, at 1:53 PM indicated that Resident 2 was involved in an altercation with her roommate. No injuries were reported, and residents should remain separated to avoid further altercations. A progress note dated July 21, 2024, at 6:32 PM revealed that Resident 29 complained of pressure and headache pain. Resident 29 stated that the pain was rated as 9 out of 10 (on a scale of 1-10, with one being the least severe and 10 being the worst). She also stated that she has vertigo and blurred vision. The resident requested to be sent to the emergency department for an evaluation. The entry indicated that the physician wrote an order to send Resident 29 to the emergency department for evaluation and treatment related to headache and vertigo. The hospital after visit summary dated July 21, 2024, indicated that Resident 29 was diagnosed with a concussion without loss of consciousness. The document indicated that Resident 29 should follow up with a primary physician in one to two days and should follow up with an outpatient concussion clinic and schedule a CT head scan without contrast. During her stay, she received acetaminophen 1,000 mg (Tylenol- a pain medication), ketorolac injection 30 mg (Toradol- a nonsteroidal anti-inflammatory pain medication), and oxycodone-acetaminophen 5.0 mg-325 mg (Percocet- an opioid pain medication). A progress note dated July 22, 2024, at 10:46 AM indicated that Resident 29 returned from the emergency department without complaints of dizziness, weakness, or lightheadedness during transfer. The entry noted that the emergency department recommended follow-up with a community provider for an outpatient CT scan without contrast. A physician note dated July 22, 2024, at 3:19 PM indicates that the resident returned from the emergency department this morning with a diagnosis of a concussion. A follow-up appointment for a CT scan of the head was ordered. The note indicated that the resident complained of a 5 out of 10 pain level. During an interview on July 23, 2024, at 11:15 AM, Resident 2 denied being involved in any incident with Resident 29. She explained that Resident 29's room was changed a few days ago. During an interview on July 23, 2024, at 12:15 PM, Resident 29 stated that a few days ago she had an altercation with her roommate, Resident 2. Resident 29 stated that she was bending down near Resident 2's bed when Resident 2 deliberately pushed her bedside table into Resident 29, striking her head. Resident 29 stated that it hurt, and she was very angry and upset about the situation. She explained that she agreed to a room change following the incident. Resident 29 stated that she went to the hospital for an evaluation and she was diagnosed with a concussion based on her symptoms. She stated that she still has a headache. A review of Resident 29's Medication Administration Record for July 2024 revealed the following resident reported levels of headache pain from July 20, 2024, through July 24, 2024: July 20, 2024, at 1:40 PM: a pain level of 4/10 July 21, 2024, at 4:04 PM: a pain level of 4/10 July 22, 2024, at 5:10 PM: a pain level of 3/10 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	July 24, 2024, at 12:51 PM: a pain level of 3/10 July 24, 2024, at 6:51 PM: a pain level of 3/10 During an interview on July 25, 2024, at approximately 12:45 PM, Employee 12, Registered Nurse Unit Manager (RNM), stated that she investigated the incident between Resident 2 and 29 on July 20, 2024. She explained that both residents were assessed without injury. Employee 12, RNM, stated that Resident 29 agreed to a room change. Employee 12, stated that she contacted the police and wrote an incident report but did not obtain witness statements from residents or staff. Employee 12, also stated that neurological checks were initiated for Resident 29, and on July 21, 2024, Resident 29 was sent to the hospital with complaints of a headache and vertigo. Employee 12, stated that Resident 29 returned to the facility on [DATE], and had a diagnosis of a concussion. During an interview on July 26, 2024, at approximately 9:30 AM, the Nursing Home Administrator (NHA) confirmed that Resident 29 was sent to the hospital on July 21, 2024, and was diagnosed with a concussion after being struck in the head with the overbed table by her roommate, Resident 2. The NHA confirmed that it is the facility's responsibility to ensure residents are not subjected to abuse by anyone, including other residents. Refer F609, F610 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a) Resident Rights

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records, the facility's abuse prohibition policy, and facility investigation reports, and staff interviews, it was determined the facility failed to timely and accurately report allegations of resident abuse for one resident out of 25 sampled (Resident 29) perpetrated by another resident (Resident 2) to the State Survey Agency. Findings include: A facility policy titled Abuse Prevention Policy and Procedure Manual, reviewed last by the facility on June 3, 2024, indicated it is the facility policy that abuse, neglect, and/or mistreatment of residents will not be tolerated in any manner. The purpose of the policy indicated all necessary steps shall be taken to ensure the provision of a safe and secure environment. The policy indicates that all allegations of abuse will be reported to all local and state agencies within the required time frames as mandated by the Department of Health and Act 13. For allegations of physical abuse, notify the state regional licensing agency (DOH) of any allegation of abuse utilizing the electronic event reporting system within 24 hours. If an alleged perpetrator is identified, a PB-22 form will be submitted via the electronic reporting system within five working days of the reported allegation. Review of the clinical record revealed that Resident 29 was admitted to the facility on [DATE], with diagnoses of severe morbid obesity (abnormal or excessive fat accumulation that presents a health risk) and major depressive disorder (a mental health disorder characterized by a persistently low or depressed mood, decreased interest in pleasurable activities, feelings of worthlessness, lack of energy, poor concentration, appetite changes, sleep disturbances, or suicidal thoughts). A quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 10, 2024 revealed that Resident 29 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). A clinical record review revealed Resident 2 was admitted to the facility on [DATE], with diagnoses of chronic respiratory failure (a condition where the respiratory system is unable to remove carbon dioxide from or provide oxygen to the body) and hemiplegia (paralysis on one side of the body). The resident's annual MDS assessment dated [DATE], revealed that Resident 2 is cognitively intact with a BIMS score of 15 (a score of 13-15 indicates cognition is intact). An incident report dated July 20, 2024, indicated Resident 29 reported Resident 2 pushed a bedside table, striking Resident 29 in the head. Resident 29 reported that she had her head down at the time near the table. The incident report indicated that Resident 29 was assessed with no visible redness, no edema, and no hematoma. The incident report indicates that Resident 29 states {her head} hurts. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	However, a progress note dated July 21, 2024, at 6:32 PM revealed that Resident 29 complained of pressure and headache pain. Resident 29 indicated that the pain is 9 out of 10. She also indicated that she has vertigo and blurred vision. The resident requested to be sent to the emergency department for an evaluation. The entry indicated that the physician wrote an order to send Resident 29 to the emergency department for evaluation and treatment related to headache and vertigo. The hospital after visit summary dated July 21, 2024, indicated that Resident 29 was diagnosed with a concussion without loss of consciousness. The document indicated Resident 29 should follow up with a primary physician in one to two days and should follow up with an outpatient concussion clinic and schedule a CT head scan without contrast. A physician note dated July 22, 2024, at 3:19 PM indicated that the resident returned from the emergency department this morning with a diagnosis of a concussion. A follow-up appointment for a CT scan of the head was ordered. The note indicated that the resident complained of a 5 out of 10 pain level. During an interview on July 25, 2024, at approximately 12:45 PM, Employee 12, Registered Nurse Unit Manager (RNM), stated that she investigated the incident between Resident 2 and 29, on July 20, 2024. She explained that both residents were assessed without injury. Employee 12, stated that she contacted the police and wrote an incident report but did not obtain witness statements from residents or staff. Employee 12, stated that the Nursing Home Administrator (NHA) and Director of Nursing (DON) were informed about the incident. Employee 12, stated that on July 21, 2024, Resident 29 was sent to the hospital with complaints of a headache and vertigo. Employee 12, stated that Resident 29 returned to the facility on [DATE], and had a diagnosis of concussion. Employee 12, confirmed that she did not complete a PB-22 (State Survey Agency Format for abuse investigations) or report any updated findings regarding Resident 29's transfer to the hospital or diagnoses of a concussion to any local or state agencies which was confirmed during interview with the NHA on July 26, 2024, at approximately 9:30 AM, the Nursing Home Administrator (NHA). Refer F600, Refer F610 28 Pa. Code 201.14 (c) Responsibility of licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a) Resident Rights

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records, select facility incident reports, and select facility policies, and resident and staff interviews, it was determined that the facility failed to thoroughly investigate allegations of physical abuse of one of 25 residents sampled (Resident 29). Findings include: A facility policy titled Abuse Prevention Policy and Procedure Manual, reviewed last by the facility on June 3, 2024, indicated it is the facility policy that abuse, neglect, and/or mistreatment of residents will not be tolerated in any manner. The purpose of the policy indicated all necessary steps shall be taken to ensure the provision of a safe and secure environment. The policy indicates that all allegations of abuse will be investigated thoroughly and will commence immediately upon receipt of the allegation. Investigations will be initiated immediately by the supervisor on duty. Staff, family members, visitors, and cognitively intact residents that may have observed events at the time of the allegation will be interviewed in regard to what was witnessed and knowledge of the incident. The policy indicates that signed statements will be obtained. A clinical record review revealed that Resident 29 was admitted to the facility on [DATE], with diagnoses of severe morbid obesity (abnormal or excessive fat accumulation that presents a health risk) and major depressive disorder (a mental health disorder characterized by a persistently low or depressed mood, decreased interest in pleasurable activities, feelings of worthlessness, lack of energy, poor concentration, appetite changes, sleep disturbances, or suicidal thoughts). A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 10, 2024 revealed that Resident 29 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). A clinical record review revealed Resident 2 was admitted to the facility on [DATE], with diagnoses of chronic respiratory failure (a condition where the respiratory system is unable to remove carbon dioxide from or provide oxygen to the body) and hemiplegia (paralysis on one side of the body). A review of an annual MDS assessment dated [DATE], revealed that Resident 2 is cognitively intact with a BIMS score of 15 A facility incident report dated July 20, 2024, indicated Resident 29 reported Resident 2 pushed a bedside table, striking Resident 29 in the head. Resident 29 reported that she had her head down at the time near the table. The incident report indicates that Resident 29 was assessed with no visible redness, no edema, and no hematoma. The incident report indicates that Resident 29 states {her head} hurts. A physician note dated July 22, 2024, at 3:19 PM indicates Resident 29 returned from the emergency department this morning with a diagnosis of a concussion. A follow-up appointment for a CT scan of the head was ordered. The note indicated that the resident complained of a 5 out of 10 pain level. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on July 23, 2024, at 12:15 PM, Resident 29 explained that a few days ago she had an altercation with her roommate, Resident 2. Resident 29 stated that she was bending down near Resident 2's bed when Resident 2 deliberately pushed her bedside table into Resident 29, striking her head. Resident 29 indicated that it hurt, and she was very angry and upset about the situation. She stated that she went to the hospital on July 21, 2024, for an evaluation following the incident, and she was diagnosed with a concussion based on her symptoms and stated that she still has a headache. During an interview on July 25, 2024, at approximately 12:45 PM, Employee 12, Registered Nurse Unit Manager (RNM), stated that she investigated the incident between Resident 2 and 29 on July 20, 2024. Employee 12, RNM, contacted the police and wrote an incident report but did not obtain any witness statements from residents or staff as per facility policy. Employee 12, stated that the Nursing Home Administrator (NHA) and Director of Nursing (DON) were informed about the incident. During an interview on July 26, 2024, at approximately 9:30 AM, the Nursing Home Administrator (NHA) was not able to provide evidence that the facility conducted a thorough investigation in Resident 29's report of physical abuse perpetrated by Resident 2 and that the facility's abuse prohibition policy for investigating abuse was not implemented as statements were not obtained from all potential witnesses. Refer F600, Refer F609 28 Pa. Code 201.14 (c) Responsibility of licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29 (a) Resident Rights

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on a review of clinical records, select facility incident reports, and staff interview, it was determined that the facility failed to provide adequate supervision to prevent an avoidable fall during transport of one out of six residents sampled (Resident 148). Findings include: Clinical record review revealed that Resident 148 was admitted to the facility on [DATE], with diagnoses which osteomyelitis (infection of the bone)of the left ankle and foot and anxiety. An admission progress note dated July 15, 2024, indicated the resident was alert and oriented to time, place, and person. An admission nursing assessment dated [DATE], indicated the resident was independently mobile in a wheelchair. A nurses note dated July 22, 2024, at 11:48 AM revealed that the resident's wheelchair flipped backwards while the resident was getting into the transport van for an appointment and the resident fell on his back onto the floor of the transport van and hit his head off the floor of the transport van. Employee 5 (nurse aide) who was escorting the resident to his appointment, witnessed the resident's fall. It was noted that the resident was alert and oriented times four (person, place, time, and event) and did not lose consciousness. Resident 148 complained of pain, 10/10 head, neck, and back pain and requested to go to the emergency room . CRNP (certified registered nurse practitioner) was made aware and a new order was noted for the resident's transfer to emergency room for further evaluation and treatment. A nurses note dated July 22, 2024, at 4:53 PM indicated that the resident returned from the emergency room via wheelchair. No new skin issues were noted, and the resident denied any pain or discomfort. The entry also indicated that the resident was mad at what happened today (the fall from wheelchair). Review of a facility incident report dated July 22, 2024, regarding the incident revealed a witness statement from Employee 6 (van driver), which indicated that the resident tried backing his wheelchair into the van by himself before the van driver could get in the van and help the resident, and the resident fell backward. All safety features were noted to be in place and equipment was functioning properly. Employee 6's statement noted that I told the resident to wait and I would help you but the resident proceeded to do it himself. Review of Employee 5 (nurse aide)'s witness statement noted that she was standing next to the (chair) lift and employee 6 (van driver) was not in the van when the resident started moving back. Following the incident anti-tippers were added to Resident 148's wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on July 24, 2024, at 12:50 PM Employee 5 (nurse aide) stated that Employee 6 (van driver) put the resident the on the wheelchair lift and put the lift up and Employee 5 was standing on the ground next to the lift. Employee 6 left to go around to get in the back of the van but the resident decided to wheel himself and flipped backwards into the van and hit his head off the floor. Employee 5 stated that the wheels on the wheelchair were locked but the resident unlocked them and wheeled backwards and fell . During interview on July 24, 2024, at 1:15 PM Employee 6 (van driver) stated that the resident was backed onto the van chairlift platform. Employee 6 told the resident he was going around the back of the van to let the resident in. Employee 6 stated the resident unlocked his wheelchair brakes and backed in himself, and as he was backing up hit a lip where the lift attaches to the van and flipped backwards. The resident did not fall out of the wheelchair but did hit his head. During a re-enactment of the incident on July 25, 2024, at 1:00 PM with Employee 6 (van driver) and the administrator, the facility concluded that following the incident the employee assisting the van driver with future residents' appointments will now stand in the van (instead of outside on the pavement next to the lift) and be present to supervise and intervene if needed to prevent a future occurrence of a resident attempting to push themselves backwards or moving backwards into the van before the van driver can enter the van to ensure the safety of residents. Interview with the administrator on July 25, 2024, at 1:30 PM failed to provide documented evidence that the facility provided adequate supervision to prevent this avoidable fall and ensure Resident 148's safety during transport to an appointment. 28 Pa. Code 211.12 (d)(3)(5) Nursing Services

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on review of clinical records, and staff interviews, it was determined that the facility failed to implement individualized interventions to address a resident's decline in bowel continence in an effort to restore normal bowel function to the extent possible for one resident out of three sampled (Resident 1). Findings include: Review of Resident 1's clinical record admission to the facility on [DATE], with diagnoses that included Parkinson's disease (a long-term neurodegenerative disease of mainly the chronic obstructive pulmonary disease (COPD), multiple sclerosis, chronic respiratory failure, and hypertension. The resident's Quarterly Minimum Data Set Assessments (MDS - a federally mandated standardized assessment completed at specific intervals to define resident care needs) dated December 11, 2023, and Annual MDS dated [DATE], Section H Bladder and Bowel, both indicated that the was always continent of bowels. A physician order was noted March 27, 2023, to check and change every (Q) 2 hours bladder incontinence care. Resident 1's Quarterly MDSs dated May 1, 2024, Section H Bladder and Bowel, noted that the resident was now frequently incontinent of bowels (a decline in bowel function). The resident's plan of care for bladder incontinence, date-initiated April 3, 2023, revealed planned measures included to establish voiding patterns, check as required for incontinence, date-initiated April 3, 2023, but plan of care was identified for bowel the resident's decline incontinence. A review of facility provided document entitled Nationwide Bowel and Bladder Continence Screen dated April 30, 2024, indicated the resident is not continent of stools, needs occasional laxative of enema, and that her diet is a contributing factor of fecal incontinence. A review of a health status note dated April 30, 2024, at 7:02 AM indicated that the resident's bowel/bladder was reviewed and the resident is always incontinent of bowel and bladder. Incontinent program in place. The Director of Nursing (DON) stated during interview on July 25, 2024, that the only incontinent program the resident was receiving was the check and change every (Q) 2 hours bladder incontinence care and no measures had been attempted to address Resident 1's decline in bowel function. 28 Pa. Code 211.12 (d)(5) Nursing services 28 Pa. Code 211.10 (a)(d) Resident care policies

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on a review of clinical records and select facility policies, and staff interviews it was determined that the facility failed to demonstrate that staff were competent and trained, in accordance with the professional standards of the State nursing practice act, to administer IV treatments for one resident out of 25 residents sampled receiving intravenous therapy (Resident 148). Findings include: According to the Commonwealth of Pennsylvania, Pennsylvania Code, Title 49, Professional and Vocational Standards, Department of State, Chapter 21, State Board of Nursing, Subchapter B. Practical Nurses; 21. 145, Functions of the LPN (Licensed Practical Nurse) a. The LPN is prepared to function as a member of the health-care team by exercising sound nursing judgement based on preparation, knowledge, skills, understandings and past experiences in nursing situations. The LPN participates in the planning, implementation and evaluation of nursing care in settings where nursing takes place. Section f (3) The LPN complies with written policies and procedures which are established by a committee of nurses, physicians, pharmacists and the administration of the agency or institution employing or having jurisdiction over the LPN and which sets forth standards, requirements and guidelines for the performance and venipuncture by the LPN and for the administration and withdrawal of intravenous fluids by the LPN. A current copy of the policies and procedures shall be provided to the LPN at least once every 12 months. The policies and procedures shall include standards, requirements, and guidelines which: List, identify and describe the intravenous fluids which may be administered by the LPN. Provide for and require inservice instruction and supervised practice to insure competent performance of venipuncture and competent administration and withdrawal of intravenous fluids. Review of the facility Intravenous: Peripheral IV and Midline Dressing Changes last reviewed June 2024 indicated that dressing changes will be done to prevent catheter-related infections associated with contaminated, loosened, or soiled catheter-site dressings. Review of the facility Intravenous Administration of Fluids and Electrolytes last reviewed June 2024 indicated that the licensed nurse responsible for administering fluids and electrolytes shall be knowledgeable of indications for use, appropriate doses and diluents (diluting agent), side effects, toxicities, incompatibilities, stability, storage requirements, and potential complications. The policies failed to indicate to verify scope of practice and competency requirements with State Nurse Practice Act and RN/LPN scope of practice and functions. The policies failed to list, identify and describe the intravenous fluids which may be administered by the LPN, provide for and require inservice instruction and supervised practice to insure competent performance of venipuncture and competent administration and withdrawal of intravenous fluids as required by Pennsylvania Code state nursing act listed above. A review of the clinical record revealed that Resident 148 was admitted to the facility on [DATE], with diagnoses which osteomyelitis (infection of the bone) of the left ankle and foot and anxiety. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician order dated July 15, 2024, noted an order to monitor right subclavian CVC tunnel catheter [long thin tube that is placed under the skin into a vein (insertion site) and then tunneled and brought out the chest allowing long-term access to the larger veins near the heart and is used for long-term intravenous antibiotics, nutrition, or medication, and for blood draws] every shift. A physician order dated July 15, 2024, noted an order for Daptomycin (an antibiotic) 750 mg intravenously once daily for osteomyelitis for 23 days. Normal saline flush intravenous solution 0.9% 10 ml intravenously before and after intravenous antibiotic administration. A review of Resident 148's July 15 through July 20, 2024, Treatment Administration Record revealed that on July 19, 2024, there was no indication the resident's catheter site was monitored as per physician order. On July 20, 2024, employee 14 (LPN) signed off on the day shift that the resident's tunnel catheter was intact. A review of Resident 148's July Medication Administration Record revealed that on July 18, 2024, at 9:00 AM the resident's Daptomycin 750 mg intravenously was administered by employee 15 (LPN). Review of a nursing note dated July 20, 2024, by a registered nurse noted that the resident's right subclavian CVC tunnel flushed, noting fluid into dressing around site, flush stopped immediately, dressing reinforced, no bleeding, or other issues noted, no redness at site, MD aware. Call placed to hospital IR (interventional radiology), requesting for right subclavian CVC tunnel insertion change, awaiting return call. A nursing note dated July 20, 2024, at 11:43 AM noted hospital IR physician returned call and stated that unable to change or do anything until Monday July 22, 2024. An order to put in a peripheral line until able to change out and the subclavian line will be fine to stay in until change. Resident updated and does not want any staff to put peripheral line in, requests emergency room evaluation. Physician made aware. Resident sent to emergency room . Review of emergency room paperwork dated July 20, 2024, indicated that the resident stated that the staff at the facility were attempting to redress his PICC line noted to his right chest wall. While doing so the resident stated that the staff used scissors to help remove the dressing and they nicked the catheter causing it to leak. The nurse at the emergency room did undress the catheter site and did note a small linear laceration to the catheter causing the catheter to leak at that site. A nurses note dated July 20, 2024, at 3:56 PM noted a call from the emergency room that the resident to return to facility today and had a peripheral line (PICC) placed and is to be used until seen by hospital IR on Monday (July 22, 2024). The emergency room did administer the IV antibiotic dose for July 20, 2024. A nurses note dated July 20, 2024, at 4:59 PM noted the resident returned to the facility with right antecubital (area between arm and forearm) peripheral line noted. Interview with the administrator on July 24, 2024, at approximately 2:15 PM failed to provide documented evidence that the facility initiated an investigation into Resident 148's allegation that his subclavian CVC tunnel catheter was nicked by nursing staff to determine if staff were trained and competent to perform care to this line. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence provided at the time of the survey ending July 26, 2024, of any staff education, including yearly education and competency evaluation regarding intravenous administration of medications through CVC or PICC lines or intravenous lines for LPNs in the facility. During an interview on July 25, 2024, at approximately 9:00 AM the director of nursing (DON) confirmed that LPNs in the facility should not be administering medications through intravenous lines, including PICC or CVC lines. The DON further confirmed that there was no documented evidence of educational programs provided to LPNs in the facility as required by the State nursing practice act. Refer to F865 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services 28 Pa. Code 201.20(a)(d) Staff development

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on clinical record review and staff interview it was determined that the facility failed to ensure that one of 25 residents was seen timely by a physician (Resident 45). Findings include: A review of Resident 45's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included bipolar disorder and dementia. A review of the resident's clinical record physician documentation dated between November 28, 2023, through May 23, 2024 revealed no documented physician's visits and progress notes. There was no documented evidence that the resident's attending Physician visited Resident 45 once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. Interview with the Director of Nursing on July 26, 2024 at 11 A.M. confirmed that the resident's physician did not visit the resident at the regulatory required frequency. 28 Pa. Code 211.2 (d)(3)(8) Medical director

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on clinical record review and staff interviews, it was determined that the facility failed to attempt gradual dose reductions of psychoactive medication for one resident out of five reviewed (Resident 45). Findings included: A review of Resident 45's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included bipolar disorder and dementia. The resident's current physician's orders, initially dated October 10, 2023, included Quetiapine (Seroquel, an antipsychotic medication) 25 mg, one by mouth at bedtime for mania and bipolar disorder. A review of the resident's clinical record conducted during the survey ending July 26, 2024, revealed no documented evidence that a gradual dose reduction of the resident's initially prescribed dose of Seroquel had been attempted to date. Review of the resident's clinical record during the survey ending July 26, 2024, revealed no physician documentation of resident specific information which detailed why a dose reduction attempt of the psychoactive drug was clinically contraindicated and of the resident's continued need for the medication at the current dosage. During an interview with the Director of Nursing on July 26, 2024, at 10 a.m. she confirmed that no attempts at gradually reducing the dose of the above psychoactive medication had been made and the physician documentation failed to include resident specific details in support of not attempting a GDR 28 Pa. Code 211.9 (k) Pharmacy services 28 Pa. Code 211.5 (f) Medical records 28 Pa. Code 211.2 (c) Medical director

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on observation, a review of resident council meeting minutes, and the facility's planned menus, and resident and staff interviews, it was determined that the facility failed to provide preferred foods and beverages as planned for five residents out of five interviewed during a group meeting (Residents 1, 26, 27, 83, and 89) and failed to accommodate individual food and beverage preferences, to the extent practicable for one resident out of 25 sampled (Residents 50). Findings include: A review of resident council meeting minutes dated March 19, 2024, revealed that residents in attendance raised concerns regarding receiving the wrong food and beverages on meal trays and lack of available sweeteners. A review of resident council meeting minutes dated June 18, 2024, revealed that residents in attendance at that meeting voiced concerns regarding meals served not matching the planned menu. A resident in attendance stated that on weekends no one is monitoring what is served to residents, and the kitchen throws whatever they want on the plates. During an observation of the lunch meal on July 23, 2024, at 12:00 PM, Resident 50, a cognitively intact resident, stated that she dislikes the food served and often has cold cereal and milk instead of the planned meal. Resident 50 stated that the facility has not had orange juice for a month now and that orange juice is one of the only things she drinks besides water and milk with her cereal. Resident 50 stated that she does like bananas but that she has not been receiving them. Resident 50 stated the facility is also out of ketchup. Resident 50 stated that she likes hamburgers and mashed potatoes but hardly ever receives them. A clinical record review revealed that Resident 1 was admitted to the facility on [DATE]. A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 23, 2024 revealed that Resident 1 is cognitively intact with a BIMS score of 12 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). A clinical record review revealed Resident 26 was admitted to the facility on [DATE]. A review of a quarterly MDS assessment dated [DATE], revealed that Resident 26 is cognitively intact with a BIMS score of 15. A clinical record review revealed Resident 27 was admitted to the facility on [DATE]. A review of a quarterly MDS assessment dated [DATE], revealed that Resident 27 is cognitively intact with a BIMS score of 15. A clinical record review revealed Resident 83 was admitted to the facility on [DATE]. A review of a quarterly MDS assessment dated [DATE], revealed that Resident 83 is cognitively intact with a BIMS score of 15. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A clinical record review revealed Resident 89 was admitted to the facility on [DATE]. A review of a quarterly MDS assessment dated [DATE], revealed that Resident 89 is cognitively intact with a BIMS score of 15. During a resident group interview on July 24, 2024, at 10:00 AM, five residents out of the five (Residents 1, 26, 27, 83, and 89) in attendance stated that the facility consistently fails to serve food as planned on the menus. Resident 1 stated that she is frustrated because the facility continuously runs out of salad dressing, sugar packets, salt, and orange juice. Resident 26 explained that she has voiced her displeasure with the meals to the facility many times regarding the facility running out of food items like hamburgers and condiments such as salad dressings and sugar packets, but nothing has been done to resolve the issue to date She stated that this problem continues to occur. Resident 27 stated that he is upset that the facility has not had orange juice for a while now. He stated that he prefers orange juice, but the facility has been serving apple juice instead. Resident 83 stated that the facility ran out of lettuce recently. She stated that she is a vegetarian and orders a salad every night for dinner. Resident 83 stated that she was frustrated that the facility did not have her preferred meal items available. She explained that she ordered a pizza from the community because she did not want the peanut butter and jelly sandwich that the facility served to her. During the group interview, Resident 89 stated that she has concerns with her meals when the facility runs out of condiments like sugar and salt. An interview with the foodservice director (FSD) on July 24, 2024, at approximately 1:00 PM confirmed that orange juice was out-of-stock through the facility's food supplier. The FSD also confirmed that the facility was currently out of ketchup. The FSD stated that bananas were no longer being ordered because they could only be ordered by the case, and there were only a few residents who requested bananas. The FSD confirmed that hamburgers were available as an alternate but was unable to explain how residents were made aware of the food alternates available to them. A review of the facility menu substitution list revealed that food items such as orange juice and ketchup were not available. Interview with the food service director (FSD) on July 25, 2024, at 11:40 AM confirmed that the facility was to serve food consistent with residents' food and beverage preferences to the extent possible. The FSD confirmed that commonly consumed items such as orange juice, ketchup, bananas, and lettuce should be obtained locally when not available for delivered from the facility's bulk food supplier. The FSD confirmed that residents should be made aware when menu changes are necessary to afford residents the opportunity to make alternate menu selects that honor the residents' preferences. 28 Pa. Code 211.6(a) Dietary services 28 Pa. Code 201.29 (a) Resident rights 28 Pa. Code 201.18 (e)(1)(2)(4) Management

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of scheduled facility mealtimes and select facility policy, and resident and staff interviews, it was determined that the facility failed to consistently provide snacks as desired by residents including four out of the 25 residents sampled (Residents 2, 20, 29, and 84) and experiences reported by residents during a group interview (Residents 1, 26, 27, 83, and 89). Findings include: A review of the facility's policy titled Nourishment: Serving Between Meals and Bedtime Snacks, last reviewed on June 3, 2024, indicated that it is the facility policy to serve residents with extra nourishment to provide energy. A review of the facility's scheduled mealtimes revealed that the time between dinner and breakfast the next day exceeds 14 hours. A clinical record review revealed that Resident 29 was admitted to the facility on [DATE]. A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 10, 2024 revealed that Resident 29 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). A clinical record review revealed Resident 2 was admitted to the facility on [DATE]. A review of an annual MDS assessment dated [DATE], revealed that Resident 2 is cognitively intact with a BIMS score of 15. A clinical record review revealed Resident 20 was admitted to the facility on [DATE]. A review of a quarterly MDS assessment dated [DATE], revealed that Resident 20 is cognitively intact with a BIMS score of 15. A clinical record review revealed Resident 84 was admitted to the facility on [DATE]. A review of an admission MDS assessment dated [DATE], revealed that Resident 84 is cognitively intact with a BIMS score of 15. A clinical record review revealed Resident 1 was admitted to the facility on [DATE]. A review of a quarterly MDS assessment dated [DATE], revealed that Resident 1 is cognitively intact with a BIMS score of 12. A clinical record review revealed Resident 26 was admitted to the facility on [DATE]. A review of a quarterly MDS assessment dated [DATE], revealed that Resident 26 is cognitively intact with a BIMS score of 15. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A clinical record review revealed Resident 27 was admitted to the facility on [DATE]. A review of a quarterly MDS assessment dated [DATE], revealed that Resident 27 is cognitively intact with a BIMS score of 15. A clinical record review revealed Resident 89 was admitted to the facility on [DATE]. A review of a quarterly MDS assessment dated [DATE], revealed that Resident 89 is cognitively intact with a BIMS score of 15. A clinical record review revealed Resident 83 was admitted to the facility on [DATE]. A review of a quarterly MDS assessment dated [DATE], revealed that Resident 83 is cognitively intact with a BIMS score of 15. During an interview on July 23, 2024, at 11:15 AM, Resident 2 stated that a lot of times she is not offered a snack between dinner and breakfast the next day. She stated that about twice a week the facility runs out of snacks. Resident 2 stated that the nursing staff will tell her that snacks are not available. During an interview on July 23, 2024, at 11:50 AM, Resident 84 stated that often the facility runs out of snacks. He stated that he brings the issue up with the nursing staff, but nothing seems to get done to resolve his concern. During an interview on July 23, 2024, at 12:15 PM, Resident 29 stated that she rarely is offered an evening snack between dinner and breakfast the next day. During a resident group interview on July 24, 2024, at 10:00 AM, five of the five residents in attendance stated that they are not consistently offered a nourishing evening snack and sometimes run out of snacks (Residents 1, 26, 27, 83, and 89). Resident 89 stated that she is not always offered a snack between dinner and breakfast the next day. She stated that recently she asked a nurse aide for an evening snack, and the nurse aide went to get her one but never returned. Resident 26 stated that she started buying her own snacks so that if the facility runs out or doesn't offer her something to eat, then she still has something nourishing between meals. Resident 83 stated that she was hungry and asked for a snack two days ago, but she stated that the facility ran out of snacks and did not provide her anything to eat between dinner and breakfast the next day. During an interview on July 25, 2024, at 10:55 AM, Resident 20 stated the facility staff are inconsistent about offering an evening snack to residents. She explained that in the evening she is often out of her room and spends time in the activity area in her nursing hall. Resident 20 stated that when she is in the activity room, nursing staff never ask her if she wants a snack. During an interview on July 26, 2024, at approximately 10:30 AM, the Nursing Home Administrator (NHA) was unable to explain why residents are reporting that the facility is not offering nutritious snacks as desired. The NHA confirmed that it is the facility's policy to offer and serve residents a nourishing snack in accordance with their needs, preferences, and requests at bedtime on a daily basis. 28 Pa. Code 211.12 (d)(3)(5) Nursing Services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 21738 Based on observation and staff interview, it was determined that the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in the food and nutrition services department. Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). During the initial tour of the food and nutrition services department conducted with the facility's food service director (FSD) on January 23, 2024, at 9:15 AM, revealed the following unsanitary practices with the potential to introduce contaminants into food and increase the potential for food-borne illness: The floor area leading into the kitchen was patched with a concrete type substance and heavily soiled. There were 22 4-ounce thawed nutritional shakes on a tray in the walk-in cooler. The manufacturer instructions noted to consume within 14 days of thawing. The FSD confirmed that the shakes were to be labeled with a thaw date. There was an open 36-ounce container of Thick-it (a powdered food thickener) with 2 plastic scoops with the handles in the can in direct contact with the thickener. The manufacturer instructions noted to wash and sanitize the scoop after each use. The FSD confirmed the handles should not be in direct contact with the thickener and failed to provide evidence the scoops were washed and sanitized after each use. During an observation of the dishroom on July 26, 2024, at 9:45 AM revealed the floor area under the dishwasher and along the wall extending to the two-compartment sink was heavily soiled with dirt and grime and in need of cleaning. Interview with the FSD at this time confirmed that the food and nutrition services department was to be maintained in a sanitary manner. 28 Pa. Code 201.18(e)(2.1) Management

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on a review of clinical records and staff interview, it was determined the facility failed to ensure coordination of care and services between the facility and the Hospice Agency for one resident out of two sampled residents (Resident 58). Findings include: A review of Resident 58's clinical record revealed she was admitted to the facility on [DATE], with diagnoses to include dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and diabetes. A review of physician's order dated January 23, 2024, revealed the resident was admitted into hospice services for a diagnosis of atherosclerotic heart disease (plaque buildup in artery walls). A review of the resident's care plan initially dated June 11, 2020, and last revised March 15, 2024, revealed that the resident's care plan failed to reflect coordination of services between the facility and the Hospice agency in meeting the resident's daily care needs and specific needs related to care and services provided for the resident's terminal diagnosis. An interview with the director of nursing on July 26, 2024, at approximately 9:30 AM, confirmed the resident's care plan was not coordinated with hospice services. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services 28 Pa. Code 201.21(c) Use of outside resources

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on review of select facility policy and clinical records and resident and staff interviews, it was determined that the facility failed to demonstrate the implementation of ongoing QAPI programs, to include the use of systems for investigating and analyzing the root cause of adverse events as evidenced by two residents out of 25 sampled (Residents 32 and 148). Findings include: Review of the facility policy entitled Quality Assessment and Assurance {QA&A} Compliance, and Quality Assurance and Performance Improvement (QAPI) Plan last reviewed June 3, 2024, revealed, the purpose of the committee is to review and analyze facility related data, evaluate improvement plans effectiveness and direct appropriate actions for the facility response. It is the responsibility of the QA & A compliance committee to consider all data present by the improvement team(s) and to direct the teams(s) to continue, change or conclude the assignment. Negative findings are addressed through education, development of a Performance Improvement Plan (PIP), or other means. Systems failures and/or in-depth analysis of processes are addressed through development of a QAPI. QAPI requires a systematic review of data, identification of the root cause(s) of the systems failure, and implementation of corrective actions. Review of the clinical record revealed that Resident 32 was admitted to the facility on [DATE], with diagnoses to include chronic obstructive pulmonary disease (COPD), acquired absence of left and right leg below knee, diabetes, morbid (severe) obesity due to excess calories, and peripheral vascular disease (PVD). A quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated February 12, 2024, revealed that the resident was cognitively intact, with a BIMS score (Brief Interview for Mental Status - a tool to assess cognitive function) of 15. Resident 32's care plan, dated November 22, 2021, and revised on June 9, 2022, revealed that the resident has an activity of daily living (ADL) self-care performance deficit related to fatigue, right and left below the knee amputation (BKA) and, cardiac past medical history (PMH). Planned interventions were for the use of enablers to increase bed mobility safety and independence date-initiated July 25, 2023. The resident's are plan, dated March 7, 2024, revealed an actual impairment to his skin integrity, redness was noted on the back head. Planned interventions were to ensure safety with boosting, follow guidelines for boosting a resident date-initiated March 7, 2024. A review of a Health Status Note dated March 7, 2024, at 8:00 PM indicated that staff were boosting the resident in bed and the back of the resident's head was bumped off the headboard of his bed. The back of the resident's head was red, no lump noted, but the resident did complain of an instant headache and back of head hurting. Denied any nausea or vomiting and no blood noted. Resident is on blood thinner medicine. Vital signs 130/72, 72, respirations, 20, temperature. 98.1, pulse ox 93% on oxygen. Physician called and made aware, new order (N.O.) to transfer resident to hospital emergency room (ER) for medical evaluation. 911 called. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a Health Status Note dated March 7, 2024, at 8:35 PM noted that the ambulance was at the facility and, the resident is his own responsible party and agreeable to go to ER. A review of a Health Status Note dated March 8, 2024, at 12:05 AM noted that the resident returned to facility via stretcher and was assisted to bed with assist x 4 without incident. Vital signs as follows blood pressure 166/88, temperature 97.3, pulse 76, respirations 19, pulse ox 96% on O2 via nasal canula (nc) as ordered. Resident alert and denies pain or sob. Complains of (c/o) nausea with emesis x 1 noted. Per resident he began to feel nauseous in the ER and vomited x1 at hospital. States he believes it to be motion sickness do to (d/t) ambulance ride. Cares provided and head of bed (HOB) elevated. Call bell within reach. A review of facility provided incident report entitled other incident dated March 7, 2024, at 8:00 PM, indicating that the incident as described above. Included in the typed IR was a brief resident description which stated they bumped my head on the headboard when boosting me in bed. The immediate action taken indicated the nursing assessment, and hospital emergency room (ER) evaluation. Education on boosting by Physical Therapy (PT). Attached to the IR was an undated, unsigned, document entitled Nursing Inservice, boosting a resident, general considerations, and pulling a patient up in bed. However, at the time of the review on July 25, 2024, there was no indication as to when this education was started and or completed, who provided it, who attended the in-service (sign in sheet), and if a return demonstration was completed and if the participants had successfully completed the education in a safe manner Review of facility document entitled Weekly Wound Measurement dated March 7, 2024, indicating a bump measuring 2.0 centimeters (cm) (length) x 2.0 cm (width) x 0.0 cm (depth) was noted on the residents back of head. A review of facility provided hospital document entitled after visit summary dated March 7, 2024, indicated that the resident was seen in the emergency room for head trauma. Computerized Tomography (CT) of the head was taken and found to be within normal limits. Review of radiology report entitled CT head without (WO) contrast was performed on March 7, 2024, the impression was that there are minor involutional changes which are not out of proportion of age, there is nothing suggesting an acute infarct. No acute intracranial hemorrhage or mass effect. Review of facility provided witness statement dated March 7, 2024, from Employee 1 Nurse Aide (NA), revealed that when boosting resident with other aides and LPN, staff banged his head off headboard. LPN, and registered nurse (RN) made aware. Review of facility provided witness statement dated March 7, 2024, from Employee 2 Licensed Practical Nurse (LPN), indicated that the resident bumped his head on headboard of bed while getting a boost up in bed. This was the first time I had seen the resident. Review of facility provided witness statement dated March 7, 2024, from Employee 3 Nurse Aide (NA), indicated that due to the nurse aides being unable to boost the resident with two, three aides and a nurse boosted the resident and he hit his head on the headboard. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility provided witness statement dated March 7, 2024, from Employee 4 Nurse Aide (NA), indicated that the resident needed a boost. Myself and three other staff members boosted the resident in his bed and hit his head off the head board of the bed. Interview with the alert and oriented Resident 32 on July 24, 2024, at approximately 12:55 PM revealed that the resident stated that during the evening of March 7, 2024, he slid down while in bed, and that staff had assisted him in repositioning. The resident stated it was an accident, but he stated that there was not four staff members assisting him in the repositioning, but only two nurse aides. He further stated that after staff hit his head off the headboard of the bed, several additional staff members then entered the room. He stated that he immediately felt pain, causing a headache, and a raised area (bump) was felt on the back of his head. During an interview with the Director of Nursing (DON) on July 25, 2024, at approximately 10:05 AM, the DON confirmed there was no additional documentation regarding the incident or QAPI review of the resident's injury. She further confirmed that the facility had not obtained a witness statement from the alert and oriented Resident 32, other than the resident description on the typed IR and was unable to explain the difference in the resident's statement to the surveyor that 2 nurse aides had boosted him, and that he denied 4 staff members had assisted in the repositioning as noted in the employee statements. The DON also acknowledged that the witness statement completed by Employee 2 Licensed Practical Nurse (LPN), did not clearly state the employee's participation in the repositioning of the resident. She further acknowledged that none of the witness statements obtained, nor the facility investigation had accurately represented the incident and the facility did not act on those discrepancies to identify the root cause of the incident. During a follow up interview with the DON on July 25, 2024, at approximately 10:45 AM, she was unable to provide documented evidence of how Resident 32 was boosted (if a draw sheet was used, bedding, under pads - chucks, or additional equipment), and or why Resident 32 required the staff's assistance when the resident is care planned for the use of enablers to increase bed mobility safety and independence. There was no evidence that the facility had identified the factual and accurate representation of the events surrounding Resident 32's head injury, causing him immediate pain, bump, and headache, necessitating hospital transfer. There was no evidence at the time of the survey that the facility demonstrated an effective QAPI program to include outcomes of quality of care and quality of life by investigating the incident and thorough documentation to support their analysis of the data collected and any corrective actions developed and implemented. A review of the clinical record revealed that Resident 148 was admitted to the facility on [DATE], with diagnoses which osteomyelitis (infection of the bone) of the left ankle and foot and anxiety. A physician order dated July 15, 2024, noted an order to monitor right subclavian CVC tunnel catheter [long thin tube that is placed under the skin into a vein (insertion site) and then tunneled and brought out the chest allowing long-term access to the larger veins near the heart and is used for long-term intravenous antibiotics, nutrition, or medication, and for blood draws] every shift. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order dated July 15, 2024, noted an order for Daptomycin (an antibiotic) 750 mg intravenously once daily for osteomyelitis for 23 days. Normal saline flush intravenous solution 0.9% 10 ml intravenously before and after intravenous antibiotic administration. A review of Resident 148's July 15 through July 20, 2024, Treatment Administration Record revealed that on July 19, 2024, there was no indication the resident's catheter site was monitored as per physician order. On July 20, 2024, employee 14 (LPN) signed off on the day shift that the resident's tunnel catheter was intact. A review of Resident 148's July Medication Administration Record revealed that on July 18, 2024, at 9:00 AM the resident's Daptomycin 750 mg intravenously was administered by employee 15 (LPN). Review of a nursing note dated July 20, 2024, by a registered nurse noted that the resident's right subclavian CVC tunnel flushed, noting fluid into dressing around site, flush stopped immediately, dressing reinforced, no bleeding, or other issues noted, no redness at site, MD aware. Call placed to hospital IR (interventional radiology), requesting for right subclavian CVC tunnel insertion change, awaiting return call. A nursing note dated July 20, 2024, at 11:43 AM noted hospital IR physician returned call and stated that unable to change or do anything until Monday July 22, 2024. An order to put in a peripheral line until able to change out and the subclavian line will be fine to stay in until change. Resident updated and does not want any staff to put peripheral line in, requests emergency room evaluation. Physician made aware. Resident sent to emergency room . A nurses note dated July 20, 2024, at 3:56 PM noted a call from the emergency room that the resident to return to facility today and had a peripheral line (PICC) placed and is to be used until seen by hospital IR on Monday (July 22, 2024). The emergency room did administer the IV antibiotic dose for July 20, 2024. A nurses note dated July 20, 2024, at 4:59 PM noted the resident returned to the facility with right antecubital (area between arm and forearm) peripheral line noted. Review of emergency room paperwork dated July 20, 2024, indicated that the resident stated that the staff at the facility were attempting to redress his PICC line noted to his right chest wall. While doing so the resident stated that the staff used scissors to help remove the dressing and they nicked the catheter causing it to leak. The nurse at the emergency room did undress the catheter site and did note a small linear laceration to the catheter causing the catheter to leak at that site. Further review of the clinical record failed to provide documented evidence that the facility investigated the adverse event first reported on July 20, 2024, in which the resident's right subclavian CVC tunnel was flushed, noting fluid into dressing around site, and the flush was stopped immediately, dressing reinforced, no bleeding, or other issues noted, no redness at site, and MD aware. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the administrator on July 24, 2024, at approximately 2:15 PM failed to provide documented evidence that the facility initiated an investigation into the adverse event which resulted in the resident's transfer to the emergency room to determine the root cause of the laceration to the resident's subclavian CVC tunnel catheter and Resident 148's allegation that his subclavian CVC tunnel catheter was nicked by nursing staff and the emergency room documentation that a small linear laceration was noted to the catheter which caused the catheter to leak at the site. There was no evidence at the time of the survey that the facility demonstrated an effective QAPI program to include outcomes of quality of care and quality of life by investigating the adverse event and thorough documentation to support their analysis of the data collected and any corrective actions developed and implemented. Refer F694 28 Pa. Code 201.18 (b)(1)(3)(e)(1)(4) Management 28 Pa. Code 211.12 (c) Nursing Services

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 26142 Based on review of facility QA documents and staff interviews, it was determined that the facility failed to ensure that the Medical Director or designee was in attendance at quarterly Quality Assurance Process Improvement (QAPI) Committee meetings for two of four quarters (January 2024 through July 2024) Findings include: A review of QAPI Committee monthly meeting sign-in sheets for the period of January 2024 through July 2024, revealed that the Medical Director or other physician was not in attendance, virtually or in-person, at the QA meetings held from March 2024 through July 2024, missing 5 monthly meetings (March 2024 through July 2024). Interview with the administrator on July 26, 2024, at 12:00 PM confirmed that the a physician failed to attend the facility's QAPI meetings on a quarterly basis. 28 Pa. Code 211.2 (d)(5) Medical Director 28 Pa. Code 201.18 (e)(1)(3)(4) Management.

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	395929	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeview Healthcare & Rehab Center	200 Pennsylvania Avenue Shenandoah, PA 17976

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of clinical records, CDC infection control guidance, facility's infection control policy and COVID-19 testing logs, and staff interview it was determined that the facility failed to promptly implement infection control practices for cohorting like respiratory infections and testing for COVID-19 to prevent the spread of COVID-19 infections in the facility placing at least four residents (Residents 61, 73, 63 and 77) at increased risk for contracting COVID and failed to implement effective interventions to prevent the spread of COVID-19 virus. Findings include: A review of the Pennsylvania Department of Health 2023-PAHAN-694-5-11-2023 update: Interim Infection Prevention and Control Recommendations for COVID-19 in healthcare settings dated May 11, 2023, revealed, this HAN provides comprehensive information regarding infection prevention and control for COVID-19 in healthcare settings based on changes made by the Centers for Disease Control and Prevention (CDC) on May 8, 2023. A review of a facility policy for COVID-19 infection control practices reviewed by the facility May 11, 2023 revealed It is the policy of the facility to follow infection control practices recommended by the Centers for Disease Control and Prevention (CDC) to prevent transmission of SARS-CoV-2 infection (COVID-19). Procedure to include: -Perform SARS-CoV-2 viral testing: Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test as soon as possible. Asymptomatic patients with close contact with someone with SARS 0 CoV-2 infection, regardless of vaccination status, should have a series of three viral tests for SARS CoV-2 infection. If the date of discrete exposure is known, testing is recommended immediately and if negative, again 48 hours after the second negative test. This will typically be on day 1(where exposure is day 0), day 3, and day 5. Isolation of residents: Isolation in long term care facilities residents include the use of standard and transmission-based precautions for COVID-19, and private room with a private bathroom or with another resident with laboratory confirmed COVID-19, preferably in a COVID-19 care unit and restrict the resident to their room with the door closed. In some circumstances, keeping the door closed may pose resident safety risks and the door might need to be open. If the doors remain open, work with facility engineers to implement strategies to minimize air flow into the hallway. Only patients with the same respiratory pathogen should be housed in the same room. The following COVID-19 positive residents remained in their rooms with their roommates who had tested negative for COVID: Residents testing positive on July 16, 2024, and at the time of the survey beginning on July 23, 2024, continued to reside with roommates who were COVID negative: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident 67, COVID positive, cohorted with Resident 61, COVID negative, in room [ROOM NUMBER] bed 1 and 2-D unit Resident 79, COVID positive, cohorted with Resident 73 COVID negative, in room [ROOM NUMBER] bed 1 and 2-D unit Residents testing positive on July 20, 2024, and at the time of the survey beginning on July 23, 2024, continued to reside with roommates who were COVID negative: Resident 59, COVID positive, cohorted with Resident 63, COVID negative, in room [ROOM NUMBER] bed 1 and 2-D unit Residents testing positive on July 21, 2024, and at the time of the survey beginning on July 23, 2024, continued to reside with roommates who were COVID negative: Resident 60, COVID positive, cohorted with Resident 77 COVID negative, in room [ROOM NUMBER] bed 1 and 2-D unit Testing logs were requested at the time of the survey ending July 26, 2024, to which the facility provided multiple sheets of paper entitled Report of COVID-19 POC testing dated between July 16, 2024, and July 22, 2024. It could not be determined that all staff working on the affected third floor were COVID-19 tested as per CDC guidelines and facility policy. Testing logs for residents on the third floor were not available at the time of the survey ending July 26, 2024, and it could not be determined if any additional facility staff were tested at the time of the survey. The following staff members tested positive at the time of the survey: - One staff member tested positive on July 23, 2024 - two staff member tested positive on July 24, 2024 - one staff member tested positive on July 25, 2024 The facility infection control logs did not identify any signs or symptoms displayed by any of the residents or staff. At the time of the survey, there was no documentation of any contact tracing for residents or staff. There was no evidence at the time of the survey that the facility followed their COVID policy and CDC guidance for COVID testing, contract tracing and cohorting residents positive or potentially positive for COVID-19 virus. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation July 26, 2024 at 1:35 P.M., Resident 67 (tested COVID-19 positive) was observed to leave his room with a surgical mask hanging off his ear. He walked down the hallway to the nurses station without the mask properly donned. At the nurses station the nurse advised him to wear the mask properly and asked him if he wanted to go back to his room. He then turned around and returned to his room. There were multiple residents and staff in the hallway at this time. Staff had surgical masks on, however, the residents in the hallway were not wearing masks. An observation July 26, 2024 at 10:30 A.M., Resident 41, a cognitively intact resident, exited room [ROOM NUMBER], ambulated in the hallway without a mask and entered room [ROOM NUMBER], in which a currently COVID-19 positive resident resided, and picked up resident belongings, left the room and ambulated back to room [ROOM NUMBER]. Resident 41 then repeated this trip, a second time, at at which time, facility staff, redirected him not to enter a COVID positive room. An observation July 26, 2024 at 10:45 AM revealed 13 residents were seated in the third floor dining/activity room. Not all residents were wearing surgical masks. Residents were interacting with each other. Communal dining for breakfast that morning was conducted in the dining room. During an interview July 26, 2024 at 11:30, the facility's Infection Preventionist confirmed that facility staff were instructed to close the third floor dining/activity room to limit the spread of the COVID-19 virus, but staff failed to follow the guidelines to mitigate the spread of the respiratory virus. During an interview July 26, 2024, at 9 AM, the Nursing Home Administrator confirmed that the facility did not move any of the COVID-19 positive residents, or their COVID negative roommates, on the third floor unit because cohorting COVID positive residents was no longer required. She stated that when the initial staff member tested positive on July 16, 2024, the facility Infection Preventionist and the Director of Nursing were both on vacation. She stated that a second nurse employed at the facility had the infection control Preventionist certification. The NHA stated that she is not medical professional and does not have the Infection Preventionist credentials and she made made the decision not to cohort COVID-19 positive residents together. She stated that she previously worked for a different facility/corporation that did not cohort or move any COVID-19 positive (with positive) residents so she made the decision not to move any residents with this COVID-19 outbreak in the facility. 28 Pa Code 211.12 (c)(d)(1)(5) Nursing services 28 Pa. Code 211.10 (a)(c) Resident care policies

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 48276 Based on staff interviews and a review of employee personnel records, it was determined that the facility failed to provide abuse prevention training to one employee out of five reviewed (Employee 13). Findings include: During an interview on July 25, 2024, at 1:35 PM, Employee 13, a contracted registered dietitian, stated that she was never trained on the facility's abuse prohibition policy prior to assuming her duties. She stated that she began working at the facility as a dietitian on May 20, 2024. There was no documentation that Employee 13 was trained on the facility's abuse prohibition policies and procedures as part of staff orientation and training on the prohibition of all forms of abuse, neglect, and exploitation prohibition. During an interview on July 26, 2024, at approximately 9:30 AM, the Nursing Home Administrator (NHA) confirmed that the facility had no written records to show that Employee 13 was trained on the facility's abuse prevention and prohibition policies or procedures. 28 Pa. Code 201.19 (7) Personnel records. 28 Pa. Code 201.20 (b) Staff development.