STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396003	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroeville Post Acute	885 MacBeth Drive Monroeville, PA 15146

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on review of facility documents, and staff interviews it was determined that the facility failed to institute corrective actions and resolve resident grievances for seven of fifteen residents (Resident R2, R3, R4, R5, R6, R7, and R8). Findings include: Review of the facility policy Filing Grievances/Complaints dated 11/1/24, indicated the administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the residents and/or representatives. The administrator will review the findings with the grievance officer to determine what corrective actions, if any, need to be taken. Review of facility grievances filed in January 2025, revealed the following: -On 1/15/24, Resident R2 had voiced a concern about not being assisted to shower and not receiving nail care. -On 1/15/24, Resident R3 had voiced a concern about not being assisted to shower. -On 1/15/24, Resident R4 had voiced a concern about not being assisted to shower. -On 1/15/24, Resident R5 had voiced a concern about not being assisted to shower. -On 1/15/24, Resident R6 had voiced a concern about not being assisted to shower. -On 1/15/24, Resident R7 had voiced a concern about not being assisted to shower. -On 1/15/24, Resident R8 had voiced a concern about not being assisted to shower. On each of the above grievances, the recommended corrective action was documented to be Staff Education. On each of the above grievances, the question, Was grievance/concern resolved? was checked Yes, and signed by the former Director of Nursing. On 2/7/25, the current Director of Nursing was asked to provide evidence of staff education related to the above grievances. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/8/25, at approximately 3:30 p.m. the current Director of Nursing confirmed the facility was unable to provide evidence that the above education occurred. During an interview on 2/10/24, at approximately 3:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to institute corrective actions and resolve resident grievances for seven of fifteen residents. 28 PA. Code:201.18(b)(2) Management. 28 PA. Code:201.29(a) Resident's Rights.

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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 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** Based on review of state laws, facility policies, clinical records, and staff interviews, it was determined that the facility failed to implement policies and procedures to report allegations of neglect for one of four residents (Resident R122). Findings include: Review of the Older Adult Protective Services Act of 11/6/87, amended by Act 1997-13, Chapter 7, Section 701, requires any employee or administrator of a facility who suspects abuse is mandated to report the abuse. All reports of abuse should be reported to the local area agency on aging and licensing agencies. Review of the facility's policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated 11/1/24, indicated the facility will investigate and report any allegations withing timeframes required by federal requirements. Review of abuse education provided to facility staff defined abuse as willful mistreatment that can be verbal, sexual, physical, or mental. The education further stated that employees of nursing homes are mandated to immediately report any suspected abuse of a recipient of care, and provided a toll-free hot, elder abuse hot line to report abuse. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2024, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of the clinical record indicated Resident R12 was originally admitted to the facility on [DATE], and readmitted on [DATE]. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 11/27/24, included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), heart failure (a progressive heart disease that affects pumping action of the heart muscles), and muscle weakness. Review of Section GG: Functional Abilities indicated Resident R12 required partial/moderate assistance for chair/bed to chair transfers, and for the ability to get on and off the toilet. Review of Section C: Cognitive Patterns indicated Resident R12 had a BIMS score of 15. Review of a change in condition note dated 1/12/25, at 3:06 p.m. indicated Resident R12 sustained a fall and a right knee x-ray was ordered. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a note in draft status dated 1/12/25, at 5:00 p.m. indicated, Resident noted on the right side of the bed s/p (status post, after) fall no injury while attempting to transfer from bed to wheelchair with sliding board. Review of a progress note dated 1/13/25, at 11:51 a.m. indicated Resident noted on right side of bed. S/P fall no injury while attempting to transfer from bed to wheelchair with sliding board. Review of a Nurse Practitioner follow-up note dated 1/14/25, at 11:56 a.m. indicated, Patient fell out of bed on 1/12- no injuries. She said she was trying to yell for staff but no one was coming and she slid out of bed on her bottom. Review of a facility provided incident report dated 1/12/25, indicated, Per progress note was being transferred with sliding board from bed to chair and slid to floor. No injury noted. Review of a facility provided Rehab - Status Post-Fall Screen dated 1/13/25, indicated, Per patient, she was attempting to get OOB (out of bed) into her wheelchair and did not use the slideboard. She reports that she had her call bell on and when no one came in for an extended period of time, she attempted to complete the transfer herself. She reports she slid to the floor. Review of facility submitted events to the state survey agency failed to include the report of an allegation of neglect. During an interview on 2/13/23, at approximately 2:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that facility failed to implement policies and procedures to report allegations of neglect for one of four residents. 28 Pa. Code 201.14(a)(c)(e) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.18(e)(1) Management.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to implement policies and procedures to investigate possible abuse and/or neglect for two of four residents. Findings include: Review of the facility policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated 11/1/24, indicated residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Review of the Resident Assessment Instrument 3.0 User's Manual, effective October 2024, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of the clinical record revealed that Resident R11 was originally admitted to the facility on [DATE], and readmitted on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of care needs) dated 1/2/25, included diagnoses of cerebral palsy (group of disorders that affect a person's ability to move and maintain balance and posture) and autistic disorder (a neurological and developmental disorder that affects how people interact with others, communicate, learn, and behave). Review of Section C: Cognitive Patterns revealed Resident R11's BIMS score to be 00. Review of Resident R11's plan of care for behavior management initiated 7/10/24, did not include the mention of scratching or other self-inflicted behaviors until 1/21/25. Review of Resident R11's progress notes since admission related to scratches until 1/17/25. Review of physician's order dated 11/27/24, for behavior charting to be documented on the Medication Administration Record revealed that the nurse documented that he/she monitored for behaviors, but not if any behaviors occurred, or what they were. Review of a progress note dated 1/17/25, at 11:58 p.m. indicated Resident R11 was being seen for a cough and a fall. Per nursing the patient sustained a fall earlier today and was found laying on his fall mats beside his bed. He does not have any visible injuries but the fall was unwitnessed. He does not have any red marks or bruising but does have old scratch marks to his bilateral arms. Review of nurse aide charting on behaviors failed to indicate any behaviors documented. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a police report filed by [Police Officer A] in reference to a welfare check completed on Resident R11 on 1/19/25, at 5:26 p.m. indicated that a family member of Resident R11 requested a welfare check in regards to multiple scratches to both his forearms as well as the right inside and back of his neck. Resident R11's family member stated that through yes/no questioning, Resident R11 indicated Registered Nurse (RN) Employee E14 as the alleged perpetrator. In addition, the following interview dated 1/19/25, at 6:20 p.m. was documented with Resident R11: I [Police Officer B] asked Resident R11 if he knew how he received these injuries and he responded, Yes. I pointed to family member's husband and asked Resident R11 if he caused the injuries, Resident R11 replied No. I asked Resident R11 if family member caused the injuries to which he again replied, No. I showed Resident R11 a picture of an employee who family member reported as the actor to which he replied, Yes. [Police Officer A] and I later identified the employee as RN Employee E14. RN Employee E14 reported she is the registered nurse on duty and functions as the supervisor. I informed RN Employee E14 we were investigating an allegation as to an unknown employee leaving Resident R11 reclined in his chair to teach him a lesson. Family member reported that Resident R11's roommate had informed her that he overheard staff stating they were leaving Resident R11 in a reclined position to teach him a lesson. RN Employee E14 advised that she already notified the Director of Nursing of our presence and she would relay the purpose of our visit to her as well. Review of facility submitted information dated 1/20/25, indicated the facility was notified on 1/20/25, at 3:29 p. m., by an Adult Protective Services representative on the telephone, that resident, [Resident R11], his sister made allegations of scratches on resident. Resident is known to have self-inflicted scratches due to gait instability and behaviors, on BLE (bilateral lower extremities, both lower legs). Resident BIMS of 00. Resident is independent for bed mobility, an assist of 1 for transfers, and independent for wheelchair mobility. Investigation on-going. No AP (alleged perpetrator) identified at this time. Review of a progress note dated 1/21/25, at 10:34 a.m. indicated, Resident had a head-to-toe skin assessment completed by this writer after notification by APS (Adult Protective Services) that sister, had reported scratch marks on him. Resident does have scratches scattered across his body habitus, in various stages of healing. These are not new or acute findings as evidenced by provider documentation in recent history and behavior patterns observed that include wandering, restlessness, scratching, and agitation. Review of the clinical record indicated Resident R12 was originally admitted to the facility on [DATE], and readmitted on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), heart failure (a progressive heart disease that affects pumping action of the heart muscles), and muscle weakness. Review of Section GG: Functional Abilities indicated Resident R12 required partial/moderate assistance for chair/bed to chair transfers, and for the ability to get on and off the toilet. Review of Section C: Cognitive Patterns indicated Resident R12 had a BIMS score of 15. Review of a change in condition note dated 1/12/25, at 3:06 p.m. indicated Resident R12 sustained a fall and a right knee x-ray was ordered. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a note in draft status dated 1/12/25, at 5:00 p.m. indicated, Resident noted on the right side of the bed s/p (status post, after) fall no injury while attempting to transfer from bed to wheelchair with sliding board. Review of a progress note dated 1/13/25, at 11:51 a.m. indicated Resident noted on right side of bed. S/P fall no injury while attempting to transfer from bed to wheelchair with sliding board. Review of a Nurse Practitioner follow-up note dated 1/14/25, at 11:56 a.m. indicated, Patient fell out of bed on 1/12- no injuries. She said she was trying to yell for staff but no one was coming and she slid out of bed on her bottom. Review of a facility provided incident report dated 1/12/25, indicated, Per progress note was being transferred with sliding board from bed to chair and slid to floor. No injury noted. Review of a facility provided Rehab - Status Post-Fall Screen dated 1/13/25, indicated, Per patient, she was attempting to get OOB (out of bed) into her wheelchair and did not use the slideboard. She reports that she had her call bell on and when no one came in for an extended period of time, she attempted to complete the transfer herself. She reports she slid to the floor. During an interview on 2/13/24, at approximately 2:00 p.m. the Nursing Home Administrator (NHA) and the Director of Nursing (DON) confirmed that Resident R11 had no mention of self-inflicted behaviors prior to the incident above, and confirmed that an alleged perpetrator was identified, but an investigation was not completed to rule out possible abuse. The NHA and the DON further confirmed that Resident R12 had made an allegation of neglect when she stated that she attempted to self-transfer after no response to her call light, that the progress notes and the incidents reports / Post-Fall Screen did not coincide, but no further investigation was completed to rule out neglect. 28 Pa Code: 201.14(a)(c)(e) Responsibility of licensee 28 Pa Code: 201.18 (b)(1)(e)(1) Management

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, observations, and resident and staff interviews it was determined that the facility failed to provide necessary services to maintain grooming and personal hygiene for nine of 16 residents (Residents R2, R3, R4, R5, R6, R7, R8, R20, and R23). Findings include: Review of the Resident Assessment Instrument 3.0 User's Manual, effective October 2024, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of the facility policy Supporting Activities of Daily Living (ADL) dated 11/1/24, indicated appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care) b. mobility (transfer and ambulation, including walking) c. elimination (toileting). Review of facility grievances filed in January 2025, revealed the following: -On 1/15/24, Resident R2 had voiced a concern about not being assisted to shower and not receiving nail care. -On 1/15/24, Resident R3 had voiced a concern about not being assisted to shower. -On 1/15/24, Resident R4 had voiced a concern about not being assisted to shower. -On 1/15/24, Resident R5 had voiced a concern about not being assisted to shower. -On 1/15/24, Resident R6 had voiced a concern about not being assisted to shower. -On 1/15/24, Resident R7 had voiced a concern about not being assisted to shower. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 1/24/25, included diagnoses of weakness, gait abnormalities, and history of a stroke. Review of Section C: Cognitive Patterns revealed Resident R2 to have a BIMS score of 15. During an interview and observation on 2/7/25, at approximately 1:30 p.m. Resident R2 was noted to have long, dirty fingernails. When asked, Resident R2 stated he would like assistance in cleaning and clipping his fingernails. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of multiple sclerosis (a disease that affects central nervous system) and absence of both legs above the knee. Review of Section C: Cognitive Patterns revealed Resident R3 to have a BIMS score of 15. Review of Resident R3 ' s shower record for 1/9/25, through 2/7/25, revealed Resident R3 was scheduled to receive showers on Mondays and Thursdays. Resident R3 was documented as having received four showers, with no refusals documented. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of gait abnormalities, muscle weakness, and muscle wasting. Review of Section C: Cognitive Patterns revealed Resident R4 to have a BIMS score of 14. Review of Resident R4 ' s shower record for 1/9/25, through 2/7/25, revealed Resident R4 was scheduled to receive showers on Wednesday s and Saturdays. Resident R4 was documented as having received three showers, with no refusals documented. Review of the clinical record indicated Resident R5 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), muscle wasting, and hemiplegia (paralysis on one side of the body) following a stroke. Review of Section C: Cognitive Patterns revealed Resident R5 to have a BIMS score of 15. Review of Resident R5 ' s shower record for 1/9/25, through 2/7/25, revealed Resident R5 was scheduled to receive showers on Mondays and Thursdays. Resident R5 was documented as having received two showers, with three refusals documented. During an interview on 2/7/25, at 1:36 p.m. Resident R5 stated she does not receive enough showers, and further stated that she has never refused a shower. Review of the clinical record indicated Resident R6 was originally admitted to the facility on [DATE], and readmitted on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes, glaucoma (a group of eye conditions that can cause blindness), and muscle weakness. Review of Section C: Cognitive Patterns revealed Resident R6 to have a BIMS score of 15. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R6 ' s shower record for 1/9/25, through 2/7/25, revealed Resident R6 was scheduled to receive showers on Wednesday s and Saturdays. Resident R6 was documented as having received one shower, with one refusal documented. Review of the clinical record indicated Resident R7 was originally admitted to the facility on [DATE], and readmitted on [DATE]. Review of the MDS dated [DATE], included diagnoses of morbid obesity (chronic disease in which a person has a body mass index (BMI) of 40 or higher or a BMI of 35 or higher and is experiencing obesity-related health conditions), muscle weakness, and hemiplegia following a stroke. Review of Section C: Cognitive Patterns revealed Resident R7 to have a BIMS score of 9. Review of Resident R7 ' s shower record for 1/9/25, through 2/7/25, revealed Resident R7 was scheduled to receive showers on Tuesdays and Fridays. Resident R7 was documented as having received two showers, with one refusal documented. Review of the clinical record indicated Resident R8 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses dementia (a group of symptoms that affects memory, thinking and interferes with daily life), osteoporosis (condition when the bones become brittle and fragile), and muscle weakness. Section H: Bladder and Bowel indicated Resident R8 is frequently incontinent of both bladder and bowel. Review of Resident R8 ' s task care record for 2/7/25, indicated Resident R8 was incontinent of bladder, documented at 7:47 a.m. and incontinent of bowel, documented at 7:52 a.m. No further bladder or bowel movements were documented until 2/7/25, at 10:59 p.m. During an observation on 2/7/25, at 1:39 p.m. a soiled brief was observed on the floor by the door to Resident R8 ' s room. During an interview on 2/7/25, at 1:41 p.m. Registered Nurse (RN) Employee E16 confirmed the presence of the soiled brief on the floor of Resident R8 ' s room. During an observation on 2/7/25, at 2:05 p.m. the call light for Resident R20 and R23 ' s room was noted to be illuminated. An environmental service worker was observed passing the room, without entering. Licensed Practical Nurse (LPN) Employee E17 was observed entering the room next to Resident R20 and R23 ' s room. During an observation on 2/7/25, at 2:12 p.m. three staff members were observed at the nurses ' station (RN Employee E18 charting, RN Employee E4 working at a computer, and Nurse Aide Employee E19 using her personal phone). During an observation on 2/7/25, LPN Employee E17 was observed responding to Resident R20 and R23 ' s room. The three staff members at the nurses ' station were still engaged in their same activity. During an interview on 2/13/25, at approximately 2:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to institute corrective actions and resolve resident grievances for seven of fifteen residents. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 PA. Code:201.18(b)(2) Management. 28 PA. Code:201.29(a) Resident's Rights.

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F 0689 Level of Harm - 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** Based on review of facility policies and facility provided documents, clinical record review, and staff interview, it was determined that the facility failed to provide adequate supervision to prevent falls that resulted in the actual harm of a facial laceration requiring two sutures for one of three residents (Resident R1). Findings include: Review of the facility policy, Supporting Activities of Daily Living (ADL) dated 11/1/24, indicated Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs) . Review of the American Congress of Rehabilitation Medicine - Caregiver Guide and Instructions for Safe Bed Mobility published 4/28/17, indicated bed mobility refers to activities such as scooting in bed, rolling, side-lying to sitting, and sitting to lying down. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 12/29/24, included diagnoses of morbid obesity (chronic disease in which a person has a body mass index (BMI) of 40 or higher or a BMI of 35 or higher and is experiencing obesity-related health conditions), muscle weakness, and osteoarthritis (degeneration of the joint causing pain and stiffness). Review of Section GG - Functional Abilities indicated that Resident R1 was dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) for rolling left and right. Review of Resident R1's physicians' orders did not reveal an order specifying an assistance level for bed mobility. Review of Resident R1's MDS assessment history revealed the following: 09/03/21: Assist 2 people for bed mobility. 11/10/21: Assist 2 people for bed mobility. 02/01/22: Assist 2 people for bed mobility. 05/02/22: Assist 2 people for bed mobility. 08/10/22: Assist 2 people for bed mobility, using extensive assist. 11/08/22: Assist 2 people for bed mobility, using extensive assist. 02/02/23: Assist 2 people for bed mobility, using extensive assist. 05/10/23: Assist 2 people for bed mobility, using extensive assist. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	08/10/23: Assist 2 people for bed mobility, using extensive assist. 11/02/23: Assist 2 people for bed mobility, using extensive assist. 02/15/24: Assist: 2 people for bed mobility. using a sit to stand. 07/17/24: Assist: 2 people for bed mobility. using a sit to stand. 10/15/24: Assist: 2 people for bed mobility. using a sit to stand. 12/09/24: Assist: 2 people for bed mobility. using a sit to stand. Review of Resident R1's [NAME] (document that outlines the patients' ADLs, continence levels, and behaviors, as well as physician, advanced directives, diet, and allergies) as of 2/3/25, indicated Resident R1 was ADL Assist:1- 2 people for bed mobility; 2 while using a sit to stand. During an electronic communication on 2/11/25, at 3:49 p.m. the Director of Nursing confirmed that wording sit to stand would be while using a lift for transfers, not for bed mobility. Review of a Physical Therapy Discharge Summary dated 1/7/25, indicated that for Rolling Resident R1 is maximum assistance. Review of a progress note written by Unit Manager Employee E1 dated 2/4/25, at 12:28 p.m. indicated, Upon entering the room resident was observed laying face down on right side of bed. Resident noted to have a laceration to left eyebrow area. Blood noted on her face and hair. Resident C/O (complained of) headache. Did not voice visual changes, or nausea. Able to move upper and lower extremities. CRNP (Certified Registered Nurse Practitioner) into assess resident and gave orders to send to [hospital] for evaluation and treatment. Review of a CRNP note dated 2/4/25, at 1:16 p.m. indicated, [Resident R1] is being seen emergently following a fall out of bed onto the floor. On exam she is laying on her back on the floor. she has a head laceration to her left eyebrow that is bleeding significantly. she has large amounts of blood in her hair but do not see a visible laceration. she does endorse neck pain on palpation. Per her report and nursing report at bedside she was receiving care and was rolled out of bed. She states that she did try to brace herself with her hands but didn't do a good job and hit her head off the floor. She denies any hand, wrist, back, hip or knee pain. Review of a progress note dated 2/4/25, at 7:11 p.m. indicated, resident returned from [hospital] with stated closed head injury with facial laceration. Review of a CRNP note dated 2/5/25, at 9:32 a.m. indicated, [Resident R1] evaluated today for a mechanical fall that occurred yesterday. The fall did result in injury. Pt (patient) sustained a laceration to her L (left) eyebrow. Bleeding was large in amount, pt was sent to [hospital] where she received wound cleanse and 2 sutures to the area. Imaging results not immediately available for review, however, pt verbalizes that her imaging was unremarkable. The pt states that she was leaning her head on her bedside table, but was stuck between the stable and another furniture object (?). A staff member came to help her get unstuck, but the table was pulled from underneath her, and she fell, hitting the left side of her body. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of emergency room discharge paperwork dated 2/4/25, revealed Resident R1 was treated for a left eyebrow laceration that was repaired with sutures, and evaluated for a closed head injury, left knee pain, and left ankle pain. Review of facility submitted information dated 2/5/25, indicated, [Resident R1] was being washed by CNA (nurse aide) when she rolled out of bed and received a small laceration to her forehead. Resident was an assist of 1 for bed mobility and was receiving care per her care plan/orders. No suspected abuse. Resident was assessed by the RN and the CRNP and was sent to the ER for further precautionary eval. MD (doctor of medicine) and family were aware. Resident received 2 sutures, and all of the scans were negative for any further findings. Resident has since returned to facility and has been re-evaluated by the care plan team. resident is now an assist of 2 in bed during care to assist in prevention of future incidents. Review of an employee statement written by Nurse aide (NA) Employee E8 dated 2/4/25, indicated, I [NA Employee] was doing care on [Resident R1]. Her bed was waist level and she was a full bed change. I rolled her to the right and told her to hold on to the headboard. She said that other people told her not to do that. I told her to do it so she wouldn ' t't roll out of bed. I tried to catch her but it happened too fast. I saw blood coming from her head so I ran and got the nurse. During an interview on 2/8/25, at approximately 3:30 p.m. the Director of Nursing confirmed that the nurse aide requested Resident R1 to grasp the headboard to assist in maintaining her position in bed, which indicated the expectation of Resident R1 being able to assist in her care, contrary to her MDS level of Dependent. During interviews completed on 2/8/25, to confirm staff understood how to review bed mobility status, revealed the following: NA Employee E9 stated to review the [NAME]. NA Employee E10 stated to review the computer. NA Employee E11 stated to review the [NAME]. RN Employee E12 stated to review the [NAME]. RN Employee E13 stated she was familiar with her residents. Licensed Practical Nurse Employee E3 was not able to describe a process. During an interview on 2/8/25, at approximately 3:00 p.m. the Director of Nursing confirmed the facility failed to provide adequate supervision to prevent falls that resulted in the actual harm of a facial laceration requiring two sutures for one of three residents. 28 Pa. Code: 201.14(a) Responsibility of licensee 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 PA. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical record, and staff and family interviews, it was determined that the facility failed to provide medically-related social services related to a resident transfer for one of three residents (Resident R11). Findings include: Review of the Resident Assessment Instrument 3.0 User's Manual, effective October 2024, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of the facility policy, Social Services dated 11/1/24, indicated the facility provides medically-related social services to assure each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well-being. The social worker / social services staff are responsible for helping residents with transitions of care services (for example, community placement options, home care services, transfer arrangements, etc.). Review of the clinical record revealed that Resident R11 was originally admitted to the facility on [DATE], and readmitted on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of care needs) dated 1/2/25, included diagnoses of cerebral palsy (group of disorders that affect a person's ability to move and maintain balance and posture), autistic disorder (a neurological and developmental disorder that affects how people interact with others, communicate, learn, and behave), and a seizure disorder. Review of Section C: Cognitive Patterns revealed Resident R11's BIMS score to be 00. Review of Resident R11's plan of care for Discharge/Transfer Preference initiated on 1/7/25, indicated that Resident R11's responsible party / family member indicated a preference to discharge to an assisted living facility. During an interview on 2/7/25, at 9:32 a.m. Social Services (SS) Employee E15 confirmed that the first set of documents were completed by the physician on 11/1/24, and sent to the assisted living facility on 11/6/24. Review of facility provided documentation dated 11/1/24, revealed the following: (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Annual Physical Examination was missing documentation in the following sections: the date of birth , age, exam date, address, allergies to medications, height, weight, pulse, respirations, blood pressure, medications and treatments, visual screening, hearing screening, review of previous medical history, recommended diet, medical information pertinent to diagnosis and treatment in case of emergency, whether a walker or helmet was required, reason why the prostate exam was not completed, date of last diphtheria/tetanus (DTaP) vaccination, date of last Mantoux (tuberculosis screening test), the Seizure Procedure Verification Form indicated No Seizures, the audiometric (hearing) examination form was blank, the Abnormal Involuntary Movement Scale (AIMS) evaluation form was blank, the Vision and Eye Health Evaluation form was blank, the Dental Exam form was blank, and the Verification of Disability form was blank and unsigned. Review of information submitted by Resident R11's Autism Advocate dated 1/6/25, stated [Resident R11] client with autism and other developmental and mental health disabilities. The [ALF] has had a bed available in a community residential group home ready for him since about the end of October, 2024. Here we are two months later with simple paperwork left undone despite advocacy by family, supports coordination, Autism Connection of PA, and ALF. Here is a list of what remains outstanding which I received today from [Resident R11's] supports coordinator. I visited [Resident R11] to have him read and sign a release of his health records to his sister specifically so she could assure things were completed correctly. Every day [Resident R11] is kept in this inappropriate institutional setting harms his mental health. Please help [Resident R11] and his team correctly execute this simple paperwork and evaluation issues so he can access a least restrictive, community-based and age appropriate setting as soon as possible. During an interview on 2/12/25, at 12:15 p.m. the Vice-President of Corporate Compliance for the Assisted Living Facility (ALF) stated that an open bed became available for Resident R11 in October of 2024, and the resident/family accepted the vacancy on 10/22/24. A preadmission packet was provided to the facility on [DATE]. Per the ALF, no additional information was received from the facility until 12/20/24, at which time 10 of the required items were provided to the ALF. Additionally, one item was provided on 1/6/25, one on 1/8/25, three on 1/13/25, two corrected items received on 1/15/25, and two corrected items on 1/22/25, which allowed the Resident R11 to transfer to the facility on 1/23/25. During an interview on 2/13/25, at approximately 11:00 a.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to provide medically-related social services related to a resident transfer for one of three residents. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18 (b)(1))(3)(e)(1) Management. 28 Pa. Code 201.29 (a)(j) Resident rights. 28 Pa. Code 211.2 (a) Physician services. 28 Pa. Code 211.16 (a) Social services. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to make certain that medications were properly secured in one of three two of seven medication carts (First-floor medication cart for rooms 100-117) Findings include: Review of the facility policy Security of Medication Cart dated 11/1/24, indicated medication carts must be securely locked at all times when out of the nurse ' s view. During an observation on 2/8/24, at 2:18 p.m. of the the 100-117 medication cart was observed unlocked. The surveyor remained with the medication cart. At approximately 2:22 p.m. the surveyor opened and the medication cart drawers, and observed that the narcotic drawer was not secured. The surveyor reviewed the narcotic book, and narcotic cards. At 2:30 p.m. Registered Nurse Employee E4 was requested to confirm that the medication cart and the narcotic drawer were both unsecured. During an interview on 2/11/25, at approximately 3:00 p.m., the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to make certain that medications were properly secured in one of three two of seven medication carts. 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1)(e)(1) Management. 28 Pa. Code: 211.9 (a)(1) Pharmacy services. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of facility policy, observations, clinical records, and staff interviews, it was determined that the facility failed to accurately document meal consumption for two of two residents observed. (Residents R9 and R10). Findings include: Review of the facility policy, Meals - Feeding the Resident dated 11/1/24, indicated the percentage of the diet consumed is recorded. Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 1/30/25, included diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), anemia (too little iron in the body causing fatigue), and dysphagia (difficulty swallowing). Review of Resident R9's care plan for nutritional risk due to dementia and a mechanically altered diet initiated 6/20/24, included the intervention of Monitor intake at all meals. Review of Resident R9's ADL Care Record indicated that Amount Eaten was to be documented three times per day, (9:00 a.m., 1:00 p.m., and 6:00 p.m.). Review of the clinical record indicated Resident R10 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior), and dysphagia (difficulty swallowing). Review of Resident R10's care plan for nutritional risk due to diabetes and dysphagia initiated 10/12/22, and updated 4/18/24, included the intervention of PROVIDE 1:1 (one to one) ASSISTANCE WITH MEALS. Review of Resident R10's ADL Care Record indicated that Amount Eaten was to be documented three times per day, (9:00 a.m., 1:00 p.m., and 6:00 p.m.). During an observation on 2/7/25, at approximately 1:30 p.m. Resident R9 and Resident R10 were observed in the lounge across from the nurses' station. Resident R9 was seated in her wheelchair at the entrance to the lounge. Resident R10 was seated in her wheelchair at the first table upon entering the lounge. The meal trays were observed at the table behind the first table, with the lids removed. No food had been eaten from the trays. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/7/25, at 1:51 p.m. the surveyor entered the lounge, and residents and meal trays were in the same position, no food had been removed from the trays. Licensed Practical Nurse (LPN) Employee E3 was seated in a chair in the corner of the room. The surveyor seated themselves in the lounge for observation. During an observation 2/7/25, at 1:58 p.m. LPN Employee E3 exited the lounge. During an observation on 2/7/25, at 1:59 p.m. Registered Nurse (RN) Employee E5 entered the lounge, greeted the residents, and picked up the meal trays. Review of Resident R9's Task List history indicated that on 2/7/25, at 12:24 p.m. NA Employee E6 documented Resident R9's meal consumption was 51-75%. Review of Resident R10's Task List history indicated that on 2/7/25, at 1:05 p.m. NA Employee E7 documented Resident R10's meal consumption was 51-75%. During an interview on 2/7/25, at approximately 2:30 p.m. NA Employee E7 was asked why she documented 51-75% of meal consumption when Resident R10 did not consume any of her meal, almost an hour prior to Resident R10's meal tray picked up. NA Employee E7 stated, That's how much she normally consumes when she is in my presence. Ten additional residents were reviewed that NA Employee E6 charted meal consumption for on 2/7/25, revealed the following: Resident R13, Breakfast 51-75%, Lunch 51-75%: Resident R14, Breakfast 51-75%, Lunch 51-75%: Resident R15, Breakfast 51-75%, Lunch 51-75%: Resident R16, Breakfast 51-75%, Lunch 51-75%: Resident R17, Breakfast 51-75%, Lunch 51-75%: Resident R18, Breakfast 51-75%, Lunch 51-75%: Resident R19, Breakfast 51-75%, Lunch 51-75%: Resident R2, Breakfast 51-75%, Lunch 51-75%: Resident R21, Breakfast 51-75%, Lunch 51-75%: Resident R22, Breakfast 51-75%, Lunch 76-100%: During an interview on 2/7/25 at approximately 3:00 p.m., the Director of Nursing confirmed that the facility failed to accurately document meal consumption for two of two residents observed. 28 Pa. Code: 211.5(f)(g)(h) Clinical records.